

## BABYNET PUBLIC COMMENTS

### RELATED TO PROPOSED POLICIES FOR IMPLEMENTATION OF SOUTH CAROLINA'S INFANTS AND TODDLERS EARLY INTERVENTION SYSTEM

The following comments were submitted to the BabyNet Steps State Office during the Public Comment Period (March 8, 2010 through April 5, 2010) via electronic mailbox, postal mail and public hearings. Public hearings were held on the following dates and in the following locations from 6:30-8:30 p.m.

April 1, 2010: Graniteville - Byrd Learning Center Cafeteria

April 13, 2010: Florence - Doctors Bruce and Lee Foundation Library

April 15, 2010: Beaufort - Technical College of the Lowcountry

April 16, 2010: Charleston - United Way Board Room

April 27, 2010: Columbia - Peebles Auditorium, DHEC

April 29, 2010: Anderson - Anderson County Library

April 30, 2010: Spartanburg - Spartanburg County First Steps

This is a **verbatim** account of comments submitted. All personally identifiable information, which would make the commenter known, has been removed. Although the commenter is not identified, all comments from a particular individual or entity are kept together..

The BabyNet State Office has reviewed and considered all comments and made modifications deemed necessary to the policies. These will be posted again for public comment, following review by partnering agency staff, before the policies are submitted to the U.S. Department of Education, Office of Special Education Programs (OSEP) for review and approval prior to adoption.

This is provided for informational purposes only. The comments do not necessarily represent the position of the BabyNet State Office.

I respectfully would like to comment on what was just reviewed. The model of service coordination obviously refers to DDSN; Mr. Ringer's interpretation is incorrect; have asked for feedback but did not get it. The identification of SI prior to the IFSP is incorrect. Our model is based on a survey of families who said they did not want more than one person in the home. The combined model shows better satisfaction from families. We've talked with Florida and other states, and they have a blended model, and they meet requirements from OSEP. Used to be that all families got whatever they wanted. DDSN does not get all the children, and the service is not identified prior to development of the IFSP. This is no different than conducting a PT eval prior to the development of the IFSP. This has three meetings w/the families prior the development of the initial IFSP. Why does there need to be a family training plan that is separate from the IFSP. Teaming works well in lotsa places in the state, and there are places there training is needed. I think the IFSP has what is needed, if we all work together to make it work the way it's supposed to. MCHAT for every child—we've talked to the ASD director at DDSN, who says this may not be appropriate, there's a time and a place. Elig criteria: % of delay seems to work better than the AEPS, we do not particularly care for the AEPS. % or months of delay means more to families than does a cut-off. FL model of PSP had not had complete buy-in, can't tell if it's cost effective. It's a good idea, but I just think that it needs a little bit more consideration before it's adopted is needed. SI has tried to be individualized, private therapies have a more medical perspective, and more training is needed in the Part C way, and the SC needs more teeth to be able to appropriately monitor implementation of the IFSP services. Teaming and training of the family is something with which DDSN agrees, but does not think that providers have been supported enough in this. Some places of the state really are doing well, but other places could with more training. EI provider manual with HHS does give us a little bit of an 'out' for provision of educational services underwritten by Medicaid. I don't know what the medical necessity definition is going to be, but right now it does have something in it about developmental progress or developmental standing.

For the families: is the family piece, is this so that the family can do the services themselves? Yes. Have not decided yet if this will be in the IFSP, or separate. Would be developed in the context of IFSP team meetings. The IFSP goal page includes fields for inclusion of strategies and activities. I'm not sure it's emphasized enough with parents that their child will development a lot faster if there's also activities taking place between the visits of the therapists. Also, it

really needs to be made clear to families they need to be a part of this too.

I don't think that providers will ever provide services in the Part C way unless they are hired by the lead agency.

Foster parents serving as the parent, and the surrogate parent: it's my understanding that the LA is responsible for providing training.

Resources equitable across the state: is there a plan?

LICC: who is responsible for recruitment? ICC and LA. Parent leadership and advocacy skills.

LITA required for EHS and HS, but not for LEA.

Child find events: managed by LA via contract.

ASQ can still be used. LA to check on IDEA 2004 consent for screening requirements. Both PEDS and ASQ highly correlate.

Clarify why the foster parent < 1 year can not serve as surrogate parent (check IDEA 2004 statute, reauthorization of CAPTA).

LICC: remember that when these in place there was a direct line to the LA, and support was provided. BNCT does work, LICC seems more global. LICC does not seem to be described as a group that does work, especially if administrative supports are not provided by LA. If it cannot be provided and it's in the manual then we're just setting ourselves up for failure. I've heard this said twice now, and I just want to clarify, if this is draft and it still has to be approved, how is there already a training plan being developed?

Pg 31: can we still bill Medicaid for SC? Yes, so long as Medicaid covers service coordination.

Clarify interim IFSP: look at why this is required, and if there are circumstances where this would be appropriate prior to determination of eligibility, and whether the focus is on Part C or other services. Look at regs for interim IFSP AND service coordination. Basically, can/should an interim IFSP be developed only for an eligible child.

Developmental screening: every child, or just those referred on the basis of developmental delay?

Is ongoing eligibility comparable to the initial eligibility? Is there really a need to have two disciplines for continuing eligibility. Please clarify in the draft that goes to OSEP.

If a family is not getting a Part C service, do we provide service coordination? Yes.

DDSN is the service coordination agency for persons with disabilities and special needs in South Carolina. Is there room in the system for a semi-blended model? That is, if SI is identified on the IFSP as a service needed by the family to support the child's attainment of the goal, can the service coordination still be provided by this person? Is there room in the system of a source of ongoing service coordination that is not contingent upon the receipt of SI? Could the manual read a little less reggy? Can we have this conversation?

I will make a comment based on my role and now wearing several hats: I do not understand the foster parent not being able to be the surrogate parent if < 1 year. As a foster parent, if special instruction is a service added to the IFSP, it does make sense to me that this person also be able to be the service coordinator. What is the difference between this example and a physical therapist serving as a service coordinator? The PT as service coordinator wouldn't necessarily know what to tell the family about resources, services, etc., not related to motor development.

I think related too is that as an EI, I know my kids inside and out, so if I see my kids having a problem with vision/hearing, it's really easy to call the vision people to explain what I'm seeing and relating my concerns. Having SC blended with SI just makes it easier, it cuts out the middle man.

Service coordination is responsible for transition activities, not Special Instruction. I think special instructors sometimes have information that could be useful/helpful at a transition meeting that a service coordinator who is not also a service provider might not necessarily have.

I just wanted to say that we all know that there are changes that needed to be made, and we appreciate the work, and the opportunity to make comments.

Provider recruitment—target by county

Does child find include education of primary referral sources (pediatricians, early care and education, hospital systems, NICUs, non-contracted providers)? YES!!! Also, general public awareness.

Lack providers, regardless of whom identifies the provider (i.e., intake vs. ongoing). This proposed revision does not address the ongoing issue of timely service provision.

Could ongoing service provider be identified and included in initial IFSP team meeting? This would be ideal, if both could be involved, and have less impact on the 30 days to get services. Would this be a billing issue—two service coordinators billing for TCM @ the same time? Does the case management hierarchy ('primary' and 'secondary') still exist? This would really help make the change in service coordination visible to the family, and help the ongoing service coordinator have a thorough understanding of the child, family, and IFSP.

Timely provision of services:

I'm not sure the providers have a good understanding of what services through BabyNet means. There seems to be a difference especially with clinic-based providers vs. natural environment providers. TRAINING IS NEEDED!!! Individualization and training of the family—neither has occurred.

Assuming that either more providers can be recruited and/or the change in service model increases capacity, costs will go up even more than what has happened since October '09

Could the E&A Team provide evals after initial eligibility and IFSP has been determined/ developed?

Provider issues: physician makes referral to therapist, who evaluates, begins tx, then makes referral to BabyNet

Family resources: families can use Medicaid and/or commercial insurance to purchase services 'off' the plan, and at the same time, must give consent for BabyNet to use insurance resources. There are also families whose child may have a similar disability, but with different resources, who cannot access services at the same level. I hope these proposed revisions will honor the family who chooses the multidisciplinary model over the transdisciplinary or primary service provider model. Individualization is the key.

Has there been a cost study done to see if this will result in savings?

45 day process to have IFSP process: does this include the delays in getting the IFSP from DHEC/BN (often arrives already late), and have the MCO issues in getting prior authorization in a timely manner been taken into account.

Primary Service Provider Model: [description]

Can the family go outside of the IFSP to purchase additional services. Yes. Differences between MCO and IDEA.

Family determines priority, therefore not all services are delivered at the same rate or frequency. Who determines frequency

Service coordinators who conduct intake are responsible for putting 'dominos' in motion or not putting them in motion. Large concern about missing soft signs about early development, having knowledge of developmental milestones.

Re/PSP: flexibility must be part of the design to ensure individualization. For the child with very complex needs, will there remain the flexibility to have services on the IFSP at the rates and frequencies that reflect the child's and family's needs.

Difficulty with MCO decision making process for what is authorized and what is not, how long it takes, what is medically vs. educationally necessary.

Concern about making sure that personnel involved in providing our services are qualified to provide services to my family.

Need a version of this information of families.

Concerned about the government telling me my child can only have one therapy a month.

Local child find events: with local partners, can providers be reimbursed for participating in screening?

Will the rapport built between the family and the provider during the initial therapy evaluation be lost in moving to an evaluation and assessment team model?

Opposed to child care providers being on any type of diagnostic team, including screening. Need people with both the right background and the right tools at the front end.

Physician involvement in up-front screening would be beneficial, also, educating physicians in need for approval of prescription for therapy services.

Propose that families be given a choice in selection of provider for initial evaluation. What if the ongoing provider differs with the evaluation results of the E&A provider? What if the E&A team says no service is needed, and I disagree.

How many teams will the family have to go through to get to implementation of the IFSP?

An intake/eligibility team, and an ongoing service provider team.

Model of blended services with DDSN: survey of families indicated that they would prefer one provider over two. Clarification of OSEP Memo of January 6, 2010 has been requested, but not yet received. Our grade from OSEP has gone up, and other states use a blended model of service coordination and special instruction. Are we expecting OT, PT, and SLP to learn to service coordinators? Medicaid doesn't cover consultative model of service delivery. We do a pretty good job of teaming in most places most of the time. Does this ensure a payment source will be available for everyone using a consultative model. If I had a speech delay, would the MCHAT still be appropriate. Would the MCHAT be used for children, for example, with Down Syndrome. DDSN serves 74%, not 90%. What is a family training plan, and why is it needed if the IFSP is comprehensive and of high quality. Service coordination responsibilities re/COSF, these are state targets not federal targets. It would be nice to see some money spent on a new data system. How is the family training plan a good use of service coordinators and service providers time?  
SI is not identified before the initial IFSP.

Local E&A Teams: SI, OT, PT, SLP. Eligibility determination for BabyNet. Would it be one tool, or multiple tools? If it is a discipline specific test used by the E&A team, would there be another discipline specific test used by the ongoing service provider?

Multidisciplinary team goes in to assess the child prior to development of the initial IFSP, and it determines there are delays in a specific area of development. How is this different than the current model of SI indicators.

Who employs the E&A Team? Would this always be the same team, or individually contracted? How would the person representing SI on this team be identified, selected, and paid?

How is choice to provider offered to families? Would it be the same as now?

Screening: how is this different than educating primary referral sources. Paying people to screen seems contradictory to trying to save \$ in the long run.

Special instruction indicators: we've tried this before, but what we have now works in Charleston County. Look at counties that have functional receipt of services—why change what's working here even if it's not in other places of the state. Fix what's broken, leave alone what's not.

Does First Steps have plans for examining option of services for children who live in rural or outlying areas? What's happening in other parts of South Carolina, and what's happening in other states that are predominantly rural? DDSN Boards where they're needed, when they're needed, and do a pretty good job of it.

There is no EI mentioned in the new policies. This is of concern. Who employs the team and choice of providers.

Policies of January 2010, and proposed revisions of July 2010: definitions of PT and OT need to be checked to see if these are correct.

p. 5: who decides what test is used?

P 7: definition of service coordinator? Need clarification of 'public agency', and 'qualified person'.

P 9: public comments: do all get sent to Washington? Yes? Who has final say? Role of SCICC is to advise, assist, and have final approval of policies and procedures.

p. 15 clarification between use of standardized measures and only standardized measures

p. 17 families as ultimate decision makers: what if child is found ineligible, and this is in contradiction with findings of a physician and or other type of specialist?  
Complaint process, trained mediators.

Use of CPT codes: gap between BabyNet and other codes used by each discipline and that are recognized by different commercial and public insurance companies. Please reconsider the CPT codes that are used by BabyNet.

Pediatricians role re/detection of ASD diagnoses and late age of identification. Role of allied health professional is critical in making referrals not only to BN but also back to the primary care physician.

p. 25 mediator (e)—list is missing.

What is the process to determine who will be the service coordinator, and who will be the special instructor?

As a parent, does this mean I would get 2 new people, and lose the one I have now?

P 31: 1.b coordinate early intervention and other services. If they cannot find a therapist, what is the length of time that must pass before considering a clinic-based therapy service.

P 34: red flag training for established risk diagnoses.

Can only the PEDS and MCHAT be used?

How many times is would a child need to be screened?

Do children with established risk diagnoses need to be screened?

Can parents still self refer? Yes

BabyNet eligibility criteria must be considered based on all available information about the child.

P 39 eligibility as a team process

How is pediatric expertise of therapists determined?

Will teams be standardized? If so, will tools also be standardized across all teams? Will public be able to comment on the RFP that goes out?

I do find the manual difficult to follow with numbering and letting system. It's difficult to follow the way it's currently formatted. P 19 specifically mentions PSP model...one consistent person...under PSP model family and team determines who is primary based on child's current need(s); this degree of change will be

difficult to manage, lead to more IFSP team meetings, and ultimately drive up system costs. Language is demeaning—shall, do, must—implies that all are out of compliance.

Needs clarification:

Pg 39 state and local protocols

Pg 40 incoming service coordinator responsible for insuring that certain activities took place when the incoming service may or may not be involved at that point.

Pg 44 family can ask for a change in service coordinator if the state policies and procedures address this issue

Pg 44 section on service coordinator assignment of which team member will provide ongoing service coordinator—inconsistent language throughout this section.

Pg 47 interim IFSP example of when an interim IFSP would be used—services identified as needed immediately by the child/family

Pg 57 what is an early childhood goal—is the the early childhood outcomes

Pg 60 referral to Pro-Parents for every child referred to Part B—‘family will be better served’—please clarify. Why is PRO-Parents being singled out, and Family Connection is not?

I can understand this statement in the manual, because PRO-Parents can help with the IEP process if the referral is made at the time of transition.

Pg 61: documentation related to medical necessity and access to adequate funding

Are primary service providers going to be expected to implement goals from other disciplines?

On the record, as an average citizen who has a special needs kid, there is a lot of chaos in these papers. There’s a lot of money hidden in this. These are 60 pages of mess.

Pg 61

BabyNet does not pay for the majority of the services I provide. This is a conflict between FERPA and HIPPA

Consultative models are not covered by most insurance companies. Intensive models seem to provide better results. Has BN talked to the insurance companies, MCOs, and Medicaid? Providers have to follow the medical model, not the educational model.

Please remove the DHEC language from the documentation section.

Who will maintain the E&A records?

Please clarify what is meant by consult? Is this telemedicine, telephonic, FTF?

How is information being disseminated? Website, listservs.

I'm the type of person who needs to see things...I understand what is being said about the primary service provider model, but need to see what it looks like.

So prior to that, with intake, the BN Intake coordinator. We do have to have assessment of the child's unique needs and strengths prior to development of the initial IFSP.

How will the 45 day timeline be met with additional evaluations/assessments required if it's hard now with just the CBA?

Can SC be separated from SI? Yes.

As a therapist, I conduct an evaluation to determine a treatment plan that includes frequencies and duration. How is it ethical for me to conduct that evaluation, and then not follow-through with the plan? Would the ongoing therapists' evaluation be a re-evaluation if the first evaluation were not billed to Medicaid?

To the family, it would be a re-evaluation with 5 or 6 people in their house before services even get started, so wouldn't this be very frustrating to the family and the child, esp the child who is medically fragile, and wouldn't this delay services even more? The family has all these people coming in, doesn't this further delay service delivery?

It also seems like this would take longer to schedule, also. Sometimes they can't even get off work for the initial intake home visit.

The validity of the second evaluation needs to be examined; does the recency of the first evaluation have any impact on this?

If this policy is submitted to OSEP, is there a timeline for which this would be expected to be in place, and are we setting ourselves up for failure by putting a policy like this in place, especially given the interagency dynamics and current fiscal climate? It is of concern knowing in advance that training might proceed on policies, practices, and procedures about which there is not agreement across the partnering agencies.

Screening process: would these be only face-to-face, or is there a proposal to do these by phone? Proposed revisions to the policies

What if the ASQ is used as the screening tool, to determine if there is a need for further evaluation?

1. ASQ
2. CBA to determine if child is eligible
3. Conference with therapists to determine and if further evaluation is needed.
4. If yes, then the child is referred to the service coordination provider that the family chooses
5. Initial IFSP is developed
6. discipline-specific evaluations are completed
7. services are initiated

A lot of things are being proposed to be changed, and maybe a lot of things need to be changed. The one thing I have a concern about is proposing systemic change without an adequate training, CSPD, and TA system. We never come together for an opportunity to learn together. So, to me, it seems it would be better to pick one part to work on at a time, make sure that works, then move on to the next. What happens to the families in the mean time. Let's not throw out

everything.

We cannot have been the only state that has chosen a blended model of service coordination with special instruction. Are they in trouble too? The issue is not the blending, per se, but that receipt of service coordination is contingent upon receipt of special instruction.

With the assessment from OSEP that this is not individualized, this may not be based on accurate information. 500 children currently receive SC only through DHEC. The service is individualized at the family and IFSP team level. Funding will be huge barrier to the separation of these services.

Will this PPM be, at any point, more thorough regarding the provision of ongoing services? That is, guidelines to help the team members determine appropriate frequencies, intensities, durations, and when to reduce these as appropriate. Yes, public comment to this effect has already been received.

I agree that intake needs to be fixed, and agree that because we've never done it the proposed way, it probably will take longer. Why move to that when a CBA covers all domains of development and the child's unique strengths and needs. Why not just have the intake coordinator and a CBA provider. Look at the federal regs; even with a designated team, it will likely take longer than 45 days.

How will the separation of service coordination and special instruction be funded?

If submitted to OSEP, and OSEP approves, how would training begin on something agencies haven't agreed to?

I do like the proposed integrated home plan, it seems that it will help families. It does seem that if there are delays in getting services, then there will be a delay in development of this integrated plan.

I think these proposed policies missed the boat on the separation of special instruction and special instruction. I do think that DDSN could consider a more flexible model of services. At the same time, separation of these services is potentially driving up the cost of services, how often the family is visited, duplication of travel costs, etc. Are families' voices represented in this, as well as OSEP's. I recognize the CSPD side of separate skill sets needed for each service, but also know that many personnel currently in the system are capable of wearing more than one hat. I do support the proposed child find and earlier identification, although also recognize that earlier identification will also drive up costs.

Clarification: what are service coordination targets?

The system won't work if there's only funding for 2/3 (for example) of what is proposed.

Communication/connection to the child's medical home and primary care provider: would like to not see this lost in the new system.

Who's responsible for completing the family training plans, and are they a separate document from the IFSP, or within the IFSP? Would revision of the family training plan require written prior notice? Only if revision is part of an IFSP Team meeting.

In regard to the contracts for providers, and the geographic catchment area providers are expected to serve?

It seems like the intake and orientation with families will be a lot more involved, will include additional information for families to process, or added steps for families to deal with...would this lead to fewer families giving consent to proceed to evaluation; would more families drop out? I would hate to see children lose

out.

Sherry: As a parent, I really love the home plan idea; you have so many people telling you so much stuff, this would help me as a parent so much. I also like the initial evaluation and assessment team approach, non-biased, telling me up front what my child's difficulties with development may be.

Primary Service Provider model: family would not be so overwhelmed, but how would the providers who are not primary get to know the child?

Will the child lose out?

Primary service provider model is not in the proposed revisions to policies and procedures as described in the public hearing; how can people respond to the proposed changes if the content is not included in sufficient detail to comment?

PSP & special instruction indicators: SCSDB has hired certified vision and hearing teachers, and orientation and mobility specialists, sign language teaches, and Parent Advisor (special instructors). How is the primary service provider selected if the child has VI/HI needs? What the family identifies as the child's greatest area of concern + team input determines who is primary.

How will therapists learn to do this?

[Assuming policies are approved by OSEP, and become effective July 1, there will need to be a period of information and training prior to implementation. One idea is to deliver the training in IFSP teams to include the family.] This model has been used recently in SCSDB Transition training with positive results. [One set of strategies will be needed for families and providers currently in the system and one set for families and providers new to BabyNet].

How will school districts be involved in this transition? [information about the model changes will be discussed with the Department of Education for input on how best to share...]

Eligibility and Assessment: dedicated eligibility determination teams—needs clarification regarding if this is to be secured by the System Point of Entry or provided by the Lead Agency to the SPOE office.

If effective date and implementation date are two different points in time, is the system to run as it is in between those dates? [yes]

Some people learn best through scenarios—it's hard to see what this will look like until it begins.

Separation of service coordination from special instruction: this also needs to be clarified in the proposed revisions to the policies and procedures; that is, it is not clear enough to respond to. If a DDSN provider has sufficient staff, the service coordinator and special instruction provider could both be employed by the same board or company. If there are not sufficient staff, other resources would need to be provided to meet the model.

I like the separation of service coordination from special instruction, and have worked in both models. I think it provides a more consistent model, and allows for more development in a specific skill set instead of a mixed set of skills.

The evaluation and assessment teams sound like an model used in North Carolina (developmental evaluation centers); all referrals would go through these centers, each child is screened evaluated, and assessed by a team whose membership is determined by the needs of the child, but all areas of development are addressed. It

is not clear in the proposed revisions where this team is coming from.

Scenario or an ideal situation from referral to transition—please include this in writing. Continue discussions with DDSN/CO.

How can we meet the 45 day timeline if discipline specific evaluations will be included before the initial IFSP?

Can providers work off another's evaluation?

Is this all they will be 'allowed' to do?

Will families have a choice in who does the evaluation?

Are scripts needed for evaluations?

With the transition conferences, parents can decline those, correct? Yes. If that occurs, we note that in the service notes and now—again—in BabyTrac.

Will there be activities to support earlier identification, so that services may be less intense, less costly, and not last as long?

Prescriptions for services: whose responsibility is this...the service provider, or the service coordinator, or the family? Service providers may be in violation of professional ethics by asking the PCP for the script to get the evaluation; EIs &/or service coordinators say this is not in their job description to get the initial Rx (per DDSN website info). This needs to be consistent per 34 CFR 303.23. Empowerment/education of families to do this is certainly a goal, but may not be able to take place in time to ensure timely delivery of services.

Re/evaluation and assessment teams: pg 40: how will 'appropriate pediatric background' be determined? [with input from professionals and or via public comment] Not just pediatric experience, but also experience/knowledge of developing and maintaining joint attention, pre-verbal skills, early communicative intent, etc.

On the initial IFSP, for the intake person, if pre-authorization will be required in advance for all evaluation of any/all services, the service coordination must be gather all needed info, and please write legibly. Dawn Kearny would like to review the Consent to Use Insurances form and make suggestions for revisions (see authorization form given @ hearing...)

Pg 16: looks like/doesn't look like seems to contradict the current policy of allowing d/c of services for non-responsiveness of family (dropping appts, etc.) this needs to be clarified...

Pg 15: looks like/doesn't look like re/bringing toys into families' homes. Expand this with additional natural environment concepts. Consider adding in examples of exceptions for when this might be allowed (demonstration for therapeutic purposes, ideas for holiday and birthday gifts, etc.) some materials are more conducive to learning certain concepts than others, so long as individualization is the basis for deviating from the principle

**Clarify contract, policy, & family guide language about natural environment requirements for service delivery** (use of BabyNet Service Funds to pay for services outside the natural environment). However, children eligible for Medicaid can choose to go outside the natural environment, regardless of BabyNet eligibility status.

Provision of services in child care settings: in some cases the distractions are such that the services are wasting \$. Strengthen IFSP policy language regarding how to determine when the natural environment is not appropriate; also, look at DSS requirements for visiting providers.

DSS licensed facilities are asking providers for background checks, annual TB tests, certification of 20 hours of ECE training, certificate verifying provider is free of communicable disease and annual physical by a doctor if services are delivered in a pull-out model. Is this DSS, or this particular child care provider's rules, or both...?

Can a PT subcontract with SW, psych, and/or counseling? Yes.

Pg 31...is it accurate to say that with separation of service coordination from special instruction, service coordinator handles federally required timelines but the SI can still handle phone calls, research, etc. DDSN currently bills researching information as service coordination, but what about researching info related to delivery of special instruction. Clarify this with Jennifer Buster/Melody McGlaughlin, Medicaid, etc.

Example: SI finds out family has just learned about a new dx, SC researches info to share with family, asks family if ok to share with rest of team, etc...

Dedicated service coordination must be delivered at least once every 30 days, but should be individualized

Written prior notice changing to every 10 days to be consistent with SDE

PAY ATTENTION TO...Guidelines for caseload sizes must be balanced with work load for billing, reauthorization of services, and quarterly progress reporting.

Training, re-tooling, up skilling on workforce.

Accountability for training of therapy and interpreter providers.

Can the operational description of the primary service provider model be posted? Yes, in the final draft of the policies to be sent to OSEP.

The policies that the public is able to comment on is not what is described in the hearings, so unless you come to a hearing, you don't get this description. We don't have all of what's planned before us, so it seems a reasonable person could request a second round of public comment.

When you think about this, the members of the E&A team will not be service providers. Therefore the family will be able to make a more informed decision about their priorities and concerns with the E&A info.

Have you had comments from families about the separation of service coordination from special instruction? The reality is, we're in the home every week, separation will be double the work for the EI.

SCSDB has always had this model, and I don't think the parents see a real difference.

There are issues about the transfer between the BN Intake coordinator and the assigned ongoing service coordinator.

SCSDB model: families seem to be satisfied with the 'dedicated' model, without loss of service. These are two different skill sets, and when blended, may not allow for increased depth of skills. Child has one file, service coordinator is responsible for all referrals, service notes, etc.

From a DDSN perspective: SI is a service, just as are PT, OT, and SLP. We've never practiced pure special instruction. The federal definition of SI specifies cognition & social-emotional development. Blended services may be taking away from being able to better the enhance the development in these domains.

SCSDB: when we do the IFSP, this is when SI is identified as a service needed by the family to help the child attain the IFSP goals.

If this does become the case, then I imagine we would not be able to hire sociology, SW, etc., to serve as SI providers. We would probably only be able to hire teachers. Grandfather in current workforce? We should be looking for people actually specializing in the field, not just anyone. Pre-service changes with colleges and universities would need to take place over time, not by December.

It's going to be easier on families to know who does what, and who to go to for what.

But it still seems like double work.

SI providers with SCSDB know to tell families to call the SC.

I guess the only way for this to work is for the company to have their own service coordinators, so you don't have to go outside your own company. If it's already been decided to separate, then it wouldn't make sense to stay inside a provider company.

SC caseloads—35-40 children, SI caseloads 15-20 children. The separated model also works with the adult population. It kind of gives the service coordinator better leverage to get things done, and there are also more checks and balances. As a parent, I know who to go to for what, and who's supposed to do what. Also, there seems to be less turnover.

If the ongoing service coordinator is participating in the initial IFSP team meeting, would they be selected via a matrix? Yes. In a dedicated model, if SI is identified on the plan, the ongoing SC would be responsible for offering the family a choice of providers just as they are now with the other BabyNet services.

What about a situation with a primary service coordinator and the concurrent SC? Would there be a difference, or would we continue in basically the same way? DDSN has to be the service coordinator for waiver services.

Alternate pathways cannot be suggested unless people knew to do that, and the only way to know this is by attending a hearing. It's already been decided, and now it's too late. Family participation in the public hearings is the same thing. We haven't really told parents much because we didn't understand, even when we read the document.

Section 2, p8, 4a: In reading this, does SI become a service that needs a Rx? No. Will SI be required to submit a quarterly progress report? Yes.

P. 11: PEDS & ASQ: can these be done by phone? This needs to be clarified. I feel like screening needs to FTF to ensure that the both the parent's information and the screener's observations are included in making a referral to SPOE.

Although I've heard differently today, in reading the document it appeared that the intake service coordinator would keep children who do not have SI on their IFSP.

Who will CBA provider agencies?

Initial CBA

Annual CBA w/SI and annual CBA w/o SI

These need to be clarified, CBA needs to be completed by individuals with background in child development, not SC backgrounds

CBA tools:

AEPS is difficult to translate for families in terms of quantifying the results (%/mos of delay) vs. at or below the cut-offs. This may be a training issue, or it may be a tool choice issue. Look at ways to reduce elimination of duplication of billing for administration of CBA. Other tools are easier to use, easier to explain, gives better IFSP goals. Also issues with who the tool includes and excludes from eligibility.

Contracts with provider capacity: compliance & compliance history. SI right now has that built-in compliance piece, but the other services do not—how will these providers be held accountable, and how will BN develop the capacity to do this? Sometimes children not getting services due to payee source. BNSO needs to get a better control on this—more spot checks, or something. Complaints seem to not make a difference, so what else can we do, esp when the contract just gets renewed over and over again which reinforces the provider's behavior.

I don't know the ramifications as a provider. I do worry CONSTANTLY about of course my staff, and how this will affect us. I do see that this will have stronger outcomes for children as long as we continue to focus on this. It may mean new roles/niches for us as providers, but we will continue to do what we need to do to be a part of the team.

Do we have any ideas about who will be responsibilities about the child find networks.

We routinely do not get the court order, can we refuse the referral until we receive the court order or letter verifying the child is a ward of the state?

Foster parent cannot serve as the surrogate parent if < one year—this needs to be clarified.

It's my understanding that in some parts of the state we are over-enrolled, will screening screen out or screen in.

Procedures in July.

Roll-out in January 2011, please note that there will need to be some lead time to make sure that families can be prepared, or that the separation of SC from SI occur gradually via attrition.

At any point in time will SI or SC become contracts directly through BN, or remain via the current agencies?

Memo from Dr. Buscemi to Susan DeVenny week of 26apr10: funding from DDSN...what does current system cost, and what will a revised system cost? We cannot do this without a baseline of the total state effort...

Pg. 31 3a, clarification re/existing service coordination capacity and utilization thereof. This seems in conflict with proposed revisions to eliminate ongoing service coordination from DHEC, and may just need to be removed from the draft.

Application, budget line for funding the E&A teams: currently says TBA, so what budget line would go down by a corresponding amount. What would be reduced would be monies dedicated to service funds.

E&A team: one team across the state? No, one company with capacity to respond statewide. If not statewide capacity, then local RFPs would go out.

Can the RFP be made available for comment before it is opened for bid? Kristie to check SDE procedures for this.

Will the intake service coordinator work with the family any further than the initial assessment and IFSP meeting? It appears in the text that the intake SC would also conduct the annual IFSP meetings and annual assessments.

At what point would a file be transferred to a new SC?

The document reads that the primary service provider would conduct SC, and that the SC would be chosen from the team during the initial IFSP meeting. The proposed changes then go on to state that the SC is prohibited from providing any services on the IFSP. Does this add yet another person to the team? How can the provider of the primary service for the child not carry out any IFSP services? Does the family really need one more person on the team?

What will be the role of the Early Interventionist/ Special Instructor?

Will there be a fee associated with receiving Early Intervention services?

Are IFSP's being rewritten to include the section on Early Literacy proposed by First Steps to School Readiness? Will this team always then include a First Steps Early Literacy worker?

This manual stresses that families are to be allowed to participate in any way they wish. Does this mean that it will be an option for them to be observers and not participants in therapies and meetings?

Will each child receive skilled therapy? I have several children who receive only SI/FT services and no other therapies, as the family feels that this meets their current needs. Will an outside therapist be brought in to meet the criteria that children be evaluated by two professionals? Children who are right at cutoff don't always need more than FT/SI.

If a child has two very significant and equally weighed needs, who decides which therapist is "primary"?  
From beginning to end, what will this really look like? Please provide examples.

Would there be an EI assigned with every SC?

Would EI receive referral from SC based on need of family/child?

If EI and SC responsibilities are split, would EI's keep office or work from home? Would we continue to be reimbursed for gas mileage? Would we continue having access to agency cars and phones?

If EI starts to work with family and decides that ST/PT/ or OT is needed would the EI notify the SC of this need? Would EI continue to work with family and therapist or would the therapist now be the main provider?

“BabyNet SC are prohibited from provision of services listed on a child’s IFSP”. Does this mean that Early Interventionists (Family Trainers) will no longer be acting as service coordinators?

Detailed and thorough training is needed to educate Early Interventionists on how to design and implement Family Training activities solely using materials that are available in the child’s home, since we have grown accustomed to and been trained to implement FT activities using toys and materials that we bring to the home.

What happens to the children we provide FT/SC for currently? Will they be grandfathered in with the new changes?

Are you planning on hiring SC’s to provide SC? Or are agencies deciding who will strictly provide SC and who will strictly provide FT? How can you assure that the SC will be unbiased when choosing a family trainer for the family? Will there be a matrix for EI’s?

<b>ELIGIBILITY EVALUATION AND ASSESSMENT OF CHILD AND FAMILY STRENGTHS, NEEDS, AND RESOURCES</b>	
<b>Draft Proposed Policy</b>	<b>Comment</b>
An <b>occupational therapist</b> with pediatric background.(pg. 40)	An <b>occupational therapist</b> with <i>at least 5 years of</i> pediatric experience.
A <b>physical therapist</b> with pediatric background. (pg. 40)	A <b>physical therapist</b> with <i>at least 5 years of</i> pediatric experience.
A <b>speech-language pathologist</b> with training in and sign language and cued language services.(pg. 40)	A <b>speech-language pathologist</b> with <i>at least 5 years of</i> pediatric experience.
<b>EARLY INTERVENTION SERVICES DEFINITIONS</b>	
<b>Draft Proposed Policy</b>	<b>Comment</b>
<ul style="list-style-type: none"> <li>• <b>Occupational therapy</b> which includes services to address the functional needs of a child related to the performance of adaptive skills, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child’s functional ability to perform tasks in home, school, and community settings, and include:               <ul style="list-style-type: none"> <li>a) Identification, assessment, and intervention;</li> <li>b) Adaptations of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and</li> <li>c) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability. (pg.49)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Occupational therapy</b> includes services to support a child's daily occupations and functional needs related to adaptive development, oral motor/feeding skills, play and leisure activities, sensory processing, neurobehavioral organization, musculoskeletal status, posture and respiration, and overall motor development. These services are designed to improve the child's ability to participate in childhood occupations meaningful to a family/caregivers and child in home, school, and community settings, with services that are coordinated and team-based; focused on the family as the primary recipient and based on the highest quality evidence available. Services include:               <ul style="list-style-type: none"> <li>a) Identification, assessment, and intervention to identify sensory and motor dysfunction</li> <li>b) Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate motor and sensory development and promote the acquisition of functional motor skills</li> <li>c) Prevention or minimization of the impact of initial or future impairment, delay in motor and sensory development, or loss of functional ability.</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>• <b>Physical therapy</b> which includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:       <ul style="list-style-type: none"> <li>a) Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;</li> <li>b) Obtaining, interpreting, and integrating information appropriate to program planning to prevent or alleviate movement dysfunction and related functional problems; and</li> <li>c) Providing services to prevent or alleviate movement dysfunction and related functional problems.(pg. 49)</li> </ul> </li> </ul>	<p>Can you re-format to match proposed policy, OT, section above, and SLP section below?</p> <ul style="list-style-type: none"> <li>• <b>Physical therapists</b> use their expertise in movement and apply clinical reasoning to make decisions specifically related to motor and self-care function, assistive technology, health and wellness, and medical/health care science. In collaboration with the child, family, and other health and educational team members, a physical therapist performs a relevant systems review of the child that includes a family interview.</li> </ul> <p>The systems review may also comprise:</p> <ul style="list-style-type: none"> <li>A screening for the general health of the child.</li> <li>Identification of possible health and/or developmental problems that may require consultation and/or referral to other providers.</li> <li>A review of the child’s physiologic status to determine if there are impairments in musculoskeletal, neuromuscular, cardiopulmonary, and/or integumentary systems.</li> <li>Specific developmental tests and measures.</li> </ul> <p>The review <i>may</i> also include a review of the child’s ability to communicate, affect, cognition, language, and learning style.</p> <p>Following the systems review, clinical judgments are offered. These judgments may include offering the clinical diagnosis, prognosis, and intervention, if indicated. In collaboration with the team, the recommended intensity of service delivery, outcomes, and criteria for discharge are also offered.</p> <p>Physical therapists provide services directly and by collaborating with the team, exchanging information with the family, and integrating interventions into everyday routines, activities, and locations. If treatment is indicated, physical therapists may use evidence-based practice to provide any of the following services as part of their plan of care:</p> <ul style="list-style-type: none"> <li>• Developmental activities</li> <li>• Movement and mobility</li> <li>• Strengthening</li> <li>• Motor learning</li> <li>• Balance and coordination</li> <li>• Recreation, play, and leisure</li> <li>• Adaptation of daily care activities and routines</li> <li>• Equipment design, fabrication, and fitting</li> </ul>
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	<ul style="list-style-type: none"> <li>• Tone management</li> <li>• Use of assistive technology</li> <li>• Posture, positioning, and lifting</li> <li>• Orthotics and prosthetics</li> <li>• Cardiopulmonary endurance</li> <li>• Safety, health promotion, and prevention programs</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Speech-language pathology</b> which includes <ul style="list-style-type: none"> <li>a) Identification of children with communicative or oral pharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;</li> <li>b) Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oral pharyngeal disorders and delays in development of communication skills; and</li> <li>c) Provision of services for habilitation, rehabilitation, or prevention of communicative or oral pharyngeal disorders and delays in development of communication skills.(pg. 50)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Speech-language pathology</b> includes services to support families/caregivers and their children with delays or disabilities in communication, language and language-based skills, speech, swallowing and oral-motor feeding. These services are designed to developmentally support and promote children’s participation in everyday activities and environments and to strengthen the family’s capacity to enhance their child’s development and learning, with services that are responsive to family’s concerns, focused on the family/caregivers as primary recipient of services; culturally responsive; coordinated and team-based; and based on the highest quality evidence available. Services include: <ul style="list-style-type: none"> <li>a) Identification, assessment and diagnosis of children with disorders and delays in language and communication (to include language-related areas such as play and symbolic behaviors, phonologic disorders, and emergent literacy), speech (including voice and fluency) and swallowing and feeding (oral and pharyngeal);</li> <li>b) Referral for medical or other professional services necessary for the habilitation or rehabilitation of these identified children;</li> <li>c) Consultation and education of team members, families and other professionals;</li> <li>d) Provision of services for habilitation, rehabilitation, or prevention of language, speech and swallowing/feeding disorders and delays to include both family-focused and child-focused services.</li> </ul> </li> </ul>
<b>SERVICE DELIVERY IN NATURAL ENVIRONMENTS</b>	
<b>Draft Proposed Policy</b>	<b>Comment</b>
<p><b>OT Provider Requirements:</b> OT/OTA State licensure and national certification.</p>	<p><b>OT Service Provider Requirements:</b> The following are requirements to deliver services in BabyNet system:</p> <ul style="list-style-type: none"> <li>a) State licensure and national certification for occupational therapist and occupational therapy assistants. Assistants must be under the direction of a licensed occupational therapist pursuant to state licensure regulations.</li> <li>b) At least 1 year pediatric experience OR be willing to complete the BabyNet system 1 yr. mentorship program.</li> <li>c) All evaluation, assessment and IFSP services must be provided by</li> </ul>

	<p>qualified personnel (per above) having a contract with SCFS/BabyNet; according to practice act and BN regulations, policies and procedures even if not reimbursed directly by BabyNet.</p> <p><b>OT Service Provider Mentor Requirements:</b> The following are requirements to be a service provider mentor in BabyNet system: a) be in discipline of the mentee, b) have at least 2yrs. of pediatric experience, c) willing to provide 1 yr. on the job mentoring face-to-face and or online, and d) sign-off on mentee training form as appropriate</p>
<p><b>PT Provider Requirements:</b>          Qualified personnel are licensed physical therapists or physical therapy assistants. Assistants must be under the direction of a licensed physical therapist pursuant to state licensure regulations.          2.0 All evaluation, assessment and IFSP services must be provided:          2.1 By qualified personnel having a contract with SCFS/BabyNet;          2.2 According to practice act and BN regulations, policies and procedures even if not reimbursed directly by BabyNet.          pg 35 (current policy, service guide)</p>	<p><b>PT Provider Requirements:</b> The following are requirements to deliver services in BabyNet system:</p> <ul style="list-style-type: none"> <li>a) State licensure and national certification for physical therapist and physical therapy assistants. Assistants must be under the direction of a licensed physical therapist pursuant to state licensure regulations.</li> <li>b) At least 1 year pediatric experience OR be willing to complete the BabyNet system 1 yr. mentorship program.</li> <li>c) All evaluation, assessment and IFSP services must be provided by qualified personnel (per above) having a contract with SCFS/BabyNet; according to practice act and BN regulations, policies and procedures even if not reimbursed directly by BabyNet.</li> </ul> <p><b>PT Service Provider Mentor Requirements:</b> The following are requirements to be a service provider mentor in BabyNet system: a) be in discipline of the mentee, b) have at least 2yrs. of pediatric experience, c) willing to provide 1 yr. on the job mentoring face-to-face and or online, and d) sign-off on mentee training form as appropriate.</p>
<p><b>SLP Provider Requirements:</b>          Qualified personnel must be a Licensed Speech/Language Pathologist or Licensed Speech Assistant. Assistant must be supervised in accordance with state licensure regulations.          2.0 All evaluation, assessment and IFSP services must be provided:          2.1 By qualified personnel having a contract with SCFS/BabyNet;          2.2 According to practice act and BN regulations, policies and procedures even if not reimbursed directly by BabyNet.          Pg. 16 and 44 (current policy, service guide)</p>	<p><b>SLP Provider Requirements:</b> The following are requirements to deliver services in BabyNet system:</p> <ul style="list-style-type: none"> <li>a) State licensure and national certification for speech/language pathologist or speech/ language pathology assistants. Assistants must be under the direction of a licensed speech/language pathologist pursuant to state licensure regulations.</li> <li>b) At least 1 year pediatric experience OR be willing to complete the BabyNet system 1 yr. mentorship program.</li> <li>c) All evaluation, assessment and IFSP services must be provided by qualified personnel (per above) having a contract with SCFS/BabyNet; according to practice act and BN regulations, policies and procedures even if not</li> </ul>

	reimbursed directly by BabyNet.
	<b>SLP Service Provider Mentor Requirements:</b> The following are requirements to be a service provider mentor in BabyNet system: a) be in discipline of the mentee, b) have at least 2yrs. of pediatric experience, c) willing to provide 1 yr. on the job mentoring face-to-face and or online, and d) sign-off on mentee training form as appropriate.
<b>BILLABLE ACTIVITIES</b>	
<b>Draft Proposed Policy</b>	<b>Comment</b>
<b>OCCUPATIONAL THERAPY</b> Evaluation/assessment, IFSP meetings, and IFSP services.	Evaluation/assessment, IFSP meetings, and IFSP services. No proposed changes to billing activities for OT services.
<b>PHYSICAL THERAPY</b> Evaluation, Individual Services, Therapeutic Procedure Group, Team Meeting/Consultation	Need input Comments from SLP and PT can be added as desired (e.g., OT/PT/SLP) if comments are similar, or enter separately
<b>SPEECH LANGUAGE PATHOLOGY</b> Evaluation, Re-evaluation/Assessment, Individual Services, Group Therapy/treatment of speech, language, voice, communication and or auditory processing, IFSP Team Meeting/Consultation	Need input Comments from SLP and PT can be added as desired (e.g., OT/PT/SLP) if comments are similar, or enter separately
<b>GENERAL COMMENTS</b>	
Use of COTAs to implement OT service including the OTR developed family training plan.	
Concern regarding supervision of COTA (eg. who is going to be responsible for COTA? and what system will be in place to assure supervision and communication occurs??).	
Current special instruction (SI) educational backgrounds are too general with limited educational knowledge concerning OT service and OT referrals.	
Concern regarding need for clear guidelines and examples for use of COTA and SI in PSP framework.	
OTAs and special instructors will need additional training concerning Part C service delivery in PSP model.	
Much discussion regarding reimbursement issues surrounding assessment of child after information is provided from eligibility team for OT service. Will time be reimbursable for- initial assessment, supervisory visits of OTAs, and re-assessment?	
Training is needed to focus on service provider roles within the early intervention system in order to develop trust in competency and skill; teaming; supervision; accountability; and etc.	

The use of OTAs could be an option of expanding the capacity of OT services in under identified/underutilized areas of state.

Suggest evaluation team do more of a screening than evaluation???

Modules are expensive for small private practice businesses. Suggest considering cost of training for employees. Training costs are huge for small businesses that have to reimburse for employee time spent completing the modules.

Concerns about level of training required for pediatric experienced therapist versus therapist with less pediatric experience. Feel EI Credential should consider levels of training needs for therapist with staggered system based on competency levels. Some feel current system does not consider this could be seen as a bit disrespectful of knowledge and experience of some.

Review trans-disciplinary Family Training Curriculums (e.g. AEPS, HELP, and CCC) and research any OT specific EI Family Training Curriculums.

### **COMMENTS RELATED TO ELIGIBILITY TEAMS**

**The possibility of regional eligibility/evaluation teams.** A concern was that these teams should be stable, employed by BabyNet or contracted by regions. This would ensure consistency in the eligibility process and inclusion of OT service providers in this decision making process and the initial IFSP.

It was suggested that if the eligibility/evaluation team was employed (eg. full time or part time) or contracted by Babynet then their services would not have to be billed for and then initial assessment bill would occur once the PSP or ongoing provider received the child on workload.

### **Possible responsibilities of the eligibility/evaluation team members-**

- 1) Be located throughout state to conduct thorough screenings within disciplines that could provide information to guide initial IFSP team meetings and initial family outcomes/goals and family training plan (FTP)
- 2) Discipline specific team members would provide thorough screenings versus assessments. Assessments would be conducted by ongoing service provider and FTP adjusted as necessary with family input and IFSP team meeting with ongoing providers within set time frame.
- 3) Discipline specific team members would provide paraprofessional training and oversight concerning FTP to those children with identified OT related concerns but requiring general training by special instruction services that would foster functional development within child's areas of concern.

### **COMMENTS CONCERNING SERVICE PROVIDER MENTOR**

Suggest blogging and hands on for online.

Hands on is important- mentee to spend time with mentor for suggested time frames during the 1yr. Suggest developing an equivalent total hours/days necessary over 1yr mentoring phase.

Incentives for being a mentor- CEUs and financial incentives?? Note that the National Board for Certification in Occupational Therapy (NBCOT) has a Professional Development Units (PDU) for mentoring. NBCOT states "Mentoring an OT colleague or other professional to improve skills of the protege including role as a disciplinary monitor (mentor must be currently certified). 2 hours of mentoring = 1 unit with a 18 units max per 3 year cycle."

NBCOT offers a mentoring tracking form and materials. Suggest reviewing form and mentoring program developed for a home health program. Also other allied health professionals (SLP & PT) have mentoring as a priority and some have formal mentoring plans that we can review to develop a plan for mentoring.

Group suggested adding mentoring as a requirement for contractual application for service providers.

#### **COMMENTS REGARDING INITIAL & ONGOING ASSESSMENT**

Concern of being having the eligibility/evaluation team therapist's assessment handed off to service provider therapist for initiation of ongoing treatment/services.

Concern that ICO be valued highly from OT practitioners.

#### **COMMENTS, REGARDING IFSP SERVICE PROVISION *(see proposed services chart below)***

**As child's needs change, another team member can become PSP**, representing the child's major area of concern; a child can enter and move from 1 service block to another, with justification

Block 1 involves general developmental services. Blocks 2 and 3 involve more specific skills to target in everyday activities.

**Family-focused service** always involves the child; **Child-focused service** always involves the family

All services contribute to a unified **Family Training Plan (FTP)**

May have to define or re-define other **terms such as "short-term" or "profiles"**

**Reassessments** can be treatments

**Co-treatment** could be with another team member including the family. However co-treatment with another provider (PSP) is encouraged. As a team member (not a PSP), reimbursement occurs for co-treatment.

**Service options are never decided on by test scores alone.** OT/SLP/PT tests with 0-3 are not reliable sources of child's level of function, needs, or abilities, at this time. As a result, **decisions would not be based on scores alone but on each child's profile.**

**Child profiles will be developed and** may include descriptions of child by age ranges; indicators of potential needs such as feeding/swallowing problems, developmental apraxia of speech, etc. ; scores (examples for speech: >1.5 <1.75 SD below Mean in receptive or expressive language; >1.75 – 2 SD below Mean in any area; or greater than 2 SD below Mean in any area), and other ICO information.

**Paraprofessionals would receive specialized training, supervision, and monitoring; i.e.,** SLPA/OTA/PTA's would be supervised by registered or licensed therapists, and SI's would be monitored/guided by registered/licensed therapists when the program is in their primary area of specialization. **These may also include parent groups or parent education programs.** Inclusion of well-trained paraprofessionals will increase access to quality services state-wide

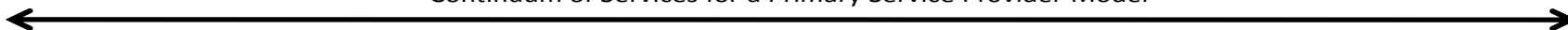
**Tried to build in checks/balances on continuation of services** for all team members

**Cost savings** comes in with fewer sessions per team member across the continuum of services, and the checks and balances built into the frequent team reviews/reassessments, creating a higher level of accountability; because it is well established that early intervention improves life-time outcomes, involving paraprofessionals helps ensure the quality and capacity of services and reduces overall service cost

**Need to have specific guidelines in place for when/how to discharge/transition those children who could go on to work on other objectives; currently, these are the children who remain on caseloads for indefinite periods because there are always skills for them to work on.** Need to investigate if/when we can D/C these children vs continuing them. Would these children go back to option 1 services, if so for how long, would they just receive service coordination or be transitioned or D/C? etc. Other specifics would be delineated in a service guide.

This model would have to consider **Medicaid and MCO needs**

Continuum of Services for a Primary Service Provider Model



See next slide for definitions and support information

Short-term family-focused services, directed by OT/SLP/PT, based on child profile. Services provided by OT/SLP/PT or paraprofessionals (SI or Assistant)

- Child is assigned an OT/SLP/PT service
- As PSP:
  - Depending on child profile, OT/SLP/ PT or paraprofessional provides 4 – 12 sessions of family-focused services. If PSP is paraprofessional (SI or Assistant), OT/SLP/ PT selects or develops program, supervises or guides, and monitors. **Reassessment and IFSP meeting determines next step at least by quarterly review time.**
- As Team member:
  - OT/SLP/PT contribute to FTP, consult with PSP, and as needed co-treat (at least quarterly)
- NEXT STEPS COULD BE:
  - Change in PSP (i.e., other team member can become PSP per team decision)
  - D/C
  - Move to next block **or repeat this block with justification**

Up to 3 months

1. Short-term, family-focused, primarily “specialized” services, directed by OT/SLP/ PT , based on child profile
2. Based on child’s profile and after re-assessment if needed, short-term child-focused service by OT/ SLP/PT

- Child is assigned an OT/SLP/ PT service
- As PSP:
  - Depending on child profile, OT/SLP/ PT provides 4 - 12 sessions of more specialized family-focused services followed by 4-12 sessions of more specialized child-focused services if needed (must be determined by profile and IFSP team by quarterly review time). **Reassessment and IFSP meeting determines next step at least by quarterly review time.**
- As Team member:
  - OT/SLP/PT contribute to FTP, consult with PSP, as needed co-treat (at least quarterly)
- NEXT STEPS COULD BE:
  - Change in PSP (i.e., other team member can become PSP per team decision)
  - D/C
  - Move to next or previous block **or repeat this block with justification**

Up to 6 months

Simultaneous family-focused and child-focused service by OT/SLP/PT, based on child profile.

- Child is assigned an OT/SLP/ PT service
- As PSP:
  - Depending on child profile OT/SLP/ PT provides specialized family-focused and specialized child-focused services simultaneously for more intensive intervention. **Reassessment at 6 month IFSP meeting or by quarterly review time determines next step.**
- As Team member:
  - Contribute to FTP, consult with PSP, as needed co-treat (at least quarterly)
- NEXT STEPS COULD BE:
  - Change in PSP (i.e., other team member can become PSP per team decision)
  - D/C
  - Move to previous block **or repeat this block with justification**

Up to 7-12 months

## Definitions, Support Information, Considerations:

- **Family-focused service** always involves the child
- **Child-focused service** always involves the family
- All services contribute to a unified **Family Training Plan (FTP)**
- May have to define or re-define other **terms such as “short-term” or “profiles”**
- **Reassessments** can be treatments
- **Co-treatment** could be with another team member including the family. However co-treatment with another provider (PSP) is encouraged.
- **Service options are never decided on by test scores alone.** OT/SLP/PT tests with 0-3 are not reliable sources of child’s level of function, needs, or abilities, at this time. As a result, **decisions would not be based on scores alone but on each child’s profile.**
- **Child profiles will be developed and** may include descriptions of child by age ranges; indicators of potential needs such as feeding/swallowing problems, developmental apraxia of speech, etc. ; scores (examples for speech: >1.5 <1.75 SD below Mean in receptive or expressive language; >1.75 – 2 SD below Mean in any area; or greater than 2 SD below Mean in any area), and other ICO information.
- **Paraprofessionals would receive specialized training, supervision, and monitoring; i.e.,** SLPA/OTA/PTA’s supervised by registered or licensed therapists, and with SI’s monitored and guided by these registered/licensed therapists when the program is in their primary area of specialization. **These may include parent groups or parent education programs.** Inclusion of well-trained paraprofessionals will increase the access to quality services state-wide.
- **For Medicaid:** Medicaid has clarified (3/26/10) that providers can work off of another provider’s plan of care (provider must have copy of original plan of care in file); provider can re-evaluate using standardized tests no less than every 6 months due to validity of testing; however, if provider receives an evaluation from another provider and there is reason to re-evaluate, this can take place within the 6 month requirement. **Re-assessment without standardized tests can take place prior to 6 months if needed and would be considered treatment .**
- **Tried to build in checks/balances on continuation of services** for all team members
- **Cost savings** comes in with fewer sessions per team member across the continuum of services, and the checks and balances built into the frequent team reviews/reassessments, creating a higher level of accountability; because it is well established that early intervention improves life-time outcomes, involving paraprofessionals helps ensure the quality and capacity of services and reduces overall service cost
- **As child’s needs change, another team member can become PSP,** representing the child’s major area of concern
- **Need to have specific guidelines in place for when/how to discharge/transition those children who could go on to work on other objectives; currently, these are the children who remain on caseloads for indefinite periods because there are always skills for them to work on.** Need to investigate if/when we can D/C these children vs continuing them. Would these children go back to option 1 services, if so for how long, would they just receive service coordination or be transitioned or D/C? etc.

I am in Spartanburg and wanted to let you know that unfortunately I will not attend the hearing on tomorrow night. I did want to give you some input. I have a

friend that did Early Intervention in Texas and when asked how the system worked there she stated that the state hired a speech therapist to lead the team in each county (region for us possibly because we are small) because speech is the most sought after service. PT and OT's and other Babynet service providers were contracted as prn nurses are to participate on the team if it is an identified need from the initial screening. A screening calendar was managed and appointments were made by screeners for children to be assessed. The screening calendar was posted region wide, possibly on a BabyTrac system somewhere, pass word protected so that every region scheduler could see simultaneously.

When the children were screened, present for the initial IFSP was the intake BabyNet Coordinator, and speech therapist. With children with a diagnosis that automatically would warrant PT and OT, the team would pull from the prn list of OT's and PT's to accompany the initial IFSP in a rotation. That way, as many disciplines as needed for the child was present from the beginning.

I then started to think, where would this prn list of therapists come from? If it were written in the BabyNet provider's contract, providers know from the beginning that they are required to participate; it should not be a problem. It actually would be a win, win situation for the different companies to get their company name out there with the hopes that the families would choose their company as a provider. Sounds like a win, win situation to me. If participation from providers is not given, it becomes a violation of their contract with BabyNet.

Take it from me, I know all about shake downs and separations these days and yes some providers may walk. If they do, they are probably the ones that are solely in this business for the money. They are probably the ones that never call back and participate in any IFSP meeting with EI's like me or supply reports timely anyway and that can be viewed as a win for the kids of SC if they left.

Total new staff to pull this off is screener based on regions, BabyNet coordinators for each county, ST for each region everyone else's involvement is prn. With BabyNet doing the initial evaluations, those dollars remain in the Babynet pot rather than to contracted providers. Providers will only bill for re-assessments and treatment, not the initial.

South Carolina's inter agency history that has lead up to First Steps becoming the primary stakeholder, is a culmination that all Carolinians can be proud of. Those who have worked to support the health and education of children from birth to three in all sectors - public and private - were needed then and the work of many is of great need today. The only difference is one of strength... that our efforts can be united...under one banner South Carolina First Steps to School Readiness. The citizens and communities across this state now have a single point of entry from which parents and other adults raising children can go to for leadership and advocacy. Adults parenting children with different needs and abilities are encouraged cross this state to receive information, coordination support and referrals through the efforts of local teams. The team members serve the parent/adult by helping them to meet the desires and hopes they have for their children in the least intrusive, most cost efficient manner tailored to their uniqueness.

Subject: eligibility teams

Is there evidence this model works in other states?

What is the cost of such a model?

If not billing insurance for discipline assessments/evals is the state paying more than it would be otherwise?

Maybe there is more reimbursement if billed as CBA? What are the reimbursement options?

The teams will not be stable due to the paucity of PT/OT providers in peds..We are pulling providers from the same pool...there is evidence that highlights the shortage of labor in these disciplines (not sure the same exists for SLPs) ...Could be pulling direct providers into full time conducting of assessments...thereby working to plug one identified gap and expanding another..

Is there a desire to allow for comprehensive privatizing of all BNET services (eligibility/direct therapy services/ EI services etc) vs a state controlled approach such as has been discussed (Columbia central eligibility teams or regionalized teams) It is my understanding that this works (privatizing) in other states...Are we exploring????

Are the comments here offered under this section indicating that a state employed or state contracted individual would be offering paraprofessional oversight to a private provider? Seems like a liability issue to me if reading this right

I don't think many peds practitioners will work long when only doing evals/assessments...most are in it for the relationships developed with families which this model does not allow unless one can contract or be employed as an eligibility team member and also still provide direct services and any avoid potential conflict of interest..

I understand the need but the cost of doing this should be offered as sustainable...specifics should be provided so that those persons making decisions will look beyond the theory of fixing one identified gap while also looking at the sustainability of the proposal as well as the effect on the system...

Do you know yet which building and which room will be used for the Public Hearing at the Technical College of the Lowcountry in Beaufort on 4/15/10? We would like to add that information to the announcement flier before we share it with families. There are numerous buildings on two sides of the road for that campus, so any additional info would be helpful.

In follow up to the Public Hearing in Beaufort, I wanted to let you know the names of the two BN contract providers who recently told me they were actively pursuing PTs to serve Region 8. It was DeeDee Mesaros with Southland Therapy and Jack Schultz with Schultz Speech Therapy Services. They may have insight into barriers (availability?, cost?, natural environment?, etc). I'm assuming there were barriers based on the continuing lack of NE PT providers in our area!

#### **INTAKE PROCESS:**

##### *Problems:*

1. Intake process is taking too long. (2 – 3 hours). Have to question the accuracy of parent report and child assessment results after this amount of time.
2. 10,000 children are referred to BabyNet. There is not enough staff to meet this demand and meet the 45 day deadline.
3. Consideration of phone screenings to offset the number of referrals. Trying to do this is like asking a doctor to diagnose a rash over the phone or a mechanic to diagnose your cars problems by attempting to imitate the sounds your car is making.

##### *POSSIBLE SOLUTIONS:*

1. Initial contact with family should be limited to the assessment and a couple of release forms. This would be more family friendly, decrease the amount of time spent on a child that may not be eligible, and hopefully obtain more accurate assessment results. After scores are obtained, the appropriate referral is made (if necessary) for evaluations.
2. The number of children being referred to BabyNet is a positive reflection of Child Find and community education of this program in our state. The last thing we would want to do is discourage referrals. Of the 10,000 children referred, 2,000 are from DSS. Is it possible for the DSS worker to complete a screening on the child upon removal from their home?

3. Automatic eligibility goes immediately to the EI/SC provider. They are performing the assessment anyway. We are all BN; therefore we should be able to complete the appropriate forms at the intake/initial visit.

### **ELIGIBILITY:**

#### *Problems:*

1. We are still not meeting the number of children who need to be served 0 – 3.
2. Children are remaining in the system too long.
3. Guidelines in the policy manual do not give enough explanation as to when a child needs to be discharged from services. (Although it is always a team decision)

#### *POSSIBLE SOLUTIONS:*

Do not reduce the number of children who are being made eligible. Do a re-evaluation of eligibility at 6 months to determine the need for on-going services. Also, have 3 month quarterly meetings (therapists have to do quarterly updates) to discuss the progress of the child and determine what services the child may need for the next quarter until the 6 month review is held. If the child continues to need services at 6 months another review is not held until the annual or the team deems it necessary.

While we are an agency in constant agreement that change can have a positive effect on all those involved there are certain parts of the new BabyNet Policies and Procedures Manual in which we would like to offer our comment. We have submitted suggestions that we hope were considered and still feel as though if some of those recommendations were enforced the system would be better as a whole. We understand that we don't know all the ends and outs to the entire system and recognize that there are decisions that have to be made based on money, politics, and other obligations. Please feel free to contact us for further clarification if necessary. Again, we would like to offer our time and as always our opinion on the future of this program.

1. Our main concern is the splitting of Special Instruction and Service Coordination services. Having provided both of these services for the past 11 years we feel as though the addition of one more professional in the home is the least family friendly approach possible. The EI is in the home, has established a rapport and can address the concerns at hand immediately. This also eliminates second and third hand information being misinterpreted.

**The current program in our state that operates with separate Service Coordinators and Special Instructors is not a family friendly, cohesive method of provision of services. We can provide examples over numerous years as to why this system has not worked.**

It is a fact that the children who are referred for services through a DDSN provider are offered family training. However, not all families choose to utilize this service. Also, special instruction is not always recommended by the team. It is an individualized decision. Every child's plan varies in needs, and services offered and provided and implementation of those services. **WE HAVE THE EVIDENCE TO PROVE THAT EARLY INTERVENTION SERVICES ARE INDIVIDUALIZED!**

2. We are constantly referring to other states and that this is the model in which they operate. We have several questions regarding this model and these other states.

I had the privilege of speaking to a "BN Coordinator" in Montana during the committee meetings in the fall. "Their state considered the PSP model in the past and voted against it because it did not seem family friendly and they continue to have the blended model"

**Are the states with the blended model being researched and considered as heavily as the states with the PSP model?**

- a. Who is doing the reporting that the PSP model is working? Is it decision makers who see final data or is it the people who actually do the job?
- b. Have these other states done it any other way? If they have, did they change models because of cost constraints and they HAD to make it work so therefore it is considered a good model?
- c. Why are other states permitted to have the blended model and SC is criticized for not being individualized?

**3. Has there been a survey sent to families to ask what they want? We constantly talk about everything is a team decision and it's the families choice but this system appears to limit choices and seems very controlling over what services a family receives.**

4. As we have stated before, what our system needs is more guidance and trainings. As we are educated, families can be educated.

5. Interpretation services are an enormous cost to the BabyNet system. How is this being addressed?
  6. Local ICC meetings? Who is going to be responsible for coordinating and upholding these monthly meetings? Not a top priority with all impending changes.
  7. **Who is going to be in charge of implementing the weekly screenings?**
  8. **According to this policy we should not “Use toys, materials and other equipment the professional brings to a visit.” This can be interpreted in many ways. First, it appears as though due to the family’s lack of resources, certain children aren’t allowed the opportunity to explore or be exposed to things outside of their environment. Then why go or do anything once if you can never experience it again? Children as well as professionals remain engaged, entertained and learn from new experiences. Our children make crafts, are left with items they enjoy and have a consistent excitement over “the magic bag.” It makes learning FUN! Families are given the choice as to whether or not they want us to bring toys into their home. We have had several families make this request and it was accommodated. Again, this is a family’s decision not a system decision!!!**
  9. According to the policy, you are not allowed to exit a child from the system because they miss appointments. Working with families over the years we have come to realize that while the children that we serve are our number 1 priority sometimes, it is not for that family. All families should be given leniency at first but you have to make all team members accountable. Again, this is a team and the family is the most important team member. We agree that some provider’s policies are too strict. Maybe one policy across the board that shows that maximum effort has been made to locate a family or educate them to the benefit of the services.
  10. Did anyone ever find out if we have to start the 45 day time clock upon receipt of referral or when the parent actually signs the form? This question was asked numerous times during the committee meetings.
  11. The PSP model is not understood by all providers who will be implementing this model. Is it fair to implement an incomplete policy because of all the small holes that hold enormous impact on so many people?
  12. The Federal Law does not state that discipline specific evaluations are required prior to eligibility. It states that all areas of development must be assessed prior to eligibility determination by qualified personnel.
  13. Why pay for an eligibility team when our state is in dire financial straits? This is one time money. What are we going to do when it is gone? Why implement a policy that cannot continue past one year? We can meet OSEP’s requirements without putting further financial burden on the state.
  14. Data Compliance. The current Babytrac system does NOT reflect accurate data. We have to submit information repeatedly. It is not fair to compare the past years data when our nation has been in an economic crisis therefore limiting personnel growth and training. We understand the importance of data but we have to be able to access a system that supports us. To punish those who do not have accurate data is only going to cause more problems within the local system. There needs to be sanctions instead of matrix removal.
- Thank you for the opportunity to offer our opinions and suggestions. We look forward to working with the entire program and its changes in the months to come.

Will the OT/PT/SLP serving on the evaluation team be responsible for developing the initial IFSP, specifically determining frequency?

What is the benefit to the child, family or EI agency to hire paraprofessionals when the cost of services will still be the same but the quality of care may decline and level of rapport be lessened. (Difficulty of finding qualified PTA’s with a strong pediatrics background and supervision.)

In moving to the family focused plans with what seems to be a more consultative model of therapy services, how will services be reimbursed? There is no form of reimbursement through Medicaid at this point.

What will be process be for changing frequency of services at quarterly reviews?

In the state of SC, physical therapists must have a doctor’s prescription to provide services after 30 days. Once a prescription is furnished, a physical therapy evaluation must be submitted. PT evaluations are also required to be submitted to Medicaid and other private insurance companies for authorization of services proposed. Will the initial collaborative evaluation include a separate PT evaluation or will the rendering therapist be required to perform a separate evaluation once

accepting a referral?

Early intervention, working under an educational model, employs the use of annual goals; however they are also the last payor of resort and therefore, private therapists must bill all insurance agencies first. Private insurance companies and Medicaid require frequent summaries of progress to be sent in documenting goal achievement. How do we reconcile working under a educational model with an annual goal and also bill insurance agencies which require proof of frequent and regular progress?

Is Babynet concerned about COSF reporting with the proposed decrease in frequency of direct therapy services?

As contracted Babynet providers, if the rendering therapist feels that an increase in frequency is required but is not approved to the IFSP plan, can services be rendered in addition to the plan by the same therapist as a private rehabilitation.

How will physicians be informed of the upcoming change in Babynet policy in regard to frequency of services?

Will children that are currently being served be grandfathered into the new system on July 1, 2010?

Will therapists hired by Babynet be employed full time as evaluators or will they also practice as private therapists? If so, how will referrals be made once a collaborative evaluation is completed and services are recommended? Will evaluating therapists be able to self-refer patients?

DDSN has long been involved with the provision of Early Intervention services in South Carolina. As part of this *effort*, we have been active partners with the previous IDEA Part C Lead Agency in serving the BabyNet children. I am committed to continuing this partnership with First Steps as the new BabyNet Lead Agency.

My *staff* and I have reviewed the proposed BabyNet policies and procedures that First Steps has recently issued. It is evident that this document is the product of a great deal of *effort*. While there are many positive aspects to this document, I do have some serious concerns. The two primary concerns relate to the short implementation timeframe and the apparent lack of cost controls. Enclosed please find some preliminary comments on this draft document which further elaborate the noted concerns.

We intend to continue our financial investment in the BabyNet program. However, due to the significant funding reductions we have sustained and the rapid escalation in BabyNet cost, DDSN will no longer be able to subsidize the BabyNet program at the same level we have for that past several years. My *staff* and I welcome further dialogue with you and your *staff* to assure that the BabyNet program continues to positively impact families and young children in a fiscally prudent manner.

DDSN is supportive of First Steps' *efforts* to enhance the BabyNet system; both to improve the benefits to children and families as well as to increase South Carolina's compliance with IDEA Part C regulatory requirements. DDSN also supports First Steps' goal of implementing a service system which is evidence based. While there are strengths to the proposed BabyNet policies and procedures, DDSN has a number of concerns and recommendations as follows.

#### Lack of System Overview

The proposed BabyNet policies include thorough guidance and expectations for many discrete functions of the BabyNet services. However, a broad overview of how the many components of the BabyNet system are expected to integrate and operate is not included. Consequently, DDSN still has many questions about how First Steps envisions the BabyNet system working. Of particular concern is the lack of detail on the role and function of the partnering state agencies (DDSN,

DHEC, DOE, SDB).

#### Lack of Cost Controls

DDSN has willingly subsidized BabyNet services provided by its network of early intervention providers for many years. However, this subsidy has grown substantially in the past three years. When combined with the significant funding reductions incurred by DDSN in the past two fiscal years, this magnitude of subsidy is no longer sustainable. It is also our understanding that the BabyNet Lead Agency has incurred significant unfunded increases in the services not provided by the DDSN network (e.g., therapies) in the past several years. It is our understanding that First Steps has also sustained substantial funding reductions in the past several years. In consideration of the austere fiscal climate in which we are operating, with the prospect of FY11/12 promising even more draconian funding cuts, it would seem the most pressing issue facing First Steps would be controlling BabyNet cost escalation.

DDSN is concerned that the proposed policies do not establish sufficient controls over the cost escalation of the BabyNet program. Specific concerns are as follows:

- There is no tightening of BabyNet eligibility criteria.
- While First Steps staff have indicated that a 50% reduction in the amount of Special Instruction provided will occur, there is no apparent mechanism to target special instruction service to only those children with the most significant needs. In fact, the elimination of the existing special instruction Indicators would appear likely to actually increase the number of BabyNet children who would be receiving special instruction with associated cost increase.
- The requirement that service coordination and special instruction be provided by a separate individual would, at least in the short term, appear likely to increase cost through increased number of staff required, broadened provider training requirements and duplicative staff travel.
- Based upon DDSN's understanding of Florida's experience, the primary provider model which appears to be adopted in the proposed policies would likely increase BabyNet therapy costs in addition to creating potential service access problems.
- Additionally, the "consulting" component of the primary provider model would appear to create potential Medicaid compensability issues potentially jeopardizing millions of dollars in Medicaid funding currently utilized to support therapies provided to BabyNet children.
- There appears to be a more vigorous "child find" protocol established which will likely increase the number of children served and the associated cost. South Carolina has had problems with meeting federal expectations for percentage of the total birth to three year old population receiving BabyNet in the past. However, South Carolina's percentage exceeds that of 26 other states as of Fall 2008. In fact it also exceeds by 19% the State Performance Plan goal accepted by the United States Department of Education.
- The requirement for multiple discipline specific assessments for each child is expected to increase the cost for therapies.
- There is no indication of the average expected level of service that would be received by a BabyNet child, so it is not possible to compare with current average service levels to determine potential fiscal impact.

#### Separation of Service Coordination and Special Instruction

DDSN has utilized a "blended" Early Intervention service model for many years. In this model the same person who provides the special instruction also provides service coordination. DDSN selected this model for several reasons. First, it was logical and more efficient for the person going into the family's home every week to work with the family to also be the person who could respond to the parent's concerns and needs as they arose. Second, families have stated their preference for only having one primary staff to work with and come into their home. DDSN is not aware of any change in the perspective of families which would support shifting to a separate service coordinator/special instructor model.

While an argument can be made regarding potential conflict of interest in having a "blended" service coordinator/ special instructor (i.e., the service coordinator

may be inclined to recommend more special instruction than is necessary), it is DDSN's understanding that First Steps would permit a service coordinator and special instructor who work for the same agency to serve one child. This would not address the conflict of interest issue.

The current "blended" model also yields efficiencies that are particularly important in the rural areas. DDSN has concern that the separation of service coordination and special instruction provider could result in service access problems in one or both of these services for families living in the less populated areas of the state.

While there are many states which employ a separate service coordination and special instruction model, there are others besides South Carolina which employ a blended model. Likewise, research supports the efficacy of both the separate as well as blended models. DDSN is not aware of any IDEA Part C regulatory compliance issues in South Carolina which are attributable to the blended model of service coordination and special instruction.

DDSN is committed to providing services in a manner which produces the best outcomes in most cost effective manner. Separating service coordination and special instruction may have the potential to improve service outcomes. However, with the current fiscal climate it is considered imprudent to undertake such a significant change in service delivery structure without further dialogue and investigation to include better analysis of the cost implications of such a significant change.

#### Inadequate Implementation Timeframe

Although DDSN is uncertain about many of the proposed changes to the BabyNet system, it appears that there are fundamental changes that are being recommended. Such fundamental changes require detailed fiscal analysis and implementation planning among all effected state agencies and service providers. Additionally, extensive re-training of the hundreds of staff and contractors who serve BabyNet children and families would be required.

It is DDSN's understanding that First Steps intends to implement the proposed changes on July 1, 2010. Such a short implementation period is considered inadequate to assure a successful transition to a new model of service delivery. In fact, the "Report of Technical Teams to First Steps Transition Leadership Team" notes that while alternate service models should be considered, this should be done with ongoing input from stakeholders. Such a rapid implementation of the proposed changes would not allow for such stakeholder input or thorough cost analysis.

#### Assessment/Evaluation Recommendations

DDSN suggests consideration of standardizing the screening process using an existing or modified tool DDSN uses to screen infants, toddlers and children of other ages referred to DDSN. This process takes about 15 minutes, can be done by phone (toll-free) and has improved the percentage of children who meet criteria for DDSN services. This tool was developed by a team of psychologists who determine eligibility for DDSN High-Risk and At-Risk children.

For children screened in, the next step is a home visit to explain the BabyNet program and to conduct a CBA, if applicable, to determine eligibility for BabyNet (not all families may choose to go through eligibility process). This person needs to be reliable in conducting CBAs (e.g. the AEPS). For children found eligible, the person conducting the CBA would use the results of the CBA to determine the most appropriate referrals for further assessment(s). The following four examples reflect several, but not all possible scenarios of how this protocol would work. Referrals for all appropriate assessments will likely need further development.

- If CBA reflects only a speech-language delay, a referral to an approved service coordination provider and to a speech/language pathologist may be appropriate referrals.
- If the CBA did not reflect a need for special instruction or if the family did not want special instruction but the CSA indicates a need for a PT assessment, a referral to an approved service coordination provider and to a PT provider may be appropriate.
- If CBA reflects global delays or a gross/fine motor skills delay and child is not deaf or blind, a referral to an approved DDSN EI provider may be appropriate along with other referrals (e.g. PT, OT, etc.) as the CBA indicates.

• IF CBA reflects global delays or gross/fine motor skills delay and child is deaf and/or blind, a referral to the School for the Deaf and Blind's EI may be appropriate.

The SC/EI would evaluate results (using specific criteria which would need to be developed) to determine which providers need to attend the initial IFSP meeting. NOTE: EIs would use a different standardized CSA to conduct their assessment for special instruction. The SC/EI would set up IFSP meeting and begin developing the IFSP at the first meeting with the team and family.

All providers are required to submit or document progress reports every quarter to SC/EI. SC/EI would be required to re-evaluate the child's eligibility for BabyNet every 6 months using the same standardized CBA as noted above.

1. The plans developed by the lead agency as described during the public hearings will efficiently address many of OSEP's longstanding concerns related to Part C implementation within the limitations imposed by structure and function of participating agencies.
2. The public hearing provided apparently much needed opportunity to learn about lead agency plans for the program. Several attendees mentioned that reason for participation was to get more information about BabyNet.
3. However, the public did not have an opportunity to provide meaningful comments on the proposed policies and procedures because key elements of the proposed plans were not included in the documented posted for review.  
This includes, for example, a full description of the "primary provider model", as well as composition, and selection and services of the evaluation and assessment teams.
4. The hearing started with presentation of problems or issues (especially those identified by OSEP), description of how they are corrected by the proposed policies, and invitation to provide the lead agency with options for addressing these problems *other* than through implementation of proposed policies.  
Again, the purpose of a public hearing is to comment on the specific proposals offered for consideration. The posted document did not allow comparison of proposed policies to existing problems (though that this would not have been difficult to do). The public would not have a description of problem and solution *except* by attending the public hearing or other lead agency presentation.
5. Information that could be obtained only at public hearings or other lead agency meetings with interested parties was necessary (but not sufficient), to fully understand lead agency plans.  
This made it critical to assure reasonable interval between final hearing and the deadline for comments.
6. The format and structure of the policy and procedure manual provided for comment doesn't "flow" in a manner that is easy to follow.
7. There are many conflicting statements from one section to the next. Specific examples are provided below. The overall affect is confusion about the lead agency intent.
8. Because the materials posted for comment were so confusing, much of the public hearing time was necessarily spent explaining the proposed policies and implications for role of contracted providers and agency partners.
9. It would have been helpful if the policies were written in terms of roles to be filled without assumptions about the specific role of currently participating agencies. These roles were not discussed with agency management in advance, and were only brought to light based on questions during the public hearings.
10. All questions related to implications of proposed policies on specific agency jobs (special instructor, intake coordinator) should have been referred to the employing agency. Lead agency has no way of knowing what adaptations will be made to comply with program policy, especially since the proposed changes were not discussed in advance of the public hearings.

11. The policies were described as having been “intentionally written with holes in them”, and that the “details” of policy implementation would be worked out in “interagency” group(s). However, some parts of the manual include detailed description of activities to be completed, while other areas don’t provide enough information to fully understand the policy, changes from current policy or implications for service providers and parents. (For example, the number of home visits required between referral and initial IFSP completion.)
12. For purposes of public comment, the practice guidelines and other general statements about how providers should *think* about tasks could have been separated from BabyNet-specific policies and procedures. If, as stated, this information is based on current practice guidelines, there was no need for public comment. Had this information been eliminated, the lead agency plans might have been easier to follow.  

At a minimum the “principle does/does not look like this” boxes should be moved to separate supporting document(s) or “cheat sheets”.
13. Public hearing procedures were problematic in that:
  - a. On-the-spot responses were provided to most questions and comments. This was in large part because most of the comments indicated that lead agency intent was not clear in the posted materials. Nonetheless, comments received during public hearings should be reviewed and considered after all comments are received, regardless of Part C Coordinator/moderator concurrence.
  - b. Part C Coordinator wrote policies, moderated public hearings and is recipient of all written comments. At a minimum a non-biased party should have conducted the hearings.
  - c. Information discussed during the public meeting was a function of what questions were asked by participants. Information about varying aspects of the program was revealed at each meeting based on these questions. The more meetings attended, the more complete the information about lead agency plans and priorities. Most participants only attended one public hearing.
  - d. The moderator recorded participant comments during the meeting, so that no official transcript of actual comments will be available for OSEP or public review. An alternative would have been to ask attendees to write down their comments before leaving the meeting. However unfortunate, much is this is understandable in that questions were required to understand the proposed policies.
14. The moderator repeatedly stated that in the majority of cases, receipt of service coordination is dependent upon receipt of special instruction (family training). However all eligible children are assigned to a service coordinator regardless of other services received.
15. Table of contents and carefully numbered sections would help public review of the document. The numbering used in the document is inconsistent. This is a simple formatting issue, but adds to the confusion following the proposed procedures.
16. Replace statements that “the *BabyNet program* will...” with “BabyNet agency staff and/or contractors will...” The “BabyNet net program” doesn’t act, only specified entities responsible for program management (lead agency) or service delivery implementation (lead agency contractors or subcontractors) can act. Making this change will also allow specific designation of parties responsible.
17. Information available to the public should have included a flow chart or concise narrative overview of the normal sequence of events from referral to exit at age three. That is very difficult to determine based on the document offered for public input.
18. The posted document is a combination of federal regulations (current or proposed), existing policy manual and other information. The entire document should be reviewed to make sure that references are relevant to SC and BabyNet. For example cross references to the “Part” of the federal regulations, or statements about what “the public agency” will do.

SPECIFIC COMMENTS ON CONTENT OF THE PROPOSED POLICIES AND PROCEDURES.

- Page 3: Definition includes only generic characteristics of the “child find system”. Need more complete description of purpose, components and use within the BabyNet system. Definition should be in operational terms
- Page 4: #14 & #15 are part of #13, not separate definitions.  
#13 & #18 defining same thing. Cross reference would clarify and eliminate duplication.
- Page 5: Suggest rewording last sentence with more “positive” description of usefulness of interim IFSP.  
#28 Great definition of intake service coordinator. This term (or “intake coordinator”) should be used consistently in the document. (Eliminate “intake/service coordinator”.)
- Page 6: Clarify number of “geographic districts”. References to 9 here and 8 on page 12.)  
Provide map with boundaries, to eliminate assumption that Part C service areas are same as DHEC Administrative Regions, in case one or the other changes.
- Page 7: #55 eliminate reference to service coordinator (circular). Model definition on that used for intake coordinator.
- Page 7: #56: replace term “public agency” with “BabyNet contract agency” or other term specific to BabyNet program.  
Same changes should be made elsewhere in the document when this generic term is used.  
#58: “Single point of entry” is defined as information and referral phone line, however this is not how the term is used in the document. It most frequently refers to the place where referrals are received and processed. Clarification needed.  
#59: Are there any subsequent references to this specific term?  
#62: Generic definition of and “transition” should be limited to Part C activities -- (a) “Between Part C provider agencies” and (c) “school to post school” should be revise or eliminated.  
Add definitions for “primary care provider” and primary provider model. Although used throughout the document, no definition or specific description of these services in the BabyNet system is provided. This is a critical omission since the planned service delivery model is highly dependent on this role. Responses to individual questions during the public hearings revealed some lead agency plans, but, since they are not documented, the public has not had opportunity to comment on an issue that is actually the foundation of the system lead agency plans to implement.  
Check repeated reference to “this part” unless sections of manual are going to be labeled “parts”.
- Page 8 #2: Multiple restatements of same information
- Page 10 (c) Check information to be reported to Secretary and public. This is going to be reported to state level of specificity? Should information in (c) go under (3)?  
Specify that term refers to 2-party agreements between lead agency and individual state agencies or entities providing Part C services, rather than a single agreement among all participating agencies. This is significant change for South Carolina Part C program and deserves full description.
- Page 11 Add statement requiring SICC to assure public access to minutes and attendance for each meeting. This requirement is included for LICC [#4(c), page 12], but not SICC.
- Page 12: Reword Policy statement in box.  
What are the designated Part C “Early Intervention Service” (EIS) agencies? No clear description is provided here or elsewhere in the document. None have been in place since January 1, 2010. Will they be established? If not, eliminate reference here.  
What is relationship to the “geographic” districts or regions referenced in the policy and EIS agency coverage?  
What geographic areas will be used for reporting data to OSEP and the public? How will those areas relate to EIS agency responsibilities?  
Are local representatives of all agencies or entities providing IDEA Part C services under agreement with lead agency expected to serve on each LICC?  
How will LICC members be selected?

	<p>Do the LICCs report <u>only</u> to the SICC? If so, what entity within established geographic area will be responsible for correction of noncompliance when compliance with IDEA Part C requires coordinated action of one or more participating agencies?</p> <p>What is the “local BabyNet state office”? Add definition.</p> <p>How do new LICC responsibilities related to current function of local interagency teams responsible for resolving issues affecting program performance within designated geographic area?</p>
Page 13:	<p>#3(c): Define “BabyNet supervisor” as generic term for person responsible for contracting agency BabyNet services at local level (or whatever the term means) as titles might vary by agency or entity.</p> <p>#3(d): Excellent description “intake coordinator” under definitions. Add similar definition for “on-going service coordinator”, and use consistently through out the document.</p> <p>#4: Add definition of “BabyNet service provider” under definitions, the use consistently within the document.</p> <p>#4a: Add definition of “ABA” here or in definitions. First use of acronym with no explanation.</p> <p>#4c: Is there a footnote?</p>
Page 15	<p>#10: Who <i>exactly</i> is responsible for assuring demonstration of competencies? Describe requirements in generic terms. (See above comment regarding use of “supervisor” designation.)</p> <p>If each contracting agency is responsible for their staff, recommend wording it that way so that when contract refers to “compliance with BabyNet policies” there will no question about contractor responsibilities.</p> <p>Alternatively, lead agency could list all such contractor requirements in the contract or in an appendix to the contract.</p>
Page 19	<p>Add complete description of role of “primary care provider” in relationship to family and child served, other providers serving the child and the service coordinator.</p>
Page 21	<p>Subsequent sections reference the separate “BabyNet Procedural Safeguards manual”. Recommend including statement acknowledging its existence and describing contents and purpose.</p>
Page 30	<p>Policy statement in box references consistency with IDEA Part B. Correct?</p> <p>Add explanation of what entities are/will be responsible for child find activities described in proposed policies, and if/how these activities will be funded.</p> <p>Clarify SPOE office responsibilities regarding screening. Is the first task in the intake process to review screening results, or complete and document PEDS and MCHAT findings?</p> <p>Will child find providers be monitored to assure referral within 48 hours of referral? If so, how will confidentiality be maintained?</p> <p>What exactly is a “child find event”? If an entity routinely completes developmental screens for children served, is that counted as an “event”?</p> <p>Will BabyNet allow use of evidence-based screening tools other than PEDS?</p> <p>How was the schedule of child find events determined? What entity is responsible for assuring that the required number of “events” are conducted and documented.</p>
Page 31	<p>#3(a) “Partnering agencies with existing service coordination systems will be utilized by BabyNet as long as they are consistent with the requirements.” What does this mean?</p>
Page 32	<p>What is the minimum information required to constitute a “referral” that initiates the 45-day time line for IFSP completion? Receipt of directory information? Receipt of directory information and completion of initial PEDS/M-CHAT screening (if results not available to the intake coordinator)?</p>
Page 35	<p>(e) What are the applicable “state and local protocols about notifying the referral source about action taken on referral”?</p>
Page 39	<p>#2(a) Add working definition of “SPOE office”. (Especially given “SPOE” definition in proposed policies.):</p> <p>Proposed policy states that “each SPOE office will employ or make arrangements to contract with a standing eligibility determination team as described below, one team for every 100 screened referrals to the SPOE office”. Lead agency explanations at public hearings indicate that this statement is</p>

incorrect.

Public was not provided enough accurate information to make meaningful comment on proposed policies related to selection, composition and function of standing eligibility determination teams within the Part C program.

At one public hearing (Beaufort) lead agency reported that RFP for the statewide evaluation and assessment teams had already gone out and at least one response had been received. At another (Charleston) lead agency reported that there would be an opportunity for public comment on the RFP. In any case, language in the RFP might be a source of information about selection, composition, and responsibilities of these teams and role in initial IFSP development.

Page 40 (g)(i) Is the incoming service coordinator part of the team developing the initial IFSP? What activities are included in “oversight of the evaluation”? Are others involved?

Page 45 3(b)(iii)(6) contains another reference to responsibilities of incoming service coordinator during the initial IFSP process. Please identify all members of initial IFSP team and responsibilities.

Page 61 Delete entire section and provide policies to be used. Especially important to remove and replace all references to DHEC responsibilities that ended with change in lead agency, or will end on June 30, 2010 (i.e. storage and archiving of BabyNet record).

This section was apparently inserted directly from the current manual. Information is in conflict with the changes included in the proposed policies.

Public is unable to provide meaningful on lead agency policies related to documentation and record management.

I’m ready to share some comments & observations with you pertaining to the proposed revisions to BabyNet Policies, Procedures, & Practices. I feel that I do have some valid insight by virtue of the fact that I have been a member of someone’s IFSP team since August 1993. To be quite honest, I thought I worked for BabyNet my first year (not DHEC or DDSN but BabyNet). I can remember when --- and I made up our own IFSP for premature infants. I can’t recall who told us we couldn’t do that; it looked really good to us. In

advance, please excuse my lack of organization and/or structure in this; my mind races to compensate for my inability to move any faster than molasses. Also, these views and comments are mine alone and do not reflect those of my employer or any other individual (other than ---).

The establishment of independent evaluation teams who will assist families in developing IFSP’s and identifying needed support services is long overdue as is utilizing dedicated service coordination for the 45 day process. The practice of using one Service Coordinator to complete ½ of an Initial IFSP and forwarding to another Service Coordinator for completion creates confusion for families and a race for the second coordinator to meet the 45 day timeframe (since the first coordinator may or may not be timely with getting information to the second coordinator). Using a team of professionals to evaluate and participate in IFSP development allows for a portrait of the child rather than the quick snapshot. It will eliminate any question of conflict of interest, and will certainly leave the family with a clearer picture of what Part C actually is and what they can expect from it. Independent evaluation teams along with a 45 day dedicated service coordinator will eliminate the determination of services prior to the Initial IFSP (ex. A child coming in with a therapy service and the parent has the expectation that the service will automatically be a BN service). I would suggest that an independent interpreter be utilized when needed also – again, this will eliminate any appearance of conflict of interest. I could comment in greater detail but time will not allow.

DDSN’s model of blended EI services is ok in theory and practice with manageable caseloads of 12 to 13/14 families. However, given the complications and increased duties of coordinating just BN services (excluding any other services), it is unrealistic to expect one individual to provide special instruction (to include travel time) and quality service coordination for the current DDSN expected caseloads of 18 to 21 - likewise with the blending of any other direct therapy service and BN service coordination. As you know, I personally support a separation of services and have for many years. I found that service quality (one or the other), decreased as caseloads got larger and larger and at the same time, service coordination duties were increasing significantly. Again, I could comment in greater detail but time will not allow.

As a new lead agency making changes and revisions, First Steps must correct the statewide misconception that BabyNet is a medical program driven by doctors' orders and prescriptions. First Steps would do well to implement checks & balances with regard to adherence to the BN contract by private providers and individuals employed by private providers. First Steps must address the issues of service saturation in preferred geographical locations (picking & choosing) and the ever increasing popularity of clinic based therapy services. Training in cultural diversity as related to developmental milestones should be required of anyone assessing, evaluating, or screening children served or seeking to be served by BabyNet. I would suggest that the cohesive IFSP Team is at present time a concept rather than a reality. I sort of feel that BabyNet has regressed over the years and is on the brink of becoming globally delayed as a result of the previous Lead Agency's failure to provide required oversight. I could comment in greater detail, but I need to go home.

#### **General Comments**

1. FS gathered teams of people within the Part C system from all over the state to work on a transition plan to guide the movement of the system from DHEC to First Steps. This group worked for over a month and produced a final product that outlined recommendations for the system. The work of those teams recommended that particular topics be explored in more detail however they are not included in this manual 4 months later. That exploration piece did not take place to determine the feasibility of such changes. It was also recommended that things be piloted in certain areas and that is not included in the draft P&PM. It was also noted that a complete redesign of the system did not need to take place and that appears to be the recommendation contained in the draft manual.
2. The agencies which are expected to do the lion's share of the work were not included in the design of this manual. Agencies should have been given the opportunity to discuss their ongoing participation and the level of that participation BEFORE the manual went out to the entire state. Except for the small section at the end of page 10, there is no acknowledgement of other agency work at all and even that section can be summed up as an area devoted to fiscal accountability over the agencies and dispute resolution. This manual does not answer questions. What is the system going to look like for children and families? Veterans within the system have been unable to answer this question after reading this manual.
3. Primary Service Provider-This manual does not explain this model at all-it doesn't account for family choice nor does it indicate if families were consulted to determine if this is what they truly want. Throughout the manual there is information about the need for consistency in service delivery and yet we are proposing a model where the primary service provider can change every couple of weeks or months if necessary. How does this promote the very consistency that the manual prescribes?
4. The numbering system in this manual is difficult to follow and while the manual cautions staff against the use of jargon the manual itself is full of jargon. Examples of numbering system include: #10 a) ii) (1)( a), #2) b) i)(5)(c). We can't expect staff to be able to ask questions or clearly communicate with each other about expectations with a manual that outlines information in this format. Examples of jargon include: "all of the intervention modalities depend on the service providers' expert understanding of the foundation of the task, ongoing observation of the response to intervention strategies and varying the selection and use of intervention strategies."
5. This manual was created in isolation by one person and emailed to staff in the field. Information communicated to staff statewide dictated that all comments come back to that same person. This person is also conducting all of the public hearings about the manual and its contents and is documenting comments made in the public hearing. This would seem to be a conflict of interest.
6. SCDDSN does not serve 90% of the children in the system currently, they serve 74%. This is clarification of something stated in the public forums.
7. To report that South Carolina is noncompliant in our service coordination activities is stretching the truth. The feds do not spell out service coordination targets; they are set by the state. Early Intervention staff in South Carolina have as many as 4 systems to enter data into and for more than a year now it has been noted that there are issues with one system (TECS - outcome system) that is affecting the state's data. EI staff in the field are having to enter and re-enter data which is making the overall data for the state look worse than it is. This is another reason that it is problematic to state that service coordination providers will be removed as providers if their data is not "good" given that there are inherent problem with the current data systems.
8. The use of SI indicators is no different than identifying the need for a discipline specific evaluation and the need for ongoing therapies before the IFSP based on the results of a CBA. You cannot say that the CBA indicates the need for a PT evaluation to be done and PT services be recommended and then

say that SI indicators that are based on the same CBA scores are somehow different. The regulations do not mandate that a child have a discipline specific evaluation before eligibility, just that they be assessed in all domains-this recommendation will drive up costs.

### **Specific Policy and Procedural Manual Comments**

1. #1(b) says that FS shall be responsible for: assigning fiscal responsibility among appropriate agencies for early intervention services???
2. #2 a) FS shall be responsible for the supervision and monitorship of agencies? You will supervise us but then in #3 b) we will be required to participate in periodic on-site monitoring. How will these visits be done? Will they be a Part C expense?
3. Emails to our staff recently have indicated that Service Coordination providers will be removed from the matrices for data that isn't within normal limits. How is that going to be done and who will monitor that? How can a SPOE office know from one day to the next who the available providers are if providers are constantly being removed and then added back to the matrices?
4. Page 2, 4 f) references the Rights of Infants and Toddlers-is that the new name for the Child and Family Rights, because that is referenced later in the document?
5. Page 3, #6 is misleading, stating that the child's eligibility will be determined by the State Dept. of Education which is not clear.
9. What is this Central Directory? Who maintains this?
10. Page 4, #18) seems to indicate that services can be provided to children in a group setting which violates the current HHS early intervention manual.
11. Page 10, 3 a-e-what is this about? Talks about additional data to be collected. FS will request and submit this info? If yes, than to whom?
12. Page 11-don't understand why the make-up of the ICC is included in the Policy and Procedure manual.
13. Page 12-Who is going to do all of this work? It implies that it is work to be done at the local level by DHEC region, but this is A LOT of work (i. e. Give 10 day public notice, minutes, attendance and ensure that the make-up of the team meets requirements including families) that gives no explanation about who will complete. This amount of work cannot be rotated around the 3 agencies that currently deliver services. This section is unrealistic and will add additional costs and should be coordinated by the lead agency. If all don't attend a particular meeting is the meeting then canceled?
14. Page 14, #5 is wrong. We don't have subcontractors under the Boards.
15. Page 15, the way in which these boxes are written is demeaning to staff in the field. These suggestions are appropriate for a training setting, but not for a P&PM manual. The last box in this section is particularly degrading. To assume that folks in early childhood would look at a child and assume that they cannot learn is ludicrous.
16. The fourth block down on the right-who does this? Who gives families worksheets to do for homework??
17. Page 20- the boxes include lots of consultative language and jargon. Who will pay for such services? With notes about making time to meet formally and informally-how will this not drive up costs?
18. Page 22, #2) b) i) (5) (c) – What? Who is this? Who are we referring them to? Family Connections?
19. Page 23-#5)c) ii)-this could be very expensive-is this at agency/provider expense or at the expense of the lead agency?
20. Page 24-#5) g)i)-who is this for agencies? Is this by provider?
21. Page 24-5 g, i)-There is a typo on "services" in this sentence and who are private early intervention service providers?
22. Page 28, #2 a) isn't clear. Who do you "initiate action" with?
23. Page 29, 1) d)-who are the local BN offices?
24. Page 30, This page is NOT clear on who is doing this work. In the ICC meeting, it was indicated that this was going to be done by public and private agencies and that they would be doing screenings to help ensure appropriate referrals. Don't understand who will do this work. It is not realistic to think that child care providers are going to screen children before they refer them. Many of them don't refer children now and some don't even let EI's come into their centers. How are you going to communicate this expectation to them and when they don't do the work before sending the referral it becomes someone else's responsibility.
25. Page 30-#7 and #8-children who come in under established risk still have to have a screening completed? This is not a good use of someone's time.
26. Page 34-1)a) i-iv) these all need to be removed. They are already captured in other sections of this manual. This entire page seems like a training

document not something that needs to be included in a P&PM.

27. Page 35 e) what state and local protocols are you referring to regarding notification of referral source?
28. Page 35 f)-This information was just stated on the previous page and elsewhere in the manual. There is too much repetitive information.
29. Page 36 1) h) iii-v-This whole section is confusing. It has the family having the option of being the assessor. Then the next section i) and ii) is repetitive again.
30. Page 36-why do we need *practices* and then *procedures* and then *purposes* of intake?
31. Page 36 2) b-this is invasive and rude. Why are we questioning families about where they will keep BN documents??
32. Page 36-2) e) i)-What about within normal limits with parental concerns?
33. Page 36-This entire section is confusing? One line talks about a child is in screening and then the next one jumps to eligibility and then straight to information to be collected.
34. Page 37-38, Is DHEC completing all CBA's? Based on reading the manual it is difficult to answer this question.
35. Page 38-under practices-1) a) after functional, strengths should be first to be more positive.
36. Page 39, how are standing eligibility teams paid for and how will we have enough staff in rural areas to maintain two or more teams? How will this not drive up costs? 3 areas of the state will have to have more than one eligibility determination team. ARRA funding is one time money that will not sustain an ongoing eligibility process long term.
37. Page 39-2)a) Is this screened in referrals or just screened referrals?
38. Page 40-all therapists must now have a pediatric background? This will be even fewer providers available to do work.
39. Page 40-Can the person who completed the CBA be on the eligibility determination team?
40. Page 40-2) c) ii) (3)-(a), (b), (c) are all unclear and not in the correct place in the manual.
41. Page 40-2) g) i) #1-6-This section is confusing. How is the incoming SC responsible for ensuring that the stuff outlined in 1-6 occurred when eligibility was being determined and the incoming SC was not involved? The things spelled out here are the responsibility of the persons completing the evaluations and/or assessments as part of their licensure.
42. Page 40, the family can now attend the eligibility evaluation?
43. Page 41, ongoing eligibility-we have had issues with this for years. Why is it the same at annual as it is in the beginning? We can't find where it is required to be reassessed annually.
44. Page 41-3)-Why would the period of eligibility begin when the incoming SC and multidisciplinary team documents eligibility? What did the evaluation team and intake coordinator just spend their time doing? There is no way this will occur within 45 days.
45. Page 41 6-this section is unclear.
46. Page 42-nearly the entire page is repetitive
47. Page 43 1) g) v)-this is the first time that primary service provider has been mentioned since page 1.
48. Page 43-1)g)viii)-we cannot tell if discipline specific evals have been done yet or not or are you determining frequency and intensity without them as this statement suggests? This also has a typo (space at beginning)
49. Page 44-1)k)iii)-the family can ask for a change in SC "*if state policies and procedures address this issue?*" What does this mean?
50. Page 44-i)ii)iii)-this language at the top of the page is all repetitive
51. Page 44-On page 40 we have an incoming SC, then on Page 43 you identify the primary service provider, then on Page 44 1)k) says that we have assignment of which team member will provide ongoing Service Coordination. Then on Page 45-3) b) iii) (2)-it says the SC that has been working with the family since the initial referral or who has been designated by the public agency. ?? Then under 3)c) we go back to the designated SC. Then on Page 46-4) a) viii) then we say the SC from the profession most immediately relevant. We are completely lost at this point about Service Coordination as a whole.
52. Page 44-1) a)-e)-why are we listing the procedures for the IFSP again?
53. Page 44, k) i)-what are state and local models of service coordination?

54. Page 45-3) b)iii-this notes that two disciplines must be at the initial and annual-what if they are receiving SC only?
55. Page 46-This entire page is a repeat of content on pages 43 and 44.
56. Page 47-6) c)-what are conference notes???
57. Page 47-the interim IFSP section is confusing. One section states that “services that have been determined to be needed immediately by the child and the child’s family” how can you know that services are needed immediately if you haven’t done an evaluation or assessment? It also notes that services can begin before evaluations or assessments.
58. Page 47-6) Annual review of the IFSP does not indicate a requirement to reassess eligibility-is this still a requirement?
59. Page 48, 1) h)-how are staff or anyone going to be trained in assistive technology and have it be covered under Part C? This notes assistance for the professional-who is this? And then goes on to say, or other individuals who provide services to or are otherwise substantially involved in the major life functions of the eligible infant or toddler-who is this? A neighbor, a family friend, etc?
60. Why would trach care, tube feedings or catheterization be listed under health services not nursing?
61. Page 50-practice section is again repetitive
62. Page 51-This page seems like it is an attempt to micro-manage work and does not have anything to do with services in Natural environments.
63. Page 52-The procedures spelled out here are all repetitive from previous pages
64. Page 53-5) b) iv)-the statement here doesn’t make sense-“*If the service is initiated using a direct method, and if family training including strategies for use between visits of the service provider has been delivery has been provided , in most cases.*”
65. Page 53 and 54-This entire section implies that consultative services have been approved by the Medicaid agency.
66. Page 54-5) c) i) (3)-the top of this page indicates participating in the multidisciplinary team’s assessment which implies that everyone gets together and completes one big assessment.
67. Page 55-6) c)-after example, Is this a typo? What is a *physical* service provider?
68. Page 56-8) a)-why are they referred to as “clinical” service notes?
69. Still see no need for a family training plan. You have a plan that outlines goals and strategies and that plan was developed as a team-why do you then need another plan that spells out the same thing? And this plan is required to be updated every 90 days? How will this not add costs to the system, if each provider must re-assess and then send that info to the SC who must then complete a Family Training Plan? How is this different than a comprehensive IFSP?
70. Page 57 – f)-What is an Early Childhood Goal? Are you referring to the Early Childhood Outcomes?
71. Page 57–Transition Box-In every other Policy area box this is just an overview but in the Transition Policy area box there are specific steps?
72. Page 58 – 1) b) iii) iv) and v) are not appropriate. These recommendations in this section are not policy statements or issues.
73. Page 57 and 58-I thought that the regulations referred to transitions as *all* transitions that the family goes through with their child not just transition at age three. Those transitions are not addressed anywhere in this manual.
74. Page 58 – 1)a) What is section A?
75. Page 59 1)d)ii-vi) This is a repeat from page 58.
76. Page 60 4)c)ii) Why is the SC responsible in communicating anything with Part B once the directory info is sent prior to 2 ½ yrs and the parent decline conference? It was assured by SDE reps that this was not necessary.
77. Page 60 4)i) Why are we going back to LITA’s? They weren’t working before why would we reinstate them?
78. Page 60 4) h)-this statement says that arrangements will be reviewed and updated annually with each local coordination team-I thought that they were local interagency coordinating councils.
79. Page 60 5)b) So a referral needs to be made to Pro-Parent for every child referred to Part B? And why would we state, “the family will be better served if...”
80. Page 61 – Documentation box – it’s very concerning that it is being made clear this is not a medical record – when HHS requires that the services be

medically necessary.

81. Page 61 – Who is the keeper of the BN record?
82. Page 61 3)a)-d) Is it required that this format be maintained by all providers?
83. Page 62 There is no mention of where the ongoing service notes go?
84. Page 62 i)-k) – Why are these separated out from one section of medicals/therapies?
85. Page 62 4)b)i) – DDSN cannot use red ink in a file.
86. Page 63 5)d)i)(1) – Lost to follow up cases. It is not specified how many attempts would be required prior to sending the WPN.
87. Page 64 5)d)i) (6)-ii) (5) – There is no mention as to what DHEC would do with the BN record if BN services are indicated, by family, to no longer be desired or needed. How will DHEC be required to get the BN record to the Lead Agency? This is not explained until the end of Page 65.
88. Page 66 7) e) How can the Lead Agency destroy an Educational Record in these time frames?

I am attaching my thoughts, concerns and recommendations concerning the changes in the BN system. I plan to attend the public hearing. Will be interested to hear the input that you are getting from throughout the state.

#### **BABYNET SYSTEM DRAFT MANUAL COMMENTS APRIL 2010**

##### **WHAT IS NOT WORKING**

#### **1. Intake, eligibility determination**

- a. Full CBA's on every child that is referred. Far too costly. Too much for workers and families to be done on one visit. Need to screen or do CBA before proceeding with all the BN paper work. If child is not eligible, then BN nor the family would have invested hours in the process.
- b. CBA's being completed by BN coordinators who lack child development expertise in some areas. Need qualified child development professionals to conduct CBA and determine eligibility.
- c. AEPS is not a good tool. It is way too long for so little usable information. Results are not easily translated to families, nor easily translated into functional goals.

#### **IFSP's not being completed within the 45 day deadline.**

Some SPOE offices are understaffed and inadequately staffed to handle the volume of referrals. SPOE should be responsible only for taking referrals, informing families about the system, discussing and documenting parents concerns, completing CBA when indicated and determining eligibility. The "way too much" required paperwork could be completed after the IFSP is done by the on-going SC. All families who are referred to BN really do not want services. They need to be able to make an informed decision which can only happen if they are provided a good description of the system up front. Whereas the physician or grandparent may have some concerns about the child's development, the family often does not or may not once everything is explained to them.

- d. Change the "IFSP clock" from date of referral to date of parental consent for evaluation.
- e. The eligibility team that is proposed in the manual would then have time to do CBA or other discipline specific evaluation , hold team meeting and complete the IFSP prior to referring to on-going Service Coordinator. This team should be separate from providers who may be providing on-going services (SC, SI, PT, etc).
- f. Do not understand the "interim" IFSP concept.

**3. SPOE office providing service coordination.** This function could be done by an EI/SC agency. Children who no longer require SI could remain with the same EI/SC to coordinate other services that may still be needed or just to monitor until the child is no longer eligible or turns three. This prevents child from getting lost in the transfer process, reduces the change in "people" the family must get to know and share their lives with; save money b/c would not require another provider.

#### **4. Therapy/interpreter provider system.**

- a. Providers are not trained or regulated. They do not follow

BN policy. They dictate the amount of services to be provided. Do not value other members of the “team”. Tend to determine the amount of therapy by the number of openings on their caseloads. Very “cookie-cutter” type of decisions made. Not likely to evaluate and say that a child does not qualify for services...or that they only need monthly monitoring. Most will not even consider home programs or consultative services. Also, the PT may see the child a couple of times and immediately recommend an OT evaluation (to the family). They do not discuss their concerns with the EI/SC prior to making the recommendation. End up with 4 month olds getting PT, OT, SLP b/c family thinks if the therapist recommends then they must have the service. Then family gets overwhelmed and misses appointments. Then the therapists complain to the EI/SC. Again, many do not understand the team concept.

- b. Therapy providers get to pick and choose their locations, hours, number of days they will work, etc. Many do not try to accommodate the family’s schedules.
- c. Interpreter services are being provided for speech therapy for children who may not even be delayed in their own language. Very costly system for children who may never speak English, b/c many of the families do not speak English in their homes. This is really an eligibility issue that needs some serious investigation.

Therapy may be the most costly part of the BN system. Much of this is due to lack of training, oversight and regulation.

### **5. LACK OF TRAINING**

There has been little to no training for any providers over the past few years. Changes in policies or procedures have mostly been communicated via e-mail.

**Before any significant changes are made to the system, comprehensive training for ALL providers must be done.** The history of the Babynet system has been inadequate training which allowed for different interpretations of policies and procedures and an overall disparity of service distribution throughout the state.

#### **WHAT IS WORKING**

**Combined SI/SC provider** is the one thing about the current system that **DOES** work. Having **one** person in the home who really gets to know the child and the family is much more “family friendly”. The EI does not have to translate family information, requests, needs, to another person who will never know the family in the same way. Communication is key and adding another layer only increases the chance for valuable information to get lost. Who are parents likely to call when they need something...the EI they see weekly or the SC they see every six months?

Will be a difficult process re-training the professionals who have been doing both jobs for years.

How will SC be funded if separated? The Babynet system serves a large number of children who are not Medicaid eligible, so who will pay for the service coordinator?

#### **OTHER COMMENTS**

We recommend that the manual be a **Policy** manual that is clear and concise. Procedural manual may be separate and follow comprehensive training. As long as service providers understand the policies, then procedures would not need to be so descriptive. Should not need to dictate procedures.

**Local ICC:** Who will run? What are the expected outcomes? Will it replace the current Babynet Coordination Teams?

#### **Train before implementing any changes!**

Thanks for listening at the public hearing. Can you tell we are all concerned and confused? We know that change is needed, it is just that some of us frontliners have a hard time envisioning a whole new system.

I hope we can take it one piece at a time and get everyone on the same page and the kinks worked out before moving to another piece. We are going thru lots of changes just with the drastic budget cuts, so this is a lot of change at one time.

We are writing to you regarding a few of the proposed changes to the BabyNet/First Steps policy manual.

First, the policy that concerns us the most is the one regarding the definition of who is considered qualified to determine if an autistic child should receive services. Currently the “gold standard” test used to identify children with autism is the Autism Diagnostic Observation Schedule (ADOS). The ADOS was developed by Western Psychological Services and found to be reliable only if performed by examiners who have been “clinically trained” by Western Psychological Services (WPS). Certified examiners are required to attend a 2 day training course to be classified as “clinically trained.” WPS also offers a video training, but they prefer potential examiners to attend the more comprehensive training with live testing demonstrations and instruction in scoring. The validity of the ADOS is considered higher if the examiner is trained on site. In addition, WPS also requires the purchase of their specific testing kit and scoring materials. Each examiner must have the exact kit sold by WPS to accurately administer and score the test.

We would like to propose that “clinically trained” medical professionals, i.e., physicians and occupational therapists, be included on the Baby net/First Steps list of examiners who can administer the ADOS, identify autistic children and recommend early intervention services.

Second, in reviewing the financial distribution breakdown of IDEA Part C funds, we noticed that there is a huge disparity, almost \$1,000,000, between allocation of monies to speech and language therapy compared to the combined total for occupational and physical therapy. Research has shown that the gross and fine motor development of children is essential to speech and language development. In other words, if a child has poor muscle tone or an overall lack of strength in the proximal upper body muscles then speech and language development will be much more difficult to attain. Therefore the disparity between the funding for speech therapy and occupational and physical therapies is blatantly questionable.

We would like to propose that the IDEA Part C fund distribution be re-examined by medical professionals to create a more appropriate division of funds so that the children of South Carolina, age birth to three, will have equal access to all possible therapeutic interventions.

Third, we are concerned about the contradiction of initial assessments being performed at the BabyNet/First Steps local office, yet all services for the child must be performed in their natural environment. If the initial assessment can be performed in a clinic setting then why there is no flexibility to the rule that therapy must be performed in the child’s natural environment. Some credentialed therapists often have limited availability to schedule natural environment therapy sessions due to varying locations, travel time, etc. This often delays the start of therapy if a credentialed therapist can’t be found within a reasonable time, which is currently understood to be within 60 days. It seems unreasonable to make a child wait to start therapy when they have already been determined to be eligible.

We propose that when therapy is deemed necessary, the reasonable time to locate available therapists to provide services in the child’s natural environment be changed from 60 days to 14 days. If a credentialed therapist is not found within 14 days then the child should be referred to a clinic setting to start therapy while the service coordinator continues to look for an available therapist. This will allow the child to start working toward attainment of goals earlier and successfully master the identified delays in a shorter amount of time.

Lastly, during the Charleston community meeting regarding proposed policy revisions you commented that you would like more physicians to refer children to BabyNet/First Steps. As a pediatrician who *does* refer quite often to BabyNet/First Steps, I am frequently puzzled when I hear that a child has been denied services after the initial phone interview by an intake coordinator who is not medically trained, and doesn’t actually see the child. As a pediatrician with almost 20 years of experience and a special interest in developmental disabilities, I am disturbed that my medical opinion and diagnosis is potentially being overridden by someone with little or no child development background. A list of questions presented to a parent over the phone is “screening” at best and should in no way be used as the primary determining factor as to whether a child qualifies for early intervention services. I think more physicians would refer if the eligibility determination process included their expert opinion (medical diagnosis) and the referral process was easier to navigate.

We propose that the practice of phone intake to determine eligibility or ineligibility be discontinued. A phone intake would be more appropriately used as a basic information gathering tool to set up an appointment, in the child's natural environment, for a face to face assessment by a highly qualified early interventionist or a similarly trained person.

We are strongly committed to improving the lives of the children in the state of South Carolina. Our proposed changes reflect our frustrations that we experience on a daily basis as we interact with families who are attempting to give their children every opportunity available to them. We appreciate your time and consideration and hope that you will find our suggestions helpful. Please feel free to contact either of us at the numbers below if you have any questions about our proposals.

I have reviewed the BN manual and have some questions about some of the proposed changes.

1. Splitting of SC and FT/SI. I have some reservations about how this will work. Who will be responsible for what paperwork? It seems to me if a family is receiving FT/SI services, then that person should also be the SC for the child and family. Families depend heavily on their EI, and are used to expressing needs to the EI. So, if a need is expressed, does the EI then contact the SC so that a goal can be added to the plan? If a child/family is not receiving FT/SI, then it makes sense to me that either EIs of the county Board or private providers provide ongoing SC for the Babynet eligible children.

2. Years ago, we had LICCs instead of the BNCTs and the LICCs, in my opinion, were never as effective as the local BNCTs have been. The BNCT catches the key players of the Babynet system in addressing strengths, weaknesses, etc at the local level. The previous LICCs were not as effective because folks who attended didn't understand the system couldn't really participate and/or always wanted to try to provide services differently than outlined by BN policy and procedure. A lot of time was spent during those meetings trying to educate people on the BN system.

3. Who will be a part of contracted eligibility determination teams? Who decides who will be on the eligibility determination team? Will the teams meet weekly? Will these teams replace the initial CBA? 4. What are Family Training Plans? We have an IFSP that drives services and determines what goals will be addressed and by whom. Is the FTP a duplication of the IFSP? Who will be responsible for completing the FTP?

5. What are the guidelines for determining SC non-compliance and what data will be referenced when removing a provider from a SC matrix? If one piece of data is out of compliance, will the SC provider be removed? Once removed from a matrix, does the SC provider have a time frame to become compliant in order to be added back to the matrix?

I have attached my comments on the BabyNet Application. Thanks for all of the work, I can only imagine the effort. Some of my comments are edits (hope it is helpful) and should not be perceived a criticisms, I know the tight timeline to get this done.

I have compiled the following comments related to the Annual BabyNet Application.

Section III A -Considering the state of BabyNet in South Carolina and the consistent inability to resolve/complete all identified issues and concerns, it would seem that a Director or Program Coordinator dedicated 100% to the project would be employed. The application references a 20% Division Director and a 10% Bureau Director to provide program oversight. This is insufficient considering the scope of work necessary to supervise and oversee a program of this scale.

The CARELINE (child find line) for this program should be supported with staff at all times especially during peak hours of the work day. Child find has been noted as an area of need in this state and sited in past compliance agreement. \$320,000 is given to one agency for child find efforts but there is not dedicated staff

to the child find line. Other agencies act as child find and offer free of charge support to this effort.

Section III – C - This section addresses ICC administrative personnel – the description of duties related to this position refers to the previous section III A – are we to assume there is not position or is this another position with no salary or duty information. Until a two months ago no ICC existed in our state and there was no administrative staff .

Section III D – The “new” ICC has no schedule of meetings, no by-laws, no activities of record.

Section II E – Direct Service “Other” – Services provided in the amount of \$389,924 should warrant some type of break down of what services this money supports.

Section III G - \$320,100 to support one non-profit agency to provide “child find activities and family support services”. There are many agencies, including non-profits that provide same services to families of children eligible for part C services. Should other agencies and non-profits not be included. Family support is an “option” for families that can be offered not one of the services specified or implied under Part C regulations.

In meetings and discussions through the past few months. There has been noted that eligible children may lose some services and criteria for new eligible children will be changed to include that all eligible children will need to meet two indicators not one. \$320,100 would cover many services for infants that are critical to their development and future well being.

Section III G - \$300,000 to the S. C. Budget and Control Board seems excessive for maintenance and up-grades to an existing system. The system has been developed, this is a recurring expenditure from previous reports.

I am writing you with concern on the proposed baby net changes that would affect myself and my two children who receive EI services.

I have been receiving services for almost 3 years and i have had no troubles or concerns with the way information and services were provided. I do however feel like changing things now and adding additional people to my children's case. Would cause commotion and confusion. My EI has been exceptional in finding and providing me the things i need to help my children. My concern falls in adding a person whom is not familiar with my children and the way they function and the services they need. With the EI now she knows my children the physicians and therapists and how to get me the help i need.

I do hope that First Steps considers all these things before making a final decision. I feel the only ones to suffer from this will be the children and families who don't understand how this effects things in the long run.

My son is in the baby net program. I have major concerns regarding the proposed changes for the EI and service coordinators. I think this will have a negative impact in reference to communication and adds another level of complexity. I am not in favor of this proposed change.

I am a parent of a young child that is being served by BabyNet. These services have really helped my son with his language development. I feel that adding another service provider will greatly affect the future progress of his development. Having direct contact with the EI and plans are very beneficial.

Thank you so much for the opportunity to weigh in on BabyNet issues. As best I can remember, these were the points I made:

1. Screenings: the point of entry is crucial, and the quality of the intake coordinators to date varies wildly. When their talent is lacking, and they miss key red flags, children do not qualify, and it's a mess. At times BabyNet ends up paying for therapy beyond the third birthday because the initial screening was a false negative.

Doctors also fail to miss key red flags. My interesting statistic: we currently have 200 children on our caseload, ranging from five months to eighteen years. The vast majority have permanent, life-impacting diagnoses. Other than those clear at birth (Down Syndrome, cleft palate), 100% (!!!) of our boys were NOT referred for any services when the parents expressed concerns to their pediatricians. 100% of the autistic, PDD, Fragile X, Tourette's, ODD, OCD boys waited one-two-three years before the doctor finally agreed to refer out. The very same problem exists with the intake coordinators, even when WE are the referral source and equip them with a written report outlining the specific deficits.

2. Solution: bypass this problem, and save a lot of wasted time, by creating 'gold standard' tx teams (the finest OT/PT/ST/EI set in each district) and contract with them one or two days a week to do screenings. They are by far more sophisticated and sensitive to early development, and will decrease the false positive/false negative rates.

3. Statistics: the stats on late evals is vague in that we don't what percentages those raw numbers represent. Such as, late evals due to no-shows, cancels, dr appts for medically fragile children, parents not answering the door. How much non-compliance is due to 'slack' professionals and how much is due to family circumstances?

4. Rural service delivery: always a problem, and certainly many other states are grappling with this. How are they managing? We are in professions that do not create wealth, and cannot spend as much time traveling as we do in direct tx generating revenue. I have suggested the following ideas over the years and finally just gave up --

A) Contract with therapists one or two days/week to travel in a state car and serve kids in the natural environment.

B) Contract with therapists to provide centralized services in WIC offices. In my opinion, any service is better than no service, and many of our kids in outlying areas simply go without any skilled intervention. I think that OSEP would agree that good support in NNE is better than no support at all.

5. Consult model: how can we determine 'lead' vs 'consult' in cases with medically fragile or otherwise very complicated kids? My example was the preemie spastic quad with reflux. Add vision disorder. There will be cases that truly need expert handling from OT/PT/ST on a regular, consistent basis. Not forever, but at least for two years while we have that open window of optimal growth and development.

6. 'Consult': this must be strictly defined. Webcam? Phone? Drop-in? We must abide by ethical guidelines (ie, face-to-face contact with the pt) as well as billing guidelines, and frequently straddle organizations with competing demands. Insurance companies and OSEP are fundamentally different entities. One issue that OSEP/BabyNet DO NOT consider is the paper trail AFTER the children age out. We cannot summarily adopt BabyNet policy without an eye to the future, particularly in terms of billing. For example, BN supervisors sometimes want to authorize initial evals before we receive a parallel authorization from the ins co. I understand that it delays entry, but we thereby (unfairly) compromise the pt's future potential for acquiring tx. This has been a difficult concept for BN folks to grasp. We have dual bureaucracies with which to comply; one that ends at age 3, one that continues far beyond age 3. Which is more important??

Again, thank you. I appreciate being able to participate in this dialogue, and trust that my response is not too verbose. I am very hopeful about the future of BabyNet in SC. Please do not hesitate to contact me with any further questions or concerns.

To say that I am shocked and dismayed by the "exception of certain services related to autism statement" would be an understatement. I literally had to read this statement several times to fully understand the implications this limitation would have on families and children affected by autism spectrum disorders. This statement is clearly discriminatory and in violation of federal requirements not to deny needed services based on cost. Evidence-based interventions such as

applied behavior analysis are expensive but are absolutely needed for some children if the intervention is going to benefit the child. The policy should be written to clearly indicate that services listed are not an exhaustive list but merely a listing of examples of services. Decisions about services should be based on student's needs and not based on the system willingness to pay for a certain services. This statement is an outstanding example of why we need increased and continued federal oversight.

It is important policy point that all children over the age 18 months participating in a child find event will be screened using the Modified Checklist for Autism in Toddlers. Additionally, we must have policies in place for children found eligible for services under other areas of disabilities, e.g. speech, to be screened using the Modified Checklist for Autism in Toddlers if red flags are present. Also, we must have systems and policies in place to "Act Early" for infants and toddlers under the age of 18 months. Policies should include training by Developmental Pediatricians to local early intervention and child service providers in red flags for infants and toddlers under the age of 18 months at risk for autism spectrum disorders. Statistics show that the state of South Carolina's system of early identification of children under the age of 3 has been extraordinarily discrepant from actual prevalence rates thus reflecting a system that fails to identify early and fails to provide much needed early and intensive intervention. Federal partners and First Step staff should monitor closely the amount of children identified with autism spectrum disorders and make a sustained and concerted effort to improve early identification of children with ASDs. There is a suspicion that there has been an overt suppression of identification of children with ASD due to the cost of evidenced-based intervention services. Again, thank you for the opportunity to improve these draft policies and procedures.

I have been a practicing provider for the BabyNet system since August of 2004. During that time, I have been held as a valued therapist within the community and local physicians with frequent referrals and usually a waiting list for my services. That being said, I am extremely frustrated and disappointed in the proposed revisions to BabyNet practices.

At the State Convention, speech therapists sat for 45 minutes and listened to the history of BabyNet and the success it had achieved with children with disabilities. These revisions, in my opinion, will be taking the children of SC back to pre-Part C days. In that workshop, it was boasted of how much good services to children under 3 had done - but to reduce services in this new fashion, is to subtract the gains you have made.

As a self-employed professional, I am personally offended that the services that I offer, which are highly valued by parents and medical professionals, would be reduced to merely a consult basis. The revisions, while very aptly written to look beneficial, would severely limit a parent's abilities to learn how to communicate with their child, how to play with their child, and how to implement home carry-over. Currently, speech therapy is already involving the parents in sessions, spending time questioning and answering parents questions, and giving suggestions for home activities. To reduce services to once monthly is the equivalent of spending one hour with a child per month teaching them to read and then sending a ton of books home with the parents and saying "good luck, call me if you need me". That is not the way our school professionals would teach and that is not the way I was taught to do therapy in my Master's degree program. I foresee these children coming into our public school system not only being limited in communication, but also having delayed language abilities which will affect their future reading and academic success.

In my practice, very few children are seen for more than a year. My goal as a therapist is to "get 'em in and get 'em out". If a parent is motivated to help their child and it is truly a language delay, most children can be exited from therapy in approximately 6 months. These revisions will not only hurt these delayed children, but exasperate and increase their frustration and future difficulties.

If a child of mine is seen long-term, it is usually due to a parents unwillingness to follow through with suggestions, or a child's major medical needs. In these cases of parental involvement, these revisions will do little to motivate a parent to change their motivation or participation in therapy. As is often said of children and

doctors, a parent knows best. In the same way, we therapists that deal with the parents first-hand know that every parent has potential, but we know our parents and we know that with certain cases, these revisions will still not work. We were told of an ASHA study in which your revisions were recommended. With parental involvement seen as optimal with fantastic results. However, please note, parents that volunteer to participate in a research study will already be motivated to help their child. So this study was already skewed in that respect as the parents that will not actively help their child, would most likely not be a participant in that study to begin with! I have searched ASHA's website and consult therapy is not at this time a recommendation of early intervention therapy. It is not how therapists were trained to practice in our graduate schools. To 'pass the torch' and pass our goals on to the 'lead therapist' (OT/PT) is not only unethical but also is against our professional practices in that we are not allowed to train anyone to do our job that is not a licensed therapist.

Let me also point out that this job is a profession that is in high demand in other settings. Should BabyNet follow through and decrease services to once monthly, as was said in the BabyNet convention session, "most therapists will be jumping ship". We cannot provide for our families in a job where our services are not valued or needed at our current recommendations. I do not plan to recommend on a therapy plan that a child be seen once monthly as I do not feel professionally that this is in the best interest of the child's needs. I am professional enough to decrease therapy to bi-monthly or even monthly when a child is not in as great a need and exit when a child is not in need at all. Otherwise, I see a child weekly as I have found that service delivery works best for their progress. To have a governmental program dictate those recommendations based on what we therapist see are primarily budget issues, is offensive as our state is choosing to limit a disabled child's care for the sake of not 'trimming the fat' in other budget areas.

I ask that you would include my name in your May 11th conference call and would request that information be provided so that I can contribute to your discussion on these matters. Thank you.

BabyNet Manual Notes

- \*this is the most confusing collaboration that I have read in a long time...I literally had to read a small section, make notations and come back
- \*the language of the manual is not cohesive at all...some sections are too detailed and others are too vague
- \*there are times when reading through a section and I wonder if the same author is writing the manual?
- \*the manual is not in very family friendly language and is very condescending and demeaning to staff and providers

### **STATE ADMINISTRATION**

(1) pg 1 states that FS in accordance with IDEA Part C and state interagency agreements...not sure what state agencies were part of this interagency agreement, but when reading through the manual it reads more like a dictation of new order, rather than a collaboration of people that are actually involved in the day to day operations of Early Intervention services. 1b.....how is FS going to be responsible for assigning financial responsibility among agencies that work under other fiscal agents/contracts as well...and are they going to be treated any different than the agencies mentioned in (3) agencies that receive assistance?

### **IDENTIFICATION AND COORDINATION OF RESOURCES**

Not sure at all what funds are being discussed to supplement and increase state and local funds for eligible children??

Is this section supposed to address the recent announcement that information that is out of compliance or not entered into the system timely will result in providers being taken off the matrix from the SPOE offices?

### **INTERAGENCY AGREEMENTS, STATE INTERAGENCY COORDINATING COUNCIL, LOCAL INTRAGENCY COORDINATING COUNCIL**

Is it really necessary to have these sections in this particular policy? Once they have been established I wouldn't think it should need to remain in the Policies and Procedural manual for continued reference.

There are 7 pages used for **THE COMPREHENSIVE SYSTEM OF PERSONNEL DEVELOPMENT**???. Do we *really* need that much devoted to information that can be found on the TECS website? The charts "this principle DOES look like this/ this principle DOES NOT look like this" are copied almost verbatim from a training seminar during the Early Intervention Conference a few years back. Nevermind that it is very degrading to staff that have worked in this field for

any length of time. We know that “professional’s toys, materials or equipment are the “magic” necessary for child progress” and “basing expectations for families on characteristics such as race, ethnicity, education, income or categorizing families as those who are more likely to work with early intervention and those who won’t” are NOT good Early Intervention practices. I can’t believe that anyone in this field would consciously make these kinds of assumptions as to have to be *reminded* in the procedural manual and policy. I would think that a quick reference to the collaboration efforts with TECS would suffice for this section. There are far more issues that need further clarification.

### **CHILD FIND**

7) All primary referral sources are encouraged to do a screening before the child find screenings or referrals to BN? It seems like it defeats the purpose of child find services if they are being pre-screened by the agencies before the child find screenings. Besides, it helps to have several sets of eyes on a child because if the first screening only relies on information from the parents that could be very different that what level the child actually functions on.

### **SERVICE COORDINATION (CASE MANAGEMENT)**

Just a general statement...it is going to be far more confusing to have yet someone else stepping into a family’s home to do the SC piece separate from the SI piece of the IFSP. They have already had a BN intake coordinator come work with them, now they are going to have to deal with 2 additional people along with all the Dr.s, therapists, specialists, etc that are involved with their child. Has anyone really asked the families if they want this new model? Has it been fully explained to them?? I am going to answer that question as no, because it really has not been explained well to us and we can’t adequately inform families of what we don’t understand ourselves. How is it that other states can have a combined model of service coordination and service delivery for early intervention services?

(3 a) partnering agencies with existing service coordination systems will be utilized by BabyNet... HOW exactly is that going to happen? In our agency our SCs work with adults with MR, Autism, and Related Disabilities. They follow the SC guidelines outlined by DDSN, not BabyNet. They are already engorged with cases due to budget cuts and caseload ratio increases. I don’t see how that would be feasible to add yet another set of rules/regulations from BabyNet on top of that. Another possibility would be to split the current Early Intervention staff to have some do SC and some doing SI...? Not a good option because whether or not an EI does any SC, the SI and travel takes up the bulk of their time and we are staffed by contracts with DDSN based on the number of children we serve and the maintaining of a caseload ratio. How will all of that play into the separation of SC and SI?? The early interventionist is in the home with the families each week or at least monthly...the families become comfortable with them and they know more about what the family and child needs than a person (SC) that only works with them on a monthly quarterly or yearly basis (what ever the criteria will be)

### **ORIENTATION AND INTAKE**

This section seems like a great training tool to be used for BN intake coordinators to use as a how-to when they get a referral, however I don’t think all the i-ii-iii-iv-v-vi-viii-ix are needed under each letter. This section is way TOO specific with how to do an intake and leaves the rest of the manual vague.

3e) who is going to be conducting the CBA (SPOE, BN Intake Coordinator, Ongoing SC)? Why would they be scheduling it with the family if someone else is going to conducting it?

3d) why would you give a signed WPN that the child is found not eligible before the CBA?

Where is the \$ going to come from for the ‘Eligibility teams’ one team for every 100+ referrals?? How are the PT OT and ST going to be incorporated in that team when we there are waiting lists for services now and shortages of providers in certain areas?

g)i) who is the incoming SC? how is that going to be determined (by a matrix, parent choice, etc)

5) Family assessments? Is this the same thing as the family information gathered by the initial IFSP development referred to in 3 c) 7 on pg 37? If so, why would this need re-done. 5 (4) states that the family assessment must be completed within 45 days of referral into the EI system prior to the initial IFSP meeting? I’m confused.

6) Again, I am totally lost and confused here...this doesn’t seem like the same person wrote this section at all

### **IFSP**

1 a- do we really need to be reminded to establish a welcoming and respectful climate for family members and caregivers??

k) who assigns the ongoing SC? based on what state and local models? You should take the out the statement “if state policy and procedures address this issue” because of course our policies addresses this issue...we wouldn’t be very family friendly if we did NOT offer families the choice of providers.

\*\*\*I have no clue who the SC is in this entire section???. One section says incoming SC, one says primary service provider, another one says ongoing SC, on pg.

45 it says that the SC that has been working with the family since the initial referral or who has been designated by the public agency?? And on pg 46 the manual refers to the SC from a profession most immediately relevant...HUH?

I like the idea of an Interm IFSP in the event that a family can not complete the annual IFSP for some outstanding reason; however is that something that is going to be offered for ongoing annual IFSP meetings after the initial?

There seems to be a lot of repetition in this section.

### **EARLY INTERVENTION SERVICES DEFINITIONS**

1) h- who is going to provide/pay for training or technical assistance for the professional or other individuals who provide services or substantially involved in the life functions of... does that include day care workers, family, friends, etc. ??

5) the items listed in a-d should be listed under nursing as they must be performed by a skilled professional likewise under the nursing c) promotion of health and development could be listed under health services instead.

### **SERVICE DELIVERY IN NATURAL ENVIRONMENT**

Why is it necessary to repeat the Practices section again? Pg. 51 has been addressed several times in other places in the manual and has nothing to do with Natural Environments. This is another section that is really demeaning to staff when reading it.

Are those the procedures for the IFSP again on pg. 52?

5)b)iv) HUH? This doesn't make sense and the sentence just stops at... in most cases...

Is it necessary to bold out 5bi and 5bv?

6)c) should that be physical therapy provider rather than physical service provider? If not, what is a physical service provider

6)d)ii) 'use someone else who is not usually a part of the child's team to substitute' should be more clearly defined as to WHO that other someone could be because as it reads grandma could provide SI training while EI is on vacation.

8a) 'clinical' service notes? Those have never been referred to as clinical before

8b) a Family Training Plan?????? What is that~ the goals and actions are already recorded on the IFSP, reviewed, and updated as needed? Why is there a need for a separate FT plan?

8c) are the Eis (Special Instructor providers) going to be required to submit a progress report to the SC as well?

8f) what are Early Childhood Goals that the providers are required to participate in at their exit from BN?

### **TRANSITIONS**

Practices 1)b)iv, v) acknowledge feelings about ending the relationship with this family??? And celebrate the accomplishments and joys??? Does that need to be incorporated in the P&P manual?

Procedures 1)a) where is section A?

5)b) why does it say that the family will be better served if the BN SC has facilitated contact with ProParents??? Are we going to be required to refer every child leaving the BN system to ProParents?

### **DOCUMENTATION/RECORD MANAGEMENT**

3)f)i) are we going to be required to use DHEC 1619 for all ongoing service notes

4)c)iv) incomplete sentence...relationship to the child at least once on each ? (page, note)

5)d) how long do we wait before sending WPN for closure

Dear Ms. DeVenny:

Thank you for the opportunity to comment on the First Steps BabyNet Policies, The Richland/Lexington Disabilities and Special Needs Board is committed to providing quality services to the children of our state.

My staff and I have reviewed the proposed BabyNet policies, spoke with Kristi Musick, Part C Coordinator, and attended the public hearing held in Columbia. We appreciate the time and work that has been done to complete this document. We do have concerns related to some of the proposed changes.

Enclosed you will find preliminary comments based on our understanding of the proposed policies and procedures. If you have any questions regarding these comments please do not hesitate to contact me. Thank you.

#### Separation of Service Coordination and Special Instruction

The proposed changes include the separation of special instruction and service coordination. In theory, this practice could address any potential conflict of interest that could occur with the person who authorizes services also providing service. It has also been stated that this separation will ensure compliance with OSEP's requirement for individualization. We assert that in reality, the separation of these two tasks will result in a loss of efficiency and will *decrease* access to services and *reduce* individualization of services for families. We have been verbally informed

the proposed change allows the same entity to provide both special instruction and service coordination. This arrangement does not seem to address a conflict of interest. Further, the issue of conflict could simply be resolved through use of a standardized assessment tool that recommends Special Instruction frequency - this solution appears to be more cost effective and could be further reviewed. In addition, we have questions about how this system change ensures a fully functioning, integrated system for families.

Currently, EI's are in a family's home on a regular basis and are familiar with the family dynamic in such a way that assessment of needs is an ongoing and natural process that is taking place constantly. EI's, in their role as Special Instructor, assess a child's strengths and delays on global measures of development. They are naturally synthesizing this information into the supports and referrals a family needs and the type of provider a family might work with best and receive most benefit from based on that family's core values and beliefs. When they translate this information into IFSP goals and make provider referrals, in their role as a Service Coordinator, they are naturally inclined to approach these tasks from the family's perspective because of their extensive first-hand knowledge of the family dynamics.

The proposed changes introduce a new person into the team process. This person is not already a functional member of that process. This person has to *become* familiar with the family's core values through an unnatural assessment process, because by definition, they are not able to be present in the family's home on as regular a basis as a Special Instructor would and do not possess first-hand knowledge of the family dynamics. This person is an additional person in the family's home. We anticipate that needs will arise and be verbalized to Special Instructors (SI), who then has to communicate those needs to the Service Coordinator (SC), who then acts on those recommendations based on their second-hand knowledge of the child and family. This unnatural process requires the additional bureaucracy in the form of standards and policies (i.e. requirements for SI's to submit regular progress reports to SC's, etc.) in order to ensure that the process runs smoothly. Currently these additional processes are not necessary.

The current blended model (having the Special Instructor also serve as a Service Coordinator) works well. It should become a model for best practice in ensuring that the Early Intervention process is "dynamic and individualized to reflect the child's and family members' preferences, learning styles, and cultural beliefs" and that "IFSP outcomes must be ... based on children's and families' needs and priorities." (Workgroup on Principles and Practices in Natural Environments (February, 2008) *Seven key principles: Looks likeldoesn 't look like*. OSEP TA Community of Practice-Part C Settings. <http://www.nectac.org/topics/families/families.asp>) The proposed system does not appear to be as family focused as the current system. Families have informed us they do not want service coordination and special instruction to be provided by a separate individual. We believe the "blended" model has the potential for becoming a model of best practice as it relates to OSEP's family centered principles.

#### Special Instruction

Under this proposed change, Special Instruction would be treated like individual therapies (much like ST, PT, and OT) and would be authorized by a Service Coordinator, whose job it is to know the family, assess the family's needs, and make recommendations about and referrals to outside services. Currently, the person going into the home every week, the EI who provides both special instruction and service coordination can address the need at the time it arises.

### Program Cost

With any major change in system infrastructure comes two things that our currently precarious system is not prepared to handle: increase in cost- even if temporary, and temporary reduction in efficiency and compliance due to the need to re-train and reorganize based on new procedures. The separation of Service Coordination from Special Instruction will *reduce* program efficiencies related to staffing patterns, particularly in rural areas of South Carolina, but potentially in all areas, where one staff person will have to be replaced by two. Additionally, providers will have to spend dollars to re-define roles, publish those changes to ensure program integrity, re-train staff and re-define quality assurance measures that capture data necessary to evaluate the new programs. This proposed change costs money that is not available. Providers in this state have experienced unprecedented program reductions over the past 2 years and additional cuts are likely forthcoming. Implementing such extensive changes in this climate is likely to be problematic. The requirement for discipline specific assessments for all children will increase costs. It is sometimes difficult to find a therapist at this time. We are concerned there will not be adequate resources available to implement this change July 1, 2010. Increased child-find activities will potentially increase the number of children eligible for services. We certainly want to ensure those children who are eligible receive needed services; however, we are concerned about funding to meet the needs of the most needy children.

### Timeframe for Implementation

A system change of this magnitude requires careful implementation. The proposed changes are complex. We are concerned the plan to implement the proposed changes on July 1, 2010 does not allow adequate time for proper implementation. The logistics of training on this large scale seem almost impossible to complete by the proposed implementation date.

--- is concerned about the proposed changes to BabyNet policy and procedures and how it will reflect on children and families during and after transition.

1. Model of coordination chosen should offer family support with the least amount of intrusion so that the child may receive the highest quality of early intervention .
2. Personnel should be knowledgeable in all areas of child development and services available.
3. Personnel should be knowledgeable in preschool outcomes so that transition may flow smoothly and appropriate services continue.

Thank you for forwarding the PowerPoints. We appreciate the opportunity to comment on BabyNet.

I was a member of the original BabyNet planning efforts many years ago. It is disappointing that many of the concerns raised at that time still have not been resolved. --- hopes, however, that the proposed changes will increase BabyNet's effectiveness. The following comments are based on the summary of the proposed changes highlighted in the PowerPoints. Since I was unable to attend the public hearing, I apologize for any erroneous statements that may have been clarified at the site.

1. The local child find networks should include providers from many disciplines, particularly mental health and persons familiar with autism spectrum disorders. We have found that some children display behaviors suggestive of emotional disabilities as early as preschool. Early intervention is critical for them.
2. As part of improving Child Find, ---suggests continuous outreach to all day care providers (including family and church-based daycare), health clinics and primary care physicians.
3. Parents should be advised of their procedural rights if a child is screened out prior to referral to BabyNet.
- 4.--- supports the effort to comply with the required 45 day timeline. Over the years we have received complaints about the slowness of the evaluation process. Time is obviously critical for these very young children and we commend the effort to improve the process.
5. In order to facilitate meaningful parental participation in the evaluation of the IFSP, --- suggests reviewing all materials provided to parents to ensure that they

are a) written in plain English; b) available in large type and other accessible formats; and c) translated into Spanish. In order to make sure that the process proceeds within the required time limits, the person responsible for setting up any meetings must know how to obtain any necessary interpreters, including Sign Language and Spanish. Service coordinators should clearly explain parents' procedural rights to them and assist in making referrals to advocacy groups. Extensions of time should be rare exceptions to what should be an expedited process.

6. --- supports the separation of service coordination from instruction or provision of services. The service coordinator should be a disinterested person whose goal is to ensure that all necessary services are promptly provided.

7. While identification of potential services should be available prior to the IFSP meeting, the IFSP, like the IEP, must not be presented as a completed plan prior to the meeting. The IFSP must be a truly interactive process in which parents are treated as equals. Service coordinators must be able to assess whether the IFSP services are effective and whether the IFSP should be modified.

8. --- strongly supports the provision of services to the child in the natural environment, whether in the home, out of home, or some combination. IFSPs should include provisions for the child to interact with children without disabilities.

9. Transportation is a major barrier to children receiving services. Since a large number of BabyNet children receive Medicaid, members of the IFSP team should coordinate transportation to provide access to services when needed.

10. It is essential that BabyNet meet federal standards for timely delivery of services. Children change daily; each day that a child with disabilities as serious as those required for BabyNet eligibility is deprived of needed services is a day that may have lifetime adverse consequences. In addition, failure to meet the standards may put the State at risk of federal sanctions.

11. BabyNet procedures must provide for a seamless transition into Part B. --- has received many complaints from parents about delays caused by changing from one system to another. These problems are especially severe over the summer vacation. Service coordinators must begin the planning process early enough to involve their counterparts from Part B.

12. BabyNet's policies and procedures must be promulgated as regulations. The Department of Education has detailed regulations for the operation of Part B. There is no reason why the same regulatory safeguards should not apply to Part C. Simple fairness, as well as the Administrative Procedures Act, requires promulgation.