

Early Steps

**Florida's Early Intervention System for Infants
and Toddlers and their Families**

Service Delivery Policy and Guidance

*Delivering Services in the Routines
and Daily Activities of Young
Children with Disabilities and their
Families*

(Effective July 1, 2004)
(Revised February 1, 2005)



Through the implementation of the new service delivery system and policies clarified in this paper, Early Steps ensures that families and caregivers of infants and toddlers with disabilities have the opportunity to enhance the development of their children within their everyday routines, activities and places. The overall goal of the system is to increase opportunities for infants and toddlers with disabilities to be integrated in their families and communities, and to learn, play and interact with children without disabilities.

Introduction

In October, 2003, Early Steps, within the Department of Health, Children's Medical Services, issued the draft position/policy paper entitled, *Provision of Early Intervention in Natural Environments: Service Delivery in the Routines and Daily Activities of Young Children with Disabilities and their Families*. This document described a new service delivery system that brings Florida into compliance with federal requirements to provide services in natural environments as mandated in IDEA, Part C (34 CFR 303.167(c)(1). The draft document recommended practices based on current literature and research, and incorporated stakeholder recommendations from March, 2003, that included the development of a consultative model of service delivery that would support relationship-based service delivery and that would meet the federal requirements to provide services in natural environments.

Federal regulations stipulate that a sixty (60) day period be made available for public comment and review of the draft position/policy paper. As a result, 52 written responses were received from stakeholders. Written responses were received from families, independent providers, provider groups, Department of Education, Local Education Agencies, Early Intervention Programs, Florida Interagency Council for Infants and Toddlers, and professional therapy organizations. Meetings, emails, and telephone conversations were also conducted with various individuals and groups. Additionally, meetings and conference calls were held with the Early Intervention Program Directors and Coordinators that resulted in policy changes and decisions that impact the implementation of the new service delivery system. These changes are reflected in this paper.

There are several recurring issues of concern that emerged from the comments received and discussions held. They are as follows:

- family options in service decisions
- role of therapy and therapists in service provision

- definition of what constitutes a natural environment
- continuum of services/flexibility of service provision
- composition and role of the team
- role of the primary service provider
- scope of practice concerns of therapists
- role of the service coordinator in the new service delivery system
- role of family in the new service delivery system

The purpose of this document is to provide clarification on the above issues and articulate policies and guidelines for service delivery. The information in this paper will be disseminated through a variety of venues, such as fact sheets, frequently asked questions (FAQ) documents, on-going public awareness activities (e.g., web-sites, e-mailings, printed documents), and training and technical assistance.

The policies set forth in this document will supersede policies in the Infants and Toddlers Program Plan and Operations Guide (PPOG) dated February, 2002, and subsequent policy memorandums. The policies stated in this paper will begin to be implemented effective July 1, 2004. The PPOG, Quality Assurance document, and the Community Plan will be revised to reflect the new policy. New fiscal, data, and contracting processes and policies are addressed in separate documents.

Concurrent with the implementation of the new service delivery system, new requirements and processes for provider enrollment and training are being finalized as part of Florida's Comprehensive System of Personnel Development (CSPD). These changes are reflected in the *Early Steps Personnel Development and Training Guide* that will be available in March, 2004.

The Office of Special Education Programs (OSEP) in the U.S. Department of Education has required Florida to make certain revisions to this paper. These revisions, which have been incorporated and are effective February 1, 2005, do not change Early Steps' policy direction. Clarifying language is added to ensure that the paper communicates that

Florida's system remains in compliance with the provisions of Part C of the Individuals with Disabilities Education Act (IDEA).

Note to Readers: The Family Support Plan (FSP) document and process has been changed to the Individualized Family Support Plan (IFSP) to align with new policies and processes in the new service delivery system. The revised IFSP document will be available July 1, 2004. These changes are reflected in this document.

Note to Readers: References in this document to the Infant Toddler Developmental Specialist (ITDS) refer to the designation of a new category of provider in the Florida Early Steps. The ITDS focuses on infant/toddler development and ways to promote development and learning, including designing learning environments and activities to promote development across all domains. The ITDS, in conjunction with other early intervention providers on the child's team, assists the family in understanding the special needs of the child and enhancing the child's development.

The ITDS is an individual with a bachelor's degree from an accredited college or university in early childhood or early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work. More information on the requirements to become an Infant Toddler Developmental Specialist may be found in the *Early Steps Personnel Development and Training Guide*.

Note to Readers: There has been no change in Florida's service definitions and rates (with the exception of the new IFSP billing codes discussed on page 42 under IFSP Development). Upon implementation of the new system, services must be provided and billed within the context of the policies set forth in this document.

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Section I: Policy and Guidance for Implementing the New Service Delivery System

Family-Centered Service Provision

Key Characteristics

- Recognizes and respects the pivotal role of the family in the lives of children.
- Supports families and other primary caregivers in their natural care-giving roles and promotes normal patterns of living.
- Brings supports and services into the family/child's life rather than fitting the family/child into services and supports.
- Ensures family collaboration and provides options in the provision of services.

Legal Foundation

The concept of family centered services is central to any discussion of service provision to infants and toddlers. Part C of the Individuals with Disabilities Education Act (IDEA) emphasizes the essential role of families in facilitating the growth and development of their children. IDEA requires as part of the Individualized Family Support Plan (IFSP) “the identification of the supports and services necessary to enhance the family’s capacity to meet the developmental needs of their infant and toddler with a disability.” Part C regulations also state that “throughout the process of developing and implementing an IFSP for an eligible child and the child’s family, it is important for agencies to recognize the variety of roles family members play in enhancing the child’s development.”

To facilitate a family-centered approach, the role of service providers in working with families is clearly emphasized in 34 CFR 303.12(c). The federal regulations list the responsibilities of service providers as follows:

- consulting with families, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services in that area

- training families and others regarding the provision of those services
- participating in the multidisciplinary team's assessment of a child and the child's family
- developing integrated goals and outcomes for the individualized family service plan

Critical elements of early intervention are communication between the family and service providers and respect for the ability of each family to make informed decisions about their child. Service providers, who have traditionally provided services from a child-centered perspective, must adapt service delivery approaches that support, strengthen and empower the family to meet their child's needs in a family or caregiver centered system. This includes enhancing one's skills in listening to, communicating with, and collaborating with families and primary caregivers. It also includes being aware of cultural diversity and respecting the individual differences of families in how they choose to address their child's needs.

Family Support

Providing services in natural environments does not preclude bringing families together to network and support one another. If a family desires family support services or family training, then an IFSP will be developed with family group participation as a strategy to address that need. The challenge to be faced is meeting the needs of families who seek support from other families of children with disabilities, while we help families to stay connected with their natural communities. The IFSP process allows for the opportunity to identify resources that can meet either or both of these needs.

Family Options

Federal law under Part C of the Individuals with Disabilities Education Act (IDEA) allows the IFSP meeting participants to decide on an individual basis when early intervention services and supports may be provided in a setting other than the natural environment, only when early intervention cannot be satisfactorily achieved for an infant or toddler in the natural environment. The inability of the participants at the IFSP

meeting to provide the services, existing barriers, personal preferences or proposed benefits of a location are not acceptable justifications for not providing early intervention services in the natural environment. Families may choose other community services outside the recommendations of the IFSP participants and the scope of Early Steps. However, the family is responsible for any costs associated with the delivery of these services.

Support Families to Meet the Developmental Needs of their Children

Key Characteristics

- Recognizes the family/caregiver as the learner/focus of the service.
- Enhances family/caregiver competence, confidence and capacity to meet their child's developmental needs and desired outcomes.
- Emphasizes the role of service providers to include consulting, training, and team participation in assessment, IFSP development and implementation.

Legal Foundation

Part C recognizes the unique and critical role that families play in the development of infants and toddlers who are eligible under this Part of the Individuals with Disabilities Act. It is clear, both from the statute and the legislative history of the Act, that Congress intended for families to play an active, collaborative role in the planning and provision of early intervention services. Thus, these regulations should have a positive impact on the family, because they strengthen the authority and encourage the increased participation of families in meeting the early intervention needs of their children (Federal Register, June 22, 1989, 54, p. 26309).

Focus of Florida's Early Steps Service Delivery System

The focus of the Early Steps service delivery system is shifting from early intervention services that are solely provided to children to providing children early intervention services while also supporting families and other caregivers to reinforce skills and training that are supportive of direct services.

The new service delivery system is highly flexible and is not intended as a “one size fits all” approach to services. Regardless of whether the Early Steps service delivery system is termed an educational or developmental model, it is clearly not the medical model of child-focused services as in the past. In the new system, the focus changes from implementing discipline-specific goals that “treat” the child, to identifying functional outcomes that assist families and caregivers to help the child perform within everyday routines, activities and places.

In the new service delivery system, direct services to the child incorporate and are in concert with consultation with the family and include parent training. Decisions related to the method of delivering services must be based on the evaluation and assessment results and the individualized needs of the child and family.

Provide Services in the Everyday Routines, Activities and Places of Children and Families

Key Characteristics

- Maximizes each child’s everyday natural learning opportunities.
- Provides supports and services where children live, learn, and play.
- Enhances each child’s learning, development, and participation in family and community life.

Legal Foundation

In the field of early intervention, the term natural environment first appeared in the Federal Register in 1989 in regulations for the Education of the Handicapped Act Amendments of 1986 (Public Law 99-457). The term appeared in the law for the first time in the Individuals with Disabilities Education Act (IDEA) Amendments of 1991 (Public Law 102-119) and later in the 1997 Amendments of IDEA (Public Law 105-17). Following are relevant sections of the legislation:

- To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate.
34 CFR 303.12 (b)
- Each state participating in IDEA, Part C must establish and implement policies and procedures to ensure that
 - 1) to the maximum extent appropriate, early intervention services are provided in natural environments; and
 - 2) the provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment. 34 CFR 303.18
- Each Individualized Family Service Plan (IFSP) must include a statement of natural environments, as described in 303.12 (b) and 303.18 in which early intervention services will be provided, and a justification of the extent, if any, to which the services will not be provided in the natural environment. 34 CFR 303.344 (d)(ii)

Natural Environments Mean Everyday Routines, Activities and Places

The implementation of policy related to natural environments must focus on helping infants and toddlers achieve appropriate developmental outcomes. Natural environments are typical places, contexts, activities and experiences that may include the child's home or early care and education settings, and could extend to a visit to the grocery store, going to a park, eating in a restaurant, reading a book at the library, going to church or the synagogue, as well as other places and situations identified by the participants in the IFSP meeting (Shelden and Rush @ <http://www.coachinginearlychildhood.org>).

The term "natural environment" is easily misinterpreted. Individuals often think only about the place *where* supports and services are provided. Although location is important, it is only one element of quality supports and services. The elements of *why* the service

is being provided, *what* the service is, *who* is providing it, *when* it is being provided, and *how* it is being provided are the other essential characteristics.

Delivering intervention services in natural environments utilizes daily activities and routines (e.g., diapering, bathing, feeding, dressing, playing) as vehicles for addressing skill development in one or more particular domains of development at a variety of times throughout the child's daily schedule of activities. Family routines might include meal time, bath time, play time, car rides, and nap time. Everyday activities might include having fun at the playground, going for a walk, spending time with friends at a playgroup, shopping, and going to the library. Everyday places might include the home, the neighborhood, and community programs such as a recreation center, library, park, or store.

Achieving Functional Outcomes in Everyday Routines, Activities and Places

Each typical daily routine provides opportunities for developmental growth. In family-centered services, the family or caregiver is encouraged to select the routines or activities they would prefer to embed the intervention techniques within, thereby defining functional outcomes (i.e., by next summer, Lonnie will let others know when he wants or needs something). The professional would then discuss with the family ways in which specific techniques could be used within each routine to facilitate development of the targeted skills. Functional outcomes can typically be achieved after relatively short-term intervention. The IFSP participants will identify new functional outcomes as intervention progresses or as the concerns and priorities of the family change. As intervention progresses, it is optimal for families/caregivers to increase their use of specific intervention techniques until they are embedded into as many daily routines and activities as possible. Refer to Appendix A for a description of the application of early intervention principles in a clinic setting versus in the natural environment.

The advantages of providing services in natural environments and inclusive settings reach far beyond the issues of built-in generalization. Service providers who work with children in natural environments gain a greater understanding of the needs of the child

within the context of family routines and family priorities for the child, and are more aware of what services and supports a particular child needs to better function in these settings. Families have the opportunity to see how they can incorporate therapists' and other providers' recommendations and home activities into their daily routines and are more likely to follow through with these activities throughout the child's day. The presence of typically developing peers can provide role models and greater motivation for children to learn, move, play, and interact, and result in positive effects in the areas of social and language development as well as functional play with objects. Integrated settings highlight not only differences, but also similarities between children with disabilities and their normally developing peers. Finally, when children are included in their communities, they are given a sense of belonging as well as the opportunity to shape their communities by changing the attitudes of others.

Service Locations

A common misunderstanding prevails that providing services in natural environments means that all services are to be provided only in the home. Providing services in natural environments facilitates integrating supports and services into the child's family and community life. The IFSP participants, when determining the appropriate location(s) for services for a particular child and family, will first consider providing services in the context of the child/family's everyday routines, activities, and places. Any justification for not providing early intervention services in the context of everyday routines, activities and places must be based on the child's outcome(s) and reflect the needs of the child and family. The justification must not be based on the inability of the IFSP participants to provide the services, existing barriers to services or proposed benefits of a location.

As of July 1, 2005, Early Steps will no longer pay a developmental day rate (blocks of hours) for the provision of early intervention services in center-based day programs. Early Steps will pay for services as written on the IFSP to be delivered in the context of the routines and activities of early care and education settings to accomplish outcomes and service locations as identified on the IFSP. Early care and education settings may include center-based programs that formerly served only children with disabilities and

that have now integrated children without disabilities, creating an early care or education program that constitutes a natural environment. An IFSP is not required to include a justification for services in such a setting; a justification is needed, however, for services in settings that are not natural environments. In general, providing services in group settings limited exclusively to infants and toddlers with disabilities would not constitute a natural environment. However, if determination is made by the participants in the IFSP meeting that, based on a review of all relevant information regarding the unique needs of the child, the child cannot satisfactorily achieve the IFSP outcomes in natural environments, then services could be provided in another environment. In such cases, a justification must be included on the IFSP (excerpt from a Policy Letter from the Office of Special Education Programs, OSEP, to Missouri Individual, November 1, 2000).

Justification of Services Not in the Natural Environment

The selection of the setting in which a service or support is provided for each child must be determined on an individual basis according to the child's need(s) and functional outcomes as described on the IFSP. Services and supports must be relevant to the life-style, culture, and routines of the family that is receiving the coaching and support to embed developmentally beneficial activities into the child's daily routines. In order to properly justify why services are not occurring in a natural environment, the IFSP must specify why the functional outcome cannot be achieved satisfactorily if early intervention services are provided to the family or caregivers in the child's natural environment.

Service decisions in early intervention are made during the development of the IFSP. Developing the IFSP is a team decision-making process and requires a justification for a service decision that establishes services outside the practice of the principles of natural environments. A decision to provide services in places and activities other than those that are typical and routine for the family or child cannot be based on family or provider choice alone. While each participant in the IFSP meeting provides significant input regarding the provision of appropriate early intervention services, the ultimate responsibility for determining what services are appropriate for a particular infant or toddler, including the location and approach of such services, rests with all participants in

the IFSP meeting. Therefore, it would be inconsistent with early intervention practice for decisions of the IFSP participants to be made based solely on preference of the family or a single team member. Early Steps bears no responsibility for services that are selected exclusively by the family, outside of the IFSP process or those services that are selected outside the bounds of natural environments without clear outcome-based justification of why the functional outcome(s) cannot be achieved satisfactorily if early intervention services are provided to the family or caregivers in the child's natural environment.

Utilize a Team Based Primary Service Provider Model

Key Characteristics

- Provides every child and family with a cohesive, consistent team for evaluation, intervention and ongoing assessment.
- Identifies a team member, based on child needs and family concerns and priorities, to serve as the primary service provider to work with the child and caregiver(s).
- Provides an integrated, collaborative delivery of services.

Legal Foundation

The federal regulations in 34 CFR, Sec. 303.17, refer to a multidisciplinary team as meaning the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in Sec. 303.322 and development of the IFSP in Sec. 303.342.

In the service delivery system described in this document, the team characteristics desired indicate a move from a multidisciplinary approach toward an interdisciplinary or transdisciplinary approach. This system of service delivery requires an intervention team that works as an integrated whole, rather than a collection of separate disciplines (Project Enrich).

Team Considerations

The primary purpose of the team based primary service provider approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and take between all members (especially the family) on a regular, planned basis. Professionals from different disciplines teach, learn and work together to accomplish a common set of intervention goals for a child and his or her family (Bruder, 1993).

The team based primary service provider model requires a high degree of interaction and collaboration between team members as they design an intervention plan detailing the recommended consultation and caregiver training. The intervention plan is reviewed and revised on an ongoing basis through team collaboration. Team members must recognize and promote ways in which developmental skills that were traditionally addressed through the therapeutic techniques of a specific discipline can be obtained using strategies and procedures that are responsibly incorporated into various routine activities to meet comprehensive needs. This does not mean that any professional will be expected to work outside of his or her professional scope of practice. The primary service provider model focuses on collaborative consultation and coaching of families and caregivers as the primary intervention strategy to implement jointly-developed, functional IFSP outcomes in natural environments with ongoing coaching and support from other team members.

Members of the team will exchange information and engage in problem solving regarding the family's or other primary caregiver's progress on incorporating developmentally beneficial strategies and activities into their daily routines in relation to the child's developmental progress and outcome achievement. This information sharing can be accomplished by a combination of face-to-face meetings, joint sessions, telephone or other means and may be augmented by sharing videotapes or other representative media. Information sharing should also include discussions with family/caregivers and should not result in decision-making that does not directly involve and respect the priorities of

the family/caregivers. The Primary Service Provider is the individual that has the responsibility to ensure that exchange of information and discussions between team members occur on a frequent basis. The service coordinator continues to be responsible for coordination of resources and service provision as reflected on the IFSP.

A Team Written IFSP

Within this model, providers face new challenges in defining their role in the team process. Decisions regarding specific services to be included in the IFSP are made through team collaboration and must take into consideration the integration of all areas of development. The level of direct involvement of providers will vary depending on the individualized needs of each child and family. The first consideration must be the family's priorities and their desired functional outcomes for their child and the needs of the family in relation to enhancing their child's development. The IFSP must include timelines for when the family or caregiver might expect early intervention services to the child and family to result in the achievement of child and family outcomes and whether modifications or revisions of outcomes or services are necessary, that may include a change in the method in delivering the service. Any change in services to the child or family will be determined by the IFSP meeting participants and be based on the individual needs of the child and family and the results of child and family evaluations and assessments. Parents will be informed of their procedural safeguards, as part of the notice for the IFSP meeting to discuss the proposed changes. Ultimately, teams must work collaboratively to develop a comprehensive plan of services that supports the child's ability to function in their natural environment.

The Primary Service Provider

The team based primary service provider model being implemented by Early Steps requires the IFSP participants to select a primary service provider for each child and family. This person can be a therapist, other licensed healing arts professional, EI Provider, or an Infant Toddler Developmental Specialist (ITDS). The primary service provider may also be the designated service coordinator. The decision is made by the participants in the IFSP meeting and is determined based on the presenting needs of the

child and family, the IFSP outcomes, relationships with the family/caregivers, and expertise in the areas of support needed by the child and family/caregivers. The same person does not always have to be in the role of the primary service provider and can change based on the changing needs of the child or family/caregivers or the focus of the current functional outcomes being addressed. Refer to Attachment B: Therapist Dos and Don'ts.

It is intended that each provider will interact with all other service providers to discuss progress, areas of need, specific observed behaviors, and how the primary service provider and the other professionals can consistently reinforce certain movements or interactions to further the broad developmental goals of the child and achieve the identified outcomes. If a therapist is the primary service provider and another therapy service provider is providing guidance on the family's use of techniques, it is appropriate for the therapist in the primary service provider role to be knowledgeable of those techniques and activities through consultation and coaching during joint visits. The frequency and intensity of joint visits depends on child and family/caregiver needs. This results in less intrusion into the family, increased communication between team members, and consistency in the implementation of the intervention plan (Shelden & Rush, 2001).

Example:

A child with significant speech and motor delays has recently been determined eligible for Early Steps (Part C). The family wants to increase the child's participation in bath time, swinging on the playground, and mealtime. Based on the supports necessary for the family to promote the child's participation in these activity settings, a physical therapist on the team may serve as the primary service provider. Since the child also has delays in speech, the speech-language pathologist may see the child for direct speech therapy services (the frequency may vary depending on the level of family involvement) and will also coach and support the family in strategies to support the child's communication. The speech-language pathologist may conduct some initial co-visits with the physical therapist. In this manner the physical therapist and the family will receive information on some strategies that can be shared with the other caregivers to increase vocalization during typical routines. The speech-language pathologist then continues to provide consultation/coaching to the family as needed to promote communication development through use of the embedded strategies and to monitor the progress toward the IFSP outcomes. Ongoing consultation with the physical therapist occurs to ensure that she is aware of the communication strategies and can reinforce or be aware that the strategies should be included in the daily activities in which she is also embedding strategies to address the motor delays. Through ongoing consultation with family members and between the speech language pathologist and physical therapist, changes will be made in the intervention plan as needed. (Adapted from Shelden and Rush @ <http://www.coachinginearlychildhood.org>).

In the past, decisions regarding services were usually made by individual therapists based on discipline specific evaluation and focusing on the level of therapy services. Typically, the first consideration was to decide how often and for how long a child would receive direct therapy to address therapists' priorities for therapeutic goals. Within a holistic

concept of child development, direct “hands on” therapy is not the most effective means to assist a child in achieving desired outcomes and function within his or her environment as it decreases family empowerment and a feeling of confidence in helping their child develop (Texas Interagency Council on Early Childhood Intervention, 1995).

Consultative services that allow for monitoring of child progress and proper use of developmentally beneficial techniques and activities can be as effective as direct services in facilitating functional outcomes. Therapists in early intervention programs must consider a variety of options and strategies to address therapeutic goals within the context of a family’s desired outcomes for their child and family. As functional outcomes change, frequent communication between team members will assist in this exchange of information. Part C requires direct therapy be provided with family support and services when identified as needed by participants at the IFSP meeting. However, direct therapy must be provided in the natural environment, or a clear outcome-based justification of why the functional outcomes cannot be satisfactorily achieved in the natural environment is required.

Scope of Practice

As defined by Part C of IDEA, training families, consulting with other service providers, participating in team assessment, and developing integrated goals and outcomes are all necessary activities of therapists providing early intervention services. Aspects related to changes in the focus of service provision by therapists in the new Early Steps service delivery system to provide services within the natural environment have been presented in a meeting with the Executive Directors of the Physical Therapy, Occupational Therapy and Speech Therapy Licensing Boards (DOH/MQA). Presentations of this information have also been made before each of these licensure boards at a regularly scheduled meeting. The scope of practice of licensed therapists includes parent training, teaming, and consultation activities specified in the new service delivery system. This service delivery system is designed to ensure that therapists provide services that are within their scope of practice, in accordance with the regulations of the licensure boards. Refer to Attachment B for an explanation of expectations of therapists collaborating with other providers. Licensed therapists have the responsibility to know what is within their scope

of practice and to refuse to be involved in activities that are outside of this scope of practice. If a situation ever occurs in which a therapist ever feels that what is being proposed is outside their scope of practice, the team will jointly develop alternate strategies.

Service Coordination in a Team Based Primary Service Provider Model

Key Characteristics

- Provides each child and family with a single identified point of contact.
- Ensures a holistic view is taken of the child/family.

Legal Foundation

Each family must have one designated service coordinator who is responsible for the legal requirements specified in the law and regulations (coordinating services across agencies and people assisting in accessing needed supports and services, helping the family to understand and exercise their rights) and who maintains the official record. Specifically the regulations state:

Sec. 303.23 Service coordination (case management).

(a) General.

(1) As used in this part, except in Sec. 303.12(d)(11), service coordination means the activities carried out by a coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.

(2) Each child eligible under this part and the child's parents must be provided with one service coordinator who is responsible for--

(i) coordinating all services across agency lines; and

(ii) serving as the single point of contact in helping parents to obtain the services and assistance they need.

(3) Service coordination is an active, ongoing process that involves--

- (i) assisting families of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan;
 - (ii) coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;
 - (iii) facilitating the timely delivery of available services; and
 - (iv) continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.
- (b) Specific service coordination activities. Service coordination activities include--
- (1) coordinating the performance of evaluations and assessments;
 - (2) facilitating and participating in the development, review, and evaluation of individualized family service plans;
 - (3) assisting families in identifying available service providers;
 - (4) coordinating and monitoring the delivery of available services;
 - (5) informing families of the availability of advocacy services;
 - (6) coordinating with medical and health providers; and
 - (7) facilitating the development of a transition plan to preschool services, if appropriate.

Role of the Service Coordinator on the Team

The method of initial assignment/selection of service coordinators will be left to local discretion as long as there is a provision that a service coordinator may change if the needs of the child change or the family requests a change. The service coordinator will remain the same from first contacts through implementation and transition unless the needs of the child change in such a way that a different service coordinator would better be able to serve the child and family or the family requests a change. Other team members may be involved in service coordination activities (e.g., providing support, networking, resource identification, etc.) and will have knowledge of procedural safeguards, however, the designated service coordinator will be ultimately responsible to

ensure that families have a single point of contact and that service coordination is not fragmented and requirements are met. The primary service provider may also be the designated service coordinator as explained in the next section, *A Dual Role for the Service Coordinator and Primary Service Provider*.

The service coordinator will actively participate in the evaluation and assessment process by being present during the evaluation in order to act as a liaison between the family and the evaluation and/or assessment team. For children who are not eligible for Medicaid, a service coordinator, as appropriate, may serve as one of the required disciplines in conducting the eligibility evaluation, if the service coordinator meets the personnel standards and competencies as an evaluator. During the IFSP meeting, the service coordinator will continue to act as a liaison between the family and evaluation and/or assessment team while facilitating the IFSP meeting. Following the IFSP meeting, the service coordinator will maintain communication with the family and primary service provider and provide information and support as needed.

A Dual Role for the Service Coordinator and Primary Service Provider

The flexibility exists in the new service delivery system for individuals to perform the dual role of service coordinator and primary service provider. Individuals performing a dual role may best be utilized by serving families with less complex needs and/or families living in remote, outlying areas in which there is a lack of other providers. An individual performing the dual role of the service coordinator/primary service provider will not maintain a caseload as high as an individual who is a “dedicated” service coordinator. Therefore, caseload ratios for those performing a dual role will be no higher than 1:20. For those children and families with complex needs, a “dedicated” service coordinator, in addition to the primary service provider, will be assigned.

Service coordination activities are not billable to Part C when Part C funds supports the salaries and benefits of individuals providing service coordination. If a primary service provider whose salary is not supported by Part C becomes the service coordinator, they would first have to meet the criteria as outlined in the next section, *Contracting Service*

Coordination. The payment for service coordination activities would be negotiated with the local Early Steps who would pay for these services with their Service Coordination Unit Cost allocation in their contract. All service coordination activities that are not billable to Medicaid must be recorded in the data system as CASE.

If a primary service provider is not the service coordinator, but performs service coordination activities for the service coordinator, it would not be a billable activity, only a convenience to the family and team because the provider would be in contact with the family. Again, all service coordination activities that are not billable must be recorded in the data system as CASE.

Contracting Service Coordination

It is not required that all service coordinators are employed by Early Steps, however, it is required that any sub-contracts and/or agreements for service coordination specify that Early Steps has authority and supervision of all service coordinators and that contracted service coordinators are held responsible for coordinating supports and services across the Early Steps service delivery system and effectively carrying out service coordination activities on an interagency basis. Additionally, contracts/agreements must require that contracted service coordinators participate in the same enrollment process, required and inservice training, staff meetings, and any other requirements in which Early Steps employees must participate. Contracted service coordinators will be housed with employees of Early Steps whenever possible.

Section II: Policy and Guidance for Implementing the IFSP Process

The Individualized Family Support Plan (IFSP) Process in a Team Based Primary Service Provider Model

The Individualized Family Support Plan process is the key to a family's smooth entry into Early Steps, the on-going provision of supports and services, and eventually, transition out of the early intervention system. The concept of natural environments, providing services in everyday routines, activities, and places, and how early intervention can best support the family in its ability to meet the child's needs, should be embedded in all materials and every discussion with the family.

Key Role of Families

Families play a key role in the successful implementation of the new Early Steps service delivery system. Beginning at first contacts, families are provided with information on the purpose of early intervention: to enhance the capacity of families to meet their child's developmental needs. Families are also provided with information on what they can expect from Early Steps, as well as the important role families play as a member of the team throughout the process. Once families have this information, they can make informed decisions in defining their particular role and involvement in Early Steps.

Essential roles of families/caregivers in the early intervention process are as follows:

- First Contacts – Families share their concerns related to their child's development, provide the team with information regarding their current schedule and what is working well at home, answer questions they are comfortable answering, and share any additional information they feel the team needs to have a holistic, ecological view of their family. During this time, families also receive information about Early Steps and complete required paperwork.

- Evaluation and Assessment Process – Families participate with their child during the evaluation and assessment process, communicating whether their child’s functioning during the evaluation and assessment process is typical and begin sharing their priorities for the focus of intervention.
- IFSP Development – Families are active participants in the IFSP meeting. They review and update, with other participants, information gathered during first contacts and the evaluation and assessment process. Families identify their priorities for outcomes they would like their child and family to achieve and strategize how these outcomes can be met within the context of their everyday routines and activities and with the important people in their child’s life.
- Service Delivery – Families work with service providers to identify and learn a variety of strategies to enhance their child’s learning and development within their typical, everyday home and community routines.
- Evaluation of Strategies and Outcomes – Families talk with service providers continually about what is making a difference in their child and family’s life. Families and service providers discuss which strategies are working, how much support the family needs in order to incorporate the strategies into their everyday routines and activities, whether outcomes have been achieved, and what changes, if any, need to be made.

IFSP development is an ongoing process in which the family’s continual communication and collaboration with Early Steps is critical. It is also critical to recognize and respect that the role a family plays in enhancing each child’s development varies from family to family and that each family’s level of participation in the process differs relative to their life-style, culture and routines.

First Contacts

The development of the Individualized Family Support Plan (IFSP) begins at the first contact with the family and other caregivers. The purpose of gathering information is to learn more about the child’s and family’s background, interests, strengths, needs, and activities within the family, community, and for some children, early care and education

settings (Dunst & Bruder, 1999). During this exchange, the family is given the opportunity to share their experiences with their child, as well as previous medical, health, or developmental evaluation information, describe their concerns and priorities, and share information about their child's development. The information obtained will be used in preparation for evaluation and assessment and development of the IFSP. In addition, the family receives information about Part C and the family-centered focus of Early Steps. It is important to gain an understanding of the family's perception of early intervention and discuss any misperceptions.

The family assessment constitutes the process of gathering information. The process of gathering information should be as conversational and noninvasive as possible. To do this, the person gathering the information should create a climate in which families feels free to talk about their child and family. The types of information gathered must be with the concurrence of the family and should include the following:

- the child's and family's strengths and interests
- settings where the child and family live and play (family, community, and child care or preschool settings), and the people who are involved
- settings in which the family would like for their child to participate if he or she did not have a developmental disability or delay
- the family's concerns and priorities for the child's participation in family and community life, and early care and education settings
- the family's need for informational, emotional, and material supports (McWilliam & Scott, 2001)

The person who gathers this information may vary from program to program. Some programs may use a service coordinator to conduct an initial interview, whereas in other programs the person doing the interview may be a service provider, who has sufficient training in conducting first contacts and who will also be a member of the team.

Regardless of who gathers this initial information, how it is conducted is most critical.

The person gathering the information must possess skills in rapport-building, active listening, and use of appropriate and effective questions. (Rush and Shelden @ <http://www.coachinginearlychildhood.org>)

IFSP Process	Requirements
<p>First Contacts</p>	<ul style="list-style-type: none"> • First contacts are conducted face-to-face with the child and family/other primary caregivers in their typical environment. • The child is present for some part of the first contacts process. • First contacts are conducted at times and locations convenient to the family. • For purposes of evaluation/assessment planning, first contacts must include a developmental screening for children who do not have an established condition or an obvious developmental delay. • Children with established conditions will not be screened. • Screening is conducted within the context of first contacts, and therefore is conducted in the home or other location in which the face-to-face contact is conducted. • Acceptable screening tools are the Ages and Stages Questionnaire (ASQ), Birth to Three Screener, or Early Learning Accomplishment Profile (ELAP) Screener. • Screening results are documented on Form C in the IFSP document. • If the child screens at age level and the family chooses not to proceed with an evaluation/assessment, the family is provided with developmental materials and referrals to community agencies, as indicated. The family is provided with contact information for Early Steps and offered a re-screening in three to six months, as appropriate. • When families choose not to proceed with an evaluation/assessment, the individual who conducted the screening must document the

	<p>parent’s decision via letter, service coordinator notes, or similar type of documentation.</p> <ul style="list-style-type: none">• If the family chooses to continue to refer their child after a screening indicates the child is functioning age appropriately in all five developmental areas, then one of the following must occur: (1) an evaluation/assessment must be provided OR (2) if a decision is made not to provide an evaluation/assessment, the family must be given prior written notice and a copy of their procedural safeguards.• First contacts must include documenting the family’s concerns and reviewing any available information regarding the child’s vision and hearing status, unless the child has a diagnosed hearing or vision impairment. Vision and hearing information must be documented on Form C in the IFSP document.• First contacts are conducted by the service coordinator who is an ongoing member of the team or a service provider who has been trained in conducting first contacts.• A formal mechanism must be in place for the individual conducting first contacts to provide other team members with a summary of first contact information, including screening results, prior to the evaluation.• First contact information is used to determine the formation of the team and the focus of the evaluation /assessment.• First contacts include educating the family on the family-centered focus of early intervention and the team based service delivery system.
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Family Assessment

The purpose of family assessment is to gather information from the family and to identify with the family their concerns, priorities, and resources, and the family’s everyday routines, activities and places.

<p>Family Assessment</p>	<ul style="list-style-type: none">• Family assessment is conducted with the concurrence of the family by the service coordinator and/or another trained team member.• Family assessment does not need to be conducted when the family chooses not to proceed with an evaluation and assessment for their child.• Family assessment is conducted to gather information from the family and to identify, with the family, their concerns, priorities, and resources and the family’s everyday routines, activities and places.• Family assessment is an ongoing process that begins at first contacts.• Family assessment is conducted within the context of first contacts, and therefore is conducted in the home or other location in which the face-to-face contact is conducted.• Family assessment results are documented on the IFSP.• Early Steps utilizes a family assessment tool, protocol, or techniques (service area choice) which emphasizes identifying family concerns, routines, activities, traditions, and desired outcomes and is documented on the IFSP.* <p>* Note: A handbook/resource guide of recommended family assessment tools, protocols, and techniques is being developed and will be consistent with training conducted on first contacts.</p>
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Evaluation and Assessment

The evaluation and assessment process builds on the concept of early intervention in everyday places, routines and activities that was introduced to the family during intake/first contacts. Evaluation and assessment must include opportunities to observe the child in typical routines in order to combine developmental information with

functional application information. As such, one team should conduct evaluation and assessment concurrently, whenever possible.

Evaluation and assessment activities are conducted for two different purposes. The outcome of evaluation is to expeditiously confirm eligibility for early intervention services by determining the child's level of functioning in all the required developmental domains: communication; self-help/adaptive; cognitive; physical (including fine and gross motor and vision and screening); social/emotional. The evaluation is conducted in all domains with a focus in the area(s) in which first contact information and/or developmental screening indicated a concern in order to determine if the child has a developmental delay in at least one area of development which is equal to or greater than -1.5 standard deviation or 25%. Evaluation is not necessary for children who have an established condition. For these children, a written confirmation from a licensed physician (or in the case of severe attachment disorder, a licensed psychologist) of the diagnosis or suspected diagnosis establishes eligibility.

For children with established conditions and children who meet eligibility criteria based on the evaluation, an assessment is conducted for intervention planning that identifies the child's unique strengths and needs in terms of each of the developmental areas and the services appropriate to meet those needs. This assessment must be conducted by the individuals who are likely to be involved in providing direct or consultative services to the child and includes the family. The team must also include those individuals necessary to meet the requirements of a multidisciplinary evaluation or assessment (and Medicaid requirements, if the child is Medicaid eligible) and to address the child's presenting issues. For children who are not eligible for Medicaid, a service coordinator, as appropriate, may serve as one of the required disciplines in conducting the eligibility evaluation, if the service coordinator meets the personnel standards and competencies as an evaluator. The assessment must include opportunities to observe the child in typical routines to combine developmental information with functional application information. Attachment C: Evaluation and Assessment Flow illustrates the process beginning with first contacts through IFSP development.

Each team will conduct an arena assessment in which all members of the team are involved in planning based on information received from first contacts and other available information. Whenever possible, evaluation and assessment must be conducted concurrently as one encounter. An arena assessment is a planned observation process which typically involves a facilitator, who serves as the primary contact with the child and family during the assessment process, and at least one other team member who may serve as a coach to support the facilitator, provide cues for missed items, or reflect on what could be done to enhance the assessment. The arena assessment may also include one or more observers who serve as the multidisciplinary “eyes and ears” and contribute expertise from a variety of backgrounds and training. The family participates as additional evaluators, observers, and contributors (Berman & Shaw, 1996).

This approach allows all team members, including the family, to be involved in planning the assessment and observing the child in the assessment setting. The child interacts with just one adult rather than all members of the assessment team. Arena assessment allows for an interactive and integrated process across domains to get a holistic picture of the child.

Early Steps service areas must conduct evaluation and assessment activities concurrently in one single encounter with the family, whenever possible. The evaluation/assessment must be conducted by the team of professionals who are likely to develop the IFSP and provide services. The advantage of providing evaluation/assessment in one encounter is convenience to the family, eliminating the need for three encounters with Early Steps before services begin for their child. Additionally, one process allows for sufficient time to complete all activities prior to the 45 day timeframe between referral and development of the Individualized Family Support Plan.

Eligibility Evaluation

The eligibility evaluation is conducted for children who do not have an established condition. The purpose of the evaluation is to expediently determine if the child has a developmental delay in at least one area of development, which is equal to or greater than Florida’s eligibility criteria. The outcome of evaluation activities is the identification of a child’s level of functioning in each of the developmental domains, including vision and hearing, that results in a standardized score in at least one area of development that confirms eligibility.

<p>Eligibility Evaluation</p>	<ul style="list-style-type: none"> • Eligibility evaluation is not conducted for children with an established condition. • The evaluation process must provide opportunities to observe the child engaged in their typical activities, as defined by families/caregivers (such as play, interaction with caregivers, etc). • The child’s vision and hearing status must be determined during evaluation or assessment. • Individuals, from at least two disciplines appropriate to address the child’s presenting condition and family concerns, must conduct the eligibility evaluation. This may include an Infant Toddler Developmental Specialist or a healing arts professional such as: Occupational Therapist, Physical Therapist, Speech Therapist, Psychologist, or Nurse. • The service coordinator must be a participant in the evaluation process and for children who are not eligible for Medicaid, may serve as one of the required disciplines, as appropriate. • The team includes medical services from a physician only for diagnostic or evaluation purposes or for a child who has a complex medical condition that requires input from a physician when developing IFSP strategies. Ideally, the child’s primary health care provider is involved rather than a physician with no ongoing
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	<p>relationship with the child.</p> <ul style="list-style-type: none">• Family/caregivers understand their role and participate in the evaluation as a member of the team.• Evaluators must utilize information gathered from first contacts, observation of the child, family/caregiver report, and any collateral information available, for example, therapy specific evaluations that may have been conducted.• Evaluation confirms eligibility for early intervention services by determining the child’s level of functioning in all the required developmental domains: communication; self-help/adaptive; cognitive; physical (fine and gross motor and vision and hearing); and social/emotional.• The results of the evaluation are documented on the Individualized Family Support Plan (IFSP). The IFSP document will serve as the team evaluation report.• All team discussions regarding the evaluation must include the family.• One of the following instruments must be used for eligibility evaluation:<ul style="list-style-type: none">• Developmental Assessment of Young Children (DAYC)• Battelle Developmental Inventory (BDI) <p>or</p> <ul style="list-style-type: none">• If evaluators are not able to derive a standardized score by using one of the above instruments, the Birth to Three Assessment and Intervention System (BTAIS) may be used. The BTAIS will yield a developmental age that can be converted to a percentage score. <p>or</p> <ul style="list-style-type: none">• Additional evaluation instruments may be administered in specific discipline areas to further pinpoint a child’s eligibility if necessary. For example, a child who is identified in the communication area by one of the test instruments could require additional testing to rule out if the delay was due to articulation errors of a developmental nature.
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Assessment

All eligible children receive an assessment for intervention planning that identifies the child's unique strengths and needs in terms of each of the developmental areas and the services appropriate to meet those needs. Combining the curriculum or instructional objective results of the assessment with the information in the family assessment provides the team with the tools they need to develop strategies to address the families concerns and priorities.

In addition to the assessment of the child's participation in typical activity settings, the team should begin to note the preferred learning styles of the family and other primary caregivers, as they will be the primary learners in the intervention process. The team should determine how the family and other primary caregivers prefer information to be presented and what information will be most useful to them based on their preferred learning styles (Shelden & Rush, 2001).

Assessment	<ul style="list-style-type: none">• Vision and hearing status must be determined as part of the evaluation/assessment process.• Assessments must be conducted by individuals from at least two disciplines appropriate to address the child’s presenting condition. This may include an Infant Toddler Developmental Specialist or a healing arts professional such as: Occupational Therapist, Physical Therapist, Speech Therapist, Psychologist, or Nurse.• The assessment must be conducted by individuals who will participate in the Individualized Family Support Plan meeting and provide services.• Whenever possible, evaluation and assessment activities are conducted concurrently in one single encounter with the family.• The service coordinator must be a participant in the assessment process, and for children who are not eligible for Medicaid, may serve
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	<p>as one of the required disciplines, as appropriate.</p> <ul style="list-style-type: none">• The team includes medical services from a physician only for diagnostic or evaluation purposes or for a child who has a complex medical condition that requires input from a physician when developing IFSP strategies. Ideally, the child’s primary health care provider is involved, rather than a physician with no ongoing relationship with the child.• An arena-style assessment must be conducted.• To the extent possible, the use of assessors and service providers with specialized expertise is encouraged to address the needs of children with complex medical needs or other issues (for example, children with sensory impairments or potential autism spectrum disorder).• Family/caregivers understand their role and participate in the assessment as a member of the team.• The assessment must provide an opportunity to observe the child in typical routines in order to combine developmental information with functional application information. Typical routines must be defined by the family, not contrived by the evaluators as typical routines for the child.• The results of the assessment and the child and family’s service needs are documented on the Individualized Family Support Plan that serves as the assessment report.• All team discussions regarding the assessment must include the family.• As indicated based on individual child need, one of the following instruments (or any portion thereof) must be used to provide information for intervention planning:<ul style="list-style-type: none">▪ Battelle Developmental Inventory (BDI), a norm- and criterion-based assessment.▪ Hawaii Early Learning Profile for Infants and Toddlers (HELP), a curriculum-based assessment.
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	<ul style="list-style-type: none">▪ Early Learning Accomplishment Profile (ELAP), a criterion-referenced test designed to generate instructional objectives.▪ Assessment, Evaluation, and Programming System for Infants and Children (AEPS), a curriculum-based assessment.▪ An additional specialized assessment instrument may be used as indicated by the child’s established condition (for example, visual impairment, hearing impairment, or autism spectrum disorder). <p>Note: A list is being developed of assessment instruments that can be used to address the needs of children with specific established conditions.</p> <ul style="list-style-type: none">▪ In addition to the use of one of the above instruments, the Individualized Family Support Plan participants may utilize other assessment instruments to determine the child’s functioning level in specific areas of development and the child’s unique strengths and needs.
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IFSP Development and Implementation

Functional outcomes on the IFSP are statements about what the family wants to change in relation to a daily routine or family activity that is impacted by their child’s disability. Strategies on the IFSP indicate the activities that the family or caregivers will perform to support the child’s acquisition of basic skills needed to obtain the functional outcome and enhance development.

Outcomes and strategies on the IFSP reflect the basic skills that the child will learn to enhance development. Basic skills are those that can be embedded into natural routines and activities in which the child and family participate (e.g., expressing wants and needs, initiating social interactions, grasping/holding objects, holding head up, feeding self, demonstrating cause-effect relationships). The strategies identified for each outcome statement reflect the specific natural routines and activities in which the skills can be

embedded (e.g., strategies to encourage the child to express wants and needs may be targeted during mealtimes when a child wants a drink or another bite of food). In addition, these routines and activities are those identified as priorities by the family through an ecological assessment, with attention to both the home and community environments. Adaptations and supports needed to assure that the outcome is achieved are mentioned in the strategies for achieving the IFSP outcomes. For example, a child might need (a) a communication board with picture symbols (adaptation) in order to express his wants and needs during mealtimes, as well as (b) the services of speech/language pathologist (support). In addition, to the greatest extent possible, the supports utilized to implement the outcome should be those found in everyday routines, activities, places and relationships (Connecticut Birth to Three System, 1999). Following are the steps in this process:

1. Identify and write functional outcomes prior to determining services that reflect:
 - routines of the family and individuals involved in the child's development
 - activities that are important to the family (including activities that they currently enjoy, as well as those activities that they would like to do but are unable to participate in due to the developmental delays or disability that their child presents)
 - skills that are essential for the child to attain and that are generalized to a variety of naturally occurring, typical routines that the child is engaged in on a daily basis
2. The steps and strategies to achieve an outcome are explored by identifying:
 - what will happen in the family's daily routines to support the outcome
 - by whom and in which of the various settings that the child and family frequent can this outcome be practiced
3. Identify necessary supports and services that are included on the IFSP.
4. Determine which team members need to be involved (integrated services).
5. Identify primary service provider and participation of other team members.

Other Services

The IFSP must include, to the extent appropriate, any medical, health and other services that the child needs, or family needs related to enhancing the development of the child, but that are not required under Part C. The IFSP must identify any of these services needed by the child and family and the funding sources to pay for the services or the steps that will be taken to secure those services through public and private sources (34 CFR §303.344(e)(i). Including such services provides a comprehensive picture of the child's total service needs. In addition, service coordinators will assist families, as needed, in gaining access not only to early intervention services, but to the other services identified in the IFSP, and will coordinate the provision of these services (34 CFR §303.23 (a)(3) and note following §303.344).

<p>IFSP Development</p>	<ul style="list-style-type: none"> • The IFSP is written by the same team that conducts the assessment, including the family, the service coordinator, and the other individual(s) conducting the assessment. • The family is encouraged to invite key adults involved in the life of the child to be part of the IFSP development. • The team offers and supports flexible options that encourage and make family participation possible. • Information, resources, training, and support relative to providing services in everyday routines, activities and places are made available to the family by the team. • Families have knowledge and understanding of a consultative team approach in the provision of supports and services in everyday routines, activities and places and their role on the team. • The team is respectful of the family’s culture and values their input and opinions as team members. • Services are provided utilizing the team members involved in the assessment and development of the IFSP.
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	<ul style="list-style-type: none">• The team chooses a primary service provider. The primary service provider may change as family circumstances and progress of the child change.• The frequency, intensity and method of delivering the service are individualized to each outcome. Note: Depending on the outcome, some services/interventions may be needed for a shorter period of time or longer than others and the frequency/intensity will vary. An IFSP review is conducted every six months, or more frequently that may require a change to the frequency and intensity and method of delivering services.• The IFSP reflects the family's prioritized concerns.• The child and family's routines and activities are identified and prioritized by using an ecological assessment.• Functional outcomes are written based on child/family routines, activities and family priorities and not solely on evaluation results.• Early intervention supports and services are provided in natural environments (i.e., home, early care and education settings) and embed strategies specific to the child's skill development into natural routines and activities in which the child and family participate.• Justification is documented on the IFSP when a service is not provided in the natural environment.• Early intervention plans for and fosters interaction among children with and without disabilities that enhance learning and increase independence (i.e., church nursery school, library story time).• The IFSP includes other supports and services the child/family needs.• Strategies on the IFSP reflect the coordination of all resources.
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	<ul style="list-style-type: none">• The IFSP is modified as outcomes are achieved and/or circumstances change.• Progress notes are written for every contact with the child/family.
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Note: The IFSP billing codes will be for the event of developing an Individualized Family Support Plan that includes all the participants in the Individualized Family Support Plan meeting, whoever they may be, except the service coordinator. The service coordinator will always bill service coordination time spent with the IFSP participants in IFSP development as Targeted Case Management (TCM) or CASE. Only the designated service coordinator can bill for service coordination.

IFSP Implementation

Following the identification of outcomes and initial strategies, the IFSP participants then develops intervention activities and experiences that promote learning and enhance development within the child’s natural environment. Cripe, Hanline, and Daley (1997) identified naturally occurring events for infants and toddlers to include child-initiated actions and play (e.g., climbing into cupboards to play with the pots and pans), daily routines (e.g., diapering, washing up), and planned activities (e.g., taking a trip to the store).

Early intervention techniques have a broad focus that includes direct early intervention services to the child and family based on individualized needs and may include modeling and soliciting behaviors (i.e., service provider or family member following the child’s interest in playing). The continuum between a directive and naturalistic focus for intervention provides many opportunities for the professional to work with the family/caregiver to formulate the specific intervention techniques that can be used within daily routines to address skill development in the delayed areas. For some children, more directive interventions may be appropriate, particularly at the beginning stages of

intervention. Naturalistic interventions may be more useful than directive interventions in increasing spontaneous use of the targeted skill. Methods that progress from a more directive focus towards a more naturalistic focus over time may help facilitate long-term goals.

<p>IFSP Implementation</p>	<ul style="list-style-type: none">• Services are provided utilizing the same team members involved in the evaluation and development of the IFSP.• The team identifies the member of the team most appropriate to serve as the primary service provider to work with the child and caregiver(s).• Primary service provider may be a specialist (therapist or any other licensed professional) or a generalist (ITDS or EI Provider).• Primary service provider is responsible for on-going communication with other team members.• Primary service provider may change as dictated by child/family needs.• The team conducts ongoing assessment.• Plans of care written by team members reflect that the team is coordinating and working in unison toward common goals and strategies to achieve the outcomes reflected on the IFSP.• The team meets on a regular basis as documented by team meeting/staffing notes.• Progress notes are written for every contact with the child/family.
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Six Month Review

Functional outcomes developed within the context of the new service delivery system will typically be shorter term than six months. The team will be meeting on a regular

basis to review effectiveness of strategies and progress toward outcomes. Functional outcomes will be revised or new functional outcomes developed throughout the child's participation in the program. This on-going assessment results in a fluid IFSP process and the six-month review becomes part of this ongoing communication and documentation.

Six Month Review	<ul style="list-style-type: none">• To the extent possible, the same team that developed the initial IFSP meets and reviews progress toward outcome attainment. Note: This team may have had adjustments in membership contingent on child/family needs, provider status, etc.• The team reviews ongoing assessment information.• The team obtains family perspective on progress toward outcomes and identification of new concerns/outcomes.• Outcomes and strategies are changed, modified or developed, as appropriate.• A new primary service provider is identified, if appropriate.• The team composition remains the same (unless needs/concerns change or by family request).
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Annual Meeting to Evaluate the IFSP

Beginning July 1, 2004, during the annual meeting to evaluate the Individualized Family Support Plan (IFSP), the following activities will occur for all currently served children and a new IFSP will be written using the new IFSP form:

- A review to ensure the outcomes reflect the following:
 - family's priorities and child's interests
 - routines of the family and individuals involved in the child's development
 - activities that are important to the family
 - skills that are essential for the child to attain

- functional outcomes (i.e., Sam will use sounds and gestures in order to gain attention) and are not stated as therapies (P.T., O.T. and Speech are not outcomes)
- Determine the steps and strategies to achieve the functional outcomes and embed strategies within typical routines and activities to the extent possible.
- Identify necessary supports and services.
- Determine frequency, intensity, and duration of supports and services.
- To the extent possible, determine a primary service provider based on the outcomes, strategies and desires of the family.
- As appropriate, determine availability of appropriate providers to achieve the outcomes as quickly as possible.

<p>Annual Meeting to Evaluate the IFSP</p>	<ul style="list-style-type: none"> • To the extent possible, the same team that developed the initial IFSP meets and updates the current developmental status of the child and reviews progress toward outcome attainment. The team includes the family, the service coordinator, the primary service provider, and any other provider(s) that has been providing services to the child and family. Note: This team may have had adjustments in membership, contingent on child/family needs, provider status, etc. • The perspective of the family on progress towards outcomes and identification of new concerns/outcomes is obtained. • A formal multidisciplinary evaluation may not be required if current evaluations in the developmental areas and other information exists. The participants at the IFSP meeting must determine the information needed. • A new IFSP is developed.
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Transition

By helping the family to identify their child’s needs within his/her daily routines and assisting the family to build on their competencies and use natural supports throughout their early intervention experience, they will be more prepared for the transition out of Early Steps.

<p>Transition</p>	<ul style="list-style-type: none"> • The same team that developed the initial IFSP develops the transition plan. Note: This team may have had adjustments in membership contingent on child/family needs, provider status, etc.) • The team follows the timelines and activities for providing information and preparing the family for transition as delineated in the <i>Infants and Toddlers Program Plan and Operations Guide</i>. • The team develops outcomes and works with families to identify community supports that will enhance the day-to-day life of the child and family at home. This includes assisting the family in developing mechanisms for addressing the needs of the child within the context of their family and the larger community when planning for the child’s transition. • The team develops outcomes for the child and/or family related to concerns about preparing the child and family to move from Early Steps, at age three, to the most appropriate early care and education setting (e.g., Head Start, Part B, preschool, or childcare).
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Section III: Glossary of Terms

Activity Settings are everyday family and community experiences, events, and situations that provide learning opportunities for children and have development-enhancing (or development-impeding) qualities and consequences. Examples of family activity settings may include bath time, eating, and play activities. Community activity settings may include child care, playground, and swimming.

Arena-Style Assessment is a planned observation process which typically involves a facilitator, who serves as the primary contact with the child and family during the assessment process; another team member who may serve as a coach to support the facilitator, provide cues for missed items, or reflect on what could be done to enhance the assessment; and may involve one or more observers who serve as the multidisciplinary “eyes and ears” if expertise from more than two backgrounds and training is necessary. The family participates as additional observers, and contributors (Berman & Shaw, 1996). This approach allows team members to be involved in planning the assessment and observing the child in the assessment setting. The child interacts with just one adult rather than all members of the assessment team. Arena assessment allows for an interactive and integrated process across domains to get a holistic picture of the child.

Assessment is the process and procedures used by appropriate qualified personnel to determine the child’s unique strengths and needs in all the required developmental domains and the services appropriate to meet those needs and to determine the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family’s capacity to meet the developmental needs of their infant or toddler.

CASE is the billing code used in the early intervention data system for service coordination activity that is not billable to Medicaid.

Collaborative Consultation is used as part of a dynamic and family-responsive IFSP process that enables team members with diverse expertise to generate creative solutions

to mutually defined problems (Idol, et al., 1987). This approach effectively empowers families to achieve the outcomes they have identified as being important for their child and themselves. Collaborative consultation also supports the provision of services primarily in natural environments and facilitates team members in their roles as service providers as defined by the IDEA Amendments of 1997 [34 CFR Ch. III (7-1-97) Subsection 303.12 c.]; that is to consult with families and others, to train families and others, and to participate in the assessment of the child and in the development of integrated goals and outcomes for the IFSP. (Working Together: Collaborative Consultation-A Family Responsive Approach to Therapy Service Delivery. University of New Mexico, Early Childhood Network)

Coaching is an interactive process of observation and reflection in which the coach promotes the other person's ability to support the child in being and doing. Coaching assists persons who are identified as being significant in the child's life, and who the child wants and needs to be with and doing what he or she wants and needs to do (Shelden & Rush, 2001).

Curriculum-Based Assessment is defined as “a form of criterion-referenced measurement in which curricular objectives act as the criteria for the identification of instructional targets and for the assessment of status and progress” (Bagnato & Neisworth, 1991). “Curriculum-based assessment uses developmental landmarks or expectancies as potential instructional goals and objectives” (Bagnato & Neisworth, 1991). Curriculum-based assessment is most appropriately used for program planning purposes (Meisels & Fenichel, 1996). Curriculum-based and criterion-referenced tools both fall under the larger classification of programmatic tools (Bricker, 1998).

Developmental Screening is the process and procedures used to determine whether a child possibly has a developmental delay and, if so, in what areas of development.

Ecological Assessment is conducted to view a child in the context of his or her relevant settings and circumstances. A child's home environment, the quality of parenting skills,

and other domestic circumstances are considered. In addition, the quality of the child's early care and education programs and/or the quality of caregiver interactions are evaluated. An ecological approach enables the team to assess the family's own estimate of strengths and concerns with regard to information, support, explanations to others, community services, and family functioning (Bagnato & Neisworth, 1997).

Evaluation is the process and procedures used by appropriate qualified personnel to determine a child's initial eligibility. This process results in a statement of the child's level of functioning in all the required developmental domains, communication, self-help/adaptive, cognitive, physical (including fine and gross motor, vision and hearing) and social/emotional and results in a standardized score in at least one area of development that supports eligibility determination.

Family Assessment is the process and procedures used by a service coordinator and/or another trained team member to gather information from a family. This process results in information about the family's concerns, priorities, and resources and the family's everyday routines, activities, and places.

Family Centered means recognizing and respecting the pivotal role of the family in the lives of children. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the child.

Functional Outcomes are statements about what the family wants to change in relation to a daily routine or family activity that is impacted by their child's disability.

Natural Learning Environments are the places where children experience everyday, typically occurring learning opportunities that promote and enhance behavioral and developmental competencies.

Norm Referenced Evaluation is the use of a specific type of evaluation instrument and process to determine the status of a child in relation to the test performance of a specified group, such as children of various ages or those with handicapping conditions (Meisels & Fenichel, 1996). Norm referenced evaluation is useful for diagnostic purposes (Bagnato & Neisworth, 1991).

Primary Service Provider is the identified professional on the team that works with the family/primary caregivers on a regular basis and with other members of the team providing service through consultation and/or joint visits.

Routines-based Assessment is an assessment process that helps determine individualized goals and outcomes for children. This involves interviewing families and primary caregivers to determine what children need to learn to become more independent, engaged, and socially competent at home and in early care and education settings.

Team is defined as a group of people who are working together and share a common philosophy and common goal for which they hold themselves mutually accountable. Teams described in this paper share a family-centered philosophy and work together in evaluation, assessment, development, implementation and review of the IFSP.

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<http://www.coachinginearlychildhood.org>

Natural Environments Bibliography compiled by Dathan Rush & M'Lisa Shelden, September 2002 contact <http://www.coachinginearlychildhood.org/docs/nebibliography.doc>

For a research summary on home-based versus clinic-based intervention contact:

<http://www.coachinginearlychildhood.org/naturalhome.php>

Colorado Department of Education, Early Childhood Connections

<http://www.cde.state.co.us/earlychildhoodconnections/natural.htm>

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Section V: Supporting Documents

Attachment A: Application of Early Intervention Principles in Clinic and Natural Settings

Attachment B: Team Based Primary Service Provider Model: Therapist Do's and Don'ts

Attachment C: Evaluation and Assessment Flow

**Attachment A:
Application of Early Intervention Principles in Clinic and Natural Settings**

Principles*	Application: Traditional Clinic Setting	Application: Natural Environment
Family members are decision makers	Children and families are consumers of therapy services; early intervention specialists assess a child and recommend treatment.	Families, viewed as experts about their children, share equally in decision making with specialists. Families set priorities for outcomes and services.
Parents are parents, not therapists	Families are encouraged to promote child's development by carrying out written home programs demonstrated in the clinic. Therapists have little first hand information about the family's cultural context, daily routines, or child-rearing practices.	Therapist and family members (siblings, extended family, friends) embed developmentally beneficial interventions within family activities and develop programs collaboratively. Therapist gains first-hand experience of family culture, daily routines, and child-rearing practices.
Collaboration with families	Families are given limited options for participation. Frequency, intensity, and duration of service usually predetermined within setting. Sometimes families and children are separated during treatment to attend parent group meetings or teach the child to cooperate apart from the family.	Families choose level and intensity of involvement with specialists and programs. Specialists understand that family members will generally participate at a level of individual capacity and increase or decrease the amount of service accordingly.
Child's needs drives how assessment is performed	Therapist's perspective of infant or toddler's abilities limited to the clinic setting. Standardized, norm-referenced testing is conducted away from child's most familiar settings; family's report of child performance not considered in scoring.	Specialists primarily see an infant or toddler's development in familiar, play-based situations and engage family members throughout assessment in various ways to ensure child's best performance.
Options for services vary according to child's needs and family's desires	Specialist's role remains constant as a direct services provider; infrequent home visits may be possible. Treatment sessions may often be conducted without family members present and focus on remediating therapist-identified delays in the child.	Family member's learning styles are considered when developing intervention options. Specialists may perform different roles as coach, instructor, or direct service provider and utilize a combination of intervention approaches over time.

Adapted by Florida Early Steps, February, 2004, from Hanft, B. E., & Pilkington, K. O., (2000). Therapy in natural environments: The means or end goal for early intervention? *Infants and Young Children*, 12(4), 1-13. Principles recommended by Bazyk.

**Attachment B:
Team Based Primary Service Provider Model: Therapist Do's and Don'ts**

In a Team Based Primary Service Provider Model:	
Therapists DO	Therapists DON'T
<ol style="list-style-type: none"> 1. Train the caregiver on activities in daily routine(s) that will enhance a child's development within the focus of a specific functional outcome. 2. Discuss the caregiver activities with other members of the team so that they can select activities that can be embedded into a daily routine in a manner that is supportive, complimentary, or at least not cross purposes to other developmentally beneficial activities (<i>e.g., if increased vocalization during diapering is a functional outcome related to communication, the physical therapist can incorporate this technique of waiting for a verbal response as she assists the caregiver in also embedding techniques to address movement issues during the parent-child diapering interactions.</i>) 3. Anticipate that the primary service provider can be a generalist ((ITDS, EI Provider)) or a specialist (therapist, or other service provider) and may be present during the visit by a second professional as she or he assists a caregiver in embedding activities into routines. The primary service provider and the second or consulting professional can actively discuss with the caregiver how the activity can be integrated into other activities in a manner that is complementary within the practicality of the daily routine and caregiver ability. This could be considered a joint early intervention session. 	<ol style="list-style-type: none"> 1. Expect the caregiver or the child development specialist to do 'therapy' with the child. Embedding activities into daily routines is different from doing therapeutic repetitions of movements, interactions or highly specialized techniques that are outside of naturally occurring opportunities. 2. Expect another therapist to (a) carryover therapy goals outside of their own discipline; (b) ask one therapist to specifically address activities from another therapy discipline during a direct therapy session or a caregiver-training session (<i>e.g. a speech therapist would not be expected to help the parent put a child into a stander but could recognize that the child being put into the stander by the caregiver is part of the daily routine and incorporate appropriate communication activities into this process</i>); (c) require monitoring, recording, or daily reporting in an area outside of their therapy discipline 3. Expect the primary service provider to be responsible for determining if the activities in a discipline area other than their own discipline are being performed correctly, with enough frequency, or to provide guidance to the caregiver on nuances of the activities. The therapist is not delegating service provision to the primary service provider. The therapist will not be supervising the primary service provider. The primary service provider can support and encourage the caregiver to do all activities without having oversight responsibility on activity performance.

<p>4. In the goal of considering the development of the whole child, the therapist can inquire to the caregiver about the performance of complementary activities often performed within the same routine as the activities related to their discipline (e.g. A speech therapist can ask, “Is Jeremy still using his stander?”).</p> <p>5. Expect that levels of service will need to change as functional outcomes change and as the child develops. Discussion by team members of child outcomes and progress concerns need to occur on an ongoing and regular basis.</p> <p>6. Expect to develop and discuss appropriate developmental activities in their discipline area, to monitor, record, and evaluate child progress in those areas and to be responsible for working with the family or caregiver and other providers to correctly perform these activities within the child’s daily routines.</p>	<p>4. Diagnose, change activities, or make unsupportive comments regarding activities outside of their discipline area. If a problem is noted or a question arises, one team member must be in contact with another team member so that the appropriate professional can address areas of concern. (e.g., “Since the stander seems to be chafing Jeremy’s leg, I will speak with the physical therapist who can talk with you about what needs to be done to help Jeremy use his stander comfortably.”)</p> <p>5. Expect that the level of service that appears on the first IFSP for the first set of functional outcomes will be the same for an extended period of time (e.g. more than 3 months). Intensity and frequency of services and the number of service providers involved directly at any one time will be linked to increasing the caregivers’ capacity to assist the child and the child’s resulting progress on functional outcomes.</p> <p>6. Develop activities, record, monitor, or evaluate child progress outside of their professional area of discipline.</p>
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Adapted by Florida Early Steps, February, 2004, from the Texas Interagency Council on Early Childhood Intervention (1995). *Therapy issues in early childhood intervention programs*. Therapy Issues Project Team. Early Childhood Intervention Document Number R95-143

**Attachment C:
Evaluation and
Assessment Flow**

