



## EDIS - Early Intervention Services Policy and Practice Questions & Answers

Supplement to MEDCOM Reg. 40-53, November 2008

*A Publication in Support of the Army EDIS Comprehensive System of Personnel Development (CSPD)*

### General

1. What is expected of an ICC? What are minimum requirements? (MEDCOM Reg. 40-53, p. 29)

*A major function of an ICC is to facilitate interagency collaboration with a focus on reducing gaps in services for children and families and decreasing service overlaps where feasible.*

*Minimally the EDIS will establish an ICC that meets at least quarterly and maintain a record of meeting agendas/minutes. ICC membership should include community agencies that interface with children and families and include 20% parent participation to the greatest extent possible. EDIS should maintain documentation of efforts to include parents as members of the ICC. While the ICC **may be** a subcommittee of another existing council, the ICC must have a separate documented purpose.*

### Referral

1. When exactly does the 45 days start?

*The 45 days starts when early intervention receives the referral. For example, if a parent calls early intervention with concerns about their child, the referral date is the day early intervention receives the phone call from the parent. If a referral is received from Well Baby Clinic (WBC), the referral date is the day early intervention receives the referral from WBC. If a mass child find screening was done by early intervention, concerns were identified during the screening, and plans were made for further evaluation (i.e., referral to EI), the referral date is the day early intervention makes plans with the parent to conduct further evaluation.*

2. What agencies are included in the definition of a referral from the “medical community?”

*Agencies included are those that are part of the Medical Treatment Facility (MTF) or other DoD medical system. This would include pediatrics, social work services, psychology. It does not include agencies on the installation side such as Army Community Services, New Parent Support Programs, Women Infants and Children, Child Development Services. If any of these agencies has a concern about a child, they should provide the EDIS contact information to the family and suggest that they seek an evaluation from EDIS.*

### Evaluation

1. What constitutes a hearing screening/evaluation?

*There is no requirement for a formal hearing evaluation by an audiologist unless there are obvious indications for such an evaluation based on a **functional hearing screening**. Any early intervention provider (skilled and comfortable to recognize and refer for any hearing related concerns) can complete a functional hearing screening. Functional hearing screening is an embedded part of the IFSP process. Functional hearing & vision screening must be completed as part of each IFSP PD (initial and annual).*

2. What is done if the standardized instrument does not provide an overall language score?

*An overall communication score is needed for evaluation as part of determining eligibility. If the standardized evaluation instrument does not provide an overall communication score, another standardized instrument, which provides an overall communication score, would have to be administered as part of the evaluation. The total score (including sub-tests of expressive and receptive language) in the area of communication will determine eligibility.*

3. Do children eligible under biological risk need to have an evaluation completed prior to service delivery?

*A formal standardized evaluation (i.e., using a standardized instrument) is not necessary, but an assessment of the child's present levels of development must be included and documented on the IFSP PD. Criterion-referenced instruments may be helpful in completing this as well as professional observation, developmental milestone checklists, and parent report.*

4. Is a well-baby exam, within the last 6 months, sufficient for a medical evaluation or physical exam as required for evaluation?

*Yes, however if there are medical questions that are not answered, then the child must be referred for a physical focused on the presenting concerns.*

5. Must the physical be filed in the EDIS record?

*No, an actual copy of the physical is not needed in the EDIS record. However, the date of the physical and an EDIS generated summary of the results, which may be based upon parent report, must be included on the IFSP PD. It is ok to put a copy in the record, if it is available, but this is not required.*

6. In determining eligibility, may a referring physician be one of the two qualified examiners conducting the developmental evaluation? Or must we have two qualified examiners in addition to the referring physician? Would the answer be different if the referring physician is a Developmental Pediatrician?

*It must be two providers from the early intervention team, excluding the physician. The physician is not administering developmental assessments for eligibility. In CONUS, the team may include an EDIS provider and an external contracted service provider.*

7. Is there a way to include the write-ups of all evaluations with such limited space on the IFSP PD? If there isn't room on document, can another page be added?

*No. However, if a provider or team wants to write an extended report they may do so, but that information would not be documented on the IFSP PD. The evaluation summary should summarize the findings of the information gathered and used to assist with the determination of eligibility. The IFSP PD form may not be altered to document more information.*

8. Must programs that use the SAFER reporting form for the RBI transfer info to the MEDCOM-published form?

*Early intervention teams may choose to use alternate methods to document the RBI, however that information should be attached to the MEDCOM published form and filed in the protocol section of the EDIS record. This documentation must include the child/family's name, the date of the RBI, and the providers conducting the RBI.*

9. At annual re-evaluation, must a standardized instrument be used or can we use a criterion-referenced measure to update the child's developmental levels?

*If there are questions about the child's continued eligibility status, then standardized instrument(s) assessing all 5 areas must be used. If there is a high degree of certainty that the child's eligibility status will remain the same, and information gathered from standardized instrument(s) will not be value added, then standardized instruments to assess all 5 areas of development are not required. However, developmental levels must be determined.*

10. Is it necessary to ensure that a physical be completed as part of the annual re-evaluation?

*At annual re-evaluation a review of the child's medical history must occur (based on parent report, if medical records [AHLTA] are not available). If the child has not received a medical evaluation or physical exam within the last 6 months, then EDIS should request that the family make an appointment for the child to have a physical exam as part of the re-evaluation. Re-evaluation is a comprehensive evaluation and must include all 5 areas, as well as the child's vision, hearing and health status. However, waiting for a physical exam should not hold up the process.*

## Eligibility

1. Can eligibility be based on clinical judgment? (MEDCOM Reg. 40-53, p. 18)

*Yes, **informed opinion** can be used as the basis for determining eligibility. **Informed opinion** is the correct terminology (over informed clinical opinion or clinical judgment) because both parents and professionals contribute information needed in the decision-making process.*

*Informed opinion as a basis for determining eligibility under developmental delay should be used **only** when:*

- Team members believe that the child's performance on standardized measures is at odds with their own ongoing observations and judgments about the child.*
- The child's capabilities are demonstrated at extreme low frequencies and inconsistently exhibited and observed thereby affecting the child's functioning.*

*See MEDCOM Form 808 to document use of informed opinion to assist with eligibility determination.*

2. If a child, under 12 months of age and initially eligible under biological risk due to extreme prematurity, does not demonstrate delays at the required 12 months (chronological age) evaluation, do we continue to provide services?

*Prematurity is not a permanent condition and would not be the basis for continued biological risk without evidence of delay. If initial eligibility under the biological risk category was based on extreme prematurity, or prematurity complicated by additional medical concerns, and the evaluation at 12 months of age demonstrates skills that are within normal limits, services would be discontinued because the initial biological risk factor is no longer an issue. However, if the evaluation at 12 months does not indicate delays in development, but the biological risk factor is still an issue (e.g., Down syndrome, deafness, cerebral palsy etc.), then eligibility continues. Tracking is an option that might be considered to assure parents that the child continues to do well.*

3. Can a child remain eligible under biological risk until they turn three and exit from the program? (MEDCOM Reg. 40-53, p. 18)

*Yes. There are essentially two categories of eligibility, (1) developmental delay and (2) biological risk – having a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay. Biological risk is not solely reserved for infants under a certain age. For example, a child older than 6 months who has a diagnosed physical or mental condition (e.g., Down syndrome) may continue eligibility for early intervention services under the biological risk category, if the condition is shown to have a high probability of resulting in delayed development.*

4. How many EDIS early intervention providers need to be at the meeting to determine eligibility? (MEDCOM Reg. 40-53, p. 17)

*The eligibility meeting must include the initial service coordinator and at least one other professional involved with the evaluation. However, if a provider who evaluated the child cannot attend the meeting, he/she may be represented by a knowledgeable individual or a written report or even participate via phone. Whenever possible, it is considered best practice to discuss and determine eligibility immediately following the evaluation. Under such circumstances both evaluators would likely be present.*

5. If an interim IFSP is needed is the Report of Eligibility form completed before developing the interim IFSP?

*Yes, the Report of Eligibility is completed prior to development of the interim IFSP and the information is entered into SNPMIS. The report of eligibility would indicate the suspected area of delay as basis of the eligibility. If the status of eligibility changes when all the evaluations are completed then an updated certificate of eligibility form or discharge summary, as appropriate, is completed. If nothing changes then a new certificate of eligibility form is not needed.*

6. Please clarify the 1.5 SD difference between sub-tests for fine and gross motor. (MEDCOM Reg. 40-53, p. 17)

*The discrepancy represents a significant concern if the lower scored sub-domain measures at least -2.0 SD. This exception to the rule is not a means to determine eligibility for children with borderline gross and fine motor skills. In situations where the child demonstrates borderline skills, tracking is a viable option. For example, a child may be eligible if the delay is measured at -.5 SD in fine motor skills and a -2.0 SD in gross motor skills, because there is a 1.5 SD difference between the two sub-domains and one of the scores is at least -2.0 SD. However, if a child's delay measures at or above 0.0 SD in one motor sub-domain and a -1.5 SD in the other sub-domain, the child may not be determined eligible, even though there is a 1.5 SD or greater difference between the two sub-domain scores.*

7. Please clarify atypical phonological processes as they are used to make a child eligible for services. (MEDCOM Reg. 40-53, p. 18)

*Phonology refers to the rules for producing and combining sounds within a language. A phonological disorder is characterized by the inaccurate production of sounds past the age at which correct production should occur. Children over 2 years of age may be eligible for early intervention if they have fewer than 65% of their consonants correct or they use phonological processes that are abnormal or should have resolved.*

*For children in a home where **English is not the primary language**, the evaluator must be able to demonstrate that the child has a **significant delay** in communication in his/her **primary or dominant language**. An interpreter in the child's primary language shall be used in the evaluation. For those children who **do not have an appropriate interpreter** in the child's primary language, but the evaluators suspect that there is actual developmental delay, then they should use **Informed Opinion** process to determine eligibility.*

8. Is a 2 standard deviation delay or greater the only way for a child to be determined eligible based on articulation?

*No. Phonological processes could also be significantly delayed or be atypical, and therefore qualify a child for EDIS early intervention services.*

9. Would a 20% delay in articulation combined with a 20% delay in one additional domain qualify a child?

*No. Articulation is specifically addressed as a stand-alone criterion for determining EDIS early intervention eligibility for children over 2 years of age. It is not an additional domain of development in and of itself and therefore when the delay in articulation is not 2 standard deviations below the mean (e.g., 1.5 up to 2 SD below the mean) it cannot be combined with another domain that is not quite 2 standard deviations below the mean (e.g., 1.5 up to 2 SD below the mean).*

## **IFSP Services**

1. When do we start using the revised IFSP-PD?

*Upon publication of the MEDCOM Regulation 40-53 (18 Aug 08). However, teams may want to wait until they receive training and/or the revised IFSP handbook.*

2. What is the correct way to write an outcome? We have had several different suggestions and would like to know how all programs in EDIS should be writing them.

*It is well known that there are different "schools" of writing outcomes that vary in style and detail. In EDIS the outcome and criteria are entered separate, therefore the specific data required to determine if the outcome is achieved is documented under the criteria section of the IFSP outcome page. With that said, the outcome statements must answer the following three questions:*

- a) What would the family like to see happen (e.g., child will...by...; parents will...)?*
- b) Where, when, &/or with whom should it occur?*
- c) What will be better (e.g., so that, in order to, to, will participate in...)?*

3. How specific does the criteria for the outcomes need to be?

*The documented criteria statements should answer the following three questions.*

- a) Can it (i.e., behavior, skill, event) be observed (seen or heard)?*
- b) Where or with whom will it occur(context)?*
- c) When or how often will it occur (conditions - by frequency, duration, date, distance, measure)?*

*This is the criteria that will be reviewed to determine if the outcome has been achieved. This is no longer the measure of progress toward the outcome. Rather it is a measure of achievement of the outcome.*

4. How should the documentation of the addition of assistive technology devices to a child's program be handled?

*If in the writing of the IFSP the team decides to use or consider use of assistive technology devices to assist with achievement of an IFSP outcome, these should be referenced under section 11 of the IFSP "assistive technology." If the assistive technology is added after the IFSP is in effect, then a Review/Change form must be completed, with a statement that the assistive technology was added.*

5. What are some examples of low-tech devices?

*Low-tech devices include low cost adaptations that make it easier for the child to do something that would otherwise be difficult or impossible. Low-tech devices include things such as handles attached to toys or utensils making it easier for the child to grasp without help; pillows and bolsters that make it easier for the child sit or engage in activities; and pictures that children can use to communicate.*

6. What should we document as support services under both support services sections of the IFSP-PD?

*Section 12 of the IFSP includes two sub-sections. These are, "... support services EDIS will provide..." and "...services the family needs or receives from other agencies..."*

The first sub-section would include EDIS funded support services (i.e., CDC placement). However, any CDC placement must comply with the following criteria:

- 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 it must 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 delivery of 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.*

*The second sub-section would include an endless array of family needs and services where the EDIS role would primarily fall within the area of Service Coordination. It includes services outside EDIS that you facilitate the family's access to (but not paid by EDIS), such as helping to find a day care source for a working parent that can handle the child's disability, including training of the day care provider. You could assist the family with access to financial counseling, marital counseling, grief counseling, respite care, or English-as-a-second-language classes. The family might need support with learning how to gather information about a child's diagnosis or prognosis for the future, or many other issues relevant to the child's diagnosis or future needs. The family might need support or advocacy with getting their living quarters handicap accessible, and the list goes on.*

7. On the service provider page, do the outcomes have to be numbered "1, 2, 3, 4, 5," or "1-5" or can we use "all?"

*It is best to be specific when identifying the outcomes associated with a service. So 1, 2, 3, 4, 5 or 1-5 is much better than saying "all." Documenting "all" could also get confusing if/when new outcomes are added to an existing IFSP.*

8. If consultation is provided, should EDIS provide justification for the service being provided in EDIS?

*The definition of consultation in IFSP service delivery is “the formal exchange of information between two or more providers in support of the family, but not with the direct involvement of the family or caregiver” (MEDCOM Reg. 40-53, p. 108). Most often, such consultation will take place within the EDIS program, which does not go against service delivery in natural environments, because it does not directly involve the child, family, or caregivers. Accordingly, specific justification for consultation service delivery in EDIS is not required.*

9. If the physical therapist (for example) is providing services, which are really special instruction services, does she list “special instruction” as the service and “physical therapist” as the service provider on the service provision page of the IFSP?

*The physical therapist lists **PHYSICAL THERAPY** as the service and physical therapist as the service provider. The provider lists the service associated with their discipline and references the outcomes those services are linked to. Physical therapy services encompass an educational component, as do all the different types of services provided in early intervention.*

10. If the OT is the primary service provider, but she is working on language stimulation activities as well, how does she indicate services on the service provision page of the IFSP?

*The service is listed as OT, the provider is the OT, and the outcomes that she is working on are indicated in the "outcome" box on the service page.*

11. Does the “Next Service Plan Date” need to be a specific date rather than “when child turns 3 or transitions?”

*The next service plan date is an actual date – it is also the date that is entered in SNPMIS as the “next service plan”. If a child is turning three the next service plan date may be projected beyond the child’s third birthday depending on the particular circumstances (e.g., the child turning three during summer months). The next service plan date can never extend beyond 12 months from the current IFSP.*

12. What date do we put in for the full IFSP date on the front page of the IFSP PD?

*Enter the date the IFSP is developed. This is the same date entered on section 14 of the IFSP PD “Date IFSP Developed.”*

13. At what point in the process is a Review/Change Process page needed? Please give examples.

*Minimally, the IFSP must be formally reviewed with this documentation on the MEDCOM Review/Change Form at least every 6-months from the date the initial or annual IFSP is written, or more frequently if conditions warrant, or if the family requests such a review. If a review occurs prior to the required 6 month review, then another review may be needed 6 months later to ensure that reviews occur at least every 6 months. For example, if an IFSP developed in January is reviewed in March then it must be reviewed again in September (i.e., 6 months from March) rather than waiting 9 months when the annual review must occur. The IFSP outcomes should be constantly reviewed (informally) as part of ongoing intervention; this is different from a formal review of the entire IFSP. If during the course of intervention a change is needed (i.e., adding a new outcome, making a change to services...) this should be documented on the MEDCOM Review/Change Form. Changes or modifications made to strategies do not require documentation on the Review/Change form.*

14. If during an IFSP review the family and family service coordinator identify a need to change services, can those changes be made without the involvement of other team members?

*No. Any change in services will be determined by a team, including the parent, the service coordinator, and any other service provider who delivers services to the family and has information relevant to the proposed change. If the additional persons are unable to attend a meeting, make arrangements for the person's involvement through other means, including the following: participating in a telephone conference call, having a knowledgeable representative attend the meeting; and making pertinent records available at the meeting. Changes in a service should never take place without that service provider's input (e.g., the family and ECSE/service coordinator would not change the speech language services without input and involvement of the SLP).*

15. When do we modify an outcome instead of writing a new outcome?

*As part of outcome review, the team may choose to continue the outcome; discontinue the outcome; or modify the outcome. If the modification includes significant changes to the outcome and criteria then you would discontinue and modify the current outcome. If the modification includes a slight change to the outcome or criteria then the modification can be noted and highlighted on the IFSP change/review form.*

16. When we add or change strategies on an outcome do we need a Review/Change form?

*The Review/Change form is completed only when changing the Outcome, not when changing or modifying a Strategy to achieve an existing outcome. You would also do a Review/Change form to document the 6-month review, to add or terminate a service, or to add assistive technology to a current IFSP.*

17. Is a team decision necessary for discharge? Can a child be discharged if the outcomes on the IFSP are met?

*Yes, a team decision is required for discharging a child/family from early intervention services. The only exception is if the family decides, for whatever reason, to discontinue early intervention services. Just meeting IFSP outcomes alone does not guarantee that the child no longer meets early intervention eligibility criteria and no longer requires early intervention services. To discharge a child/family from early intervention the team must determine that the child no longer has a significant delay in development (i.e., meets EDIS eligibility criteria). To do so the team may administer another standardized evaluation or use criterion referenced instruments addressing all five domains. Alternately, if based upon ongoing assessment the child has been performing within normal limits, a screening instrument may be used in preparation for the team meeting to confirm whether the child remains within normal limits or whether there are new developmental concerns, which warrant further assessment.*

18. Where do we note unavailability of services that are written into an IFSP?

*Use the "additional information" space on the service page of the IFSP. Also remember to document the service in SNPMIS with "no provider available."*

19. In suspending services what constitutes "for extended periods of time?" When do we need to complete a Review/Change form? (MEDCOM Reg. 40-53, p. 25)

*In general, an extended period of time is 2 months. Best practice is to complete the Review/Change form documenting the need to suspend services at the earliest possible point. As soon as it is known that a family will be away, the team should make the necessary arrangements to suspend services during their absence. If a family consistently "no-shows" for an extended period the team may suspend services, but keep the IFSP active. The service coordinator/providers must document all attempts to contact the family and send a letter to the family before suspending services.*

21. How is transition documented when no transition is anticipated at the time of IFSP? Please give us more guidance about what to write for transitions.

*Teams must **always** address transition as part of every IFSP, regardless of the child's age. Transitions extend beyond the transition to preschool at the age of three and include family relocation and transition from hospital to home. In the rare event that no type of transition is anticipated, the team can write an explanation on the transition sheet about what will occur when the child leaves EDIS.*

22. What part of the IFSP goes to the school for preschool transition?

*The entire IFSP can go to the school. However, local schools do not need all the information an entire IFSP contains, and may only request portions of the IFSP. Under such circumstances EDIS need not send the entire IFSP. EDIS and the local school must outline the transition process, including the identification of the information that EDIS will share with the school. Since the EDIS program must write a discharge summary when a child leaves the program, this document might be a possible option, as long as it contains the information the schools require to assist them with determining eligibility for their special needs program. This would include recent test scores to determine eligibility for the school program, a summary of the services the child has received from EDIS, and the progress achieved through EIS.*

23. If a family discontinues services then comes back to initiate services, what paperwork needs to be completed? What if the family comes back after only one week?

*If the family returns while the IFSP is still active, accept the IFSP as an incoming DOD IFSP. If the family returns after the IFSP end date, initiate a new referral process.*

## **Rights**

1. Is it necessary to document when the parents refuse to actually take a copy of their rights?

*No. They sign that they have received a copy.*

2. What meetings require the involvement of a team (more than one EDIS provider and the family)?

*Eligibility, development of the IFSP, changes in services on the IFSP, and discharge. Providers unable to attend a meeting may be represented by a knowledgeable individual, provide input via a written report, or even participate via phone.*

3. If parents refuse early intervention services for a severely disabled child, can EDIS providers ask for mediation in order to ensure the child gets services? At what point does refusal for services constitute medical neglect?

*This is a fine line. EIS is strictly a voluntary service. EDIS does not treat life threatening conditions and refusing EIS is not medical neglect. However, if a provider suspects that the reason for the refusal may have impact on the child's physical or emotional well-being, then EDIS must report the suspicion to the appropriate report point of contact. Suspected neglect must also be referred to the appropriate local reporting point of contact. EDIS providers are mandatory reporters of any and all suspected abuse or neglect. This does not mean that EDIS must conduct any type of investigation to confirm the suspicion. Other agencies have that responsibility. EDIS must work with the appropriate community agencies if this is a concern.*