Questions and Answers from Early Intervention Evaluation and Assessment Webinar

October 2015

The following is a list of answers to questions received during and shortly after the *Evaluation & Assessment Webinars* held in October 2015 to assist CFCs, EI Stakeholders and Providers in understanding and further clarifying the intent of the evaluation and assessment process. As stated during the Webinar, this information does not reflect a policy change but rather a reiteration of existing policy to ensure that all practices are in compliance with Part C of IDEA, Early Intervention Services System Act (325 ILCS 20) and the Early Intervention Program rule (89 ILL. Adm. Code 500).

The questions and answers are grouped by categories to make this a useful tool. You may also find additional information, such as the recorded Webinar, on the EI Training Program website at http://eitp.education.illinois.edu/faq-online-trainings.html. This website is updated regularly with additional resources.

Eligibility based upon Diagnosed Physical or Mental Condition and At-Risk Conditions

Q1. Is it acceptable for a parent to self-report his/her mental illness or do we need written documentation of the parent's diagnosis?

A1. Documentation from a medical/mental health professional is desired, but not required. At a minimum, documentation of the qualifying risk factor should be in the Service Coordinator's case notes. A good place to expand the conversation could be during the Routines Based Interview, possibly around the questions about "medications during pregnancy". Opening up the conversation could provide information to appropriately determine a self-reported mental illness.

Q2. Is a child eligible if a parent is deaf?

A2. Deafness is considered a risk factor that would qualify a child for early intervention. The team must discuss actual family needs and identified outcomes in order to make service decisions. If the risk factor of a parent's deafness impacts the parent-child relationship and the family's ability to facilitate their child's development, be sure to incorporate appropriate outcomes to meet the needs of the child/family.

Q3. When the child does not have a delay but the parent has a diagnosis that makes them eligible what do we use in the SV01?

A3. If the child's eligibility for EI is determined based upon a parent's diagnosis (existing eligibility criteria), the Service Coordinator should use assessment information to understand the child's relative strengths and weaknesses and how the parent's diagnosis may be impacting the child's development. . No child-specific diagnosis code or delay would need to be entered for a child who is eligible based on parent diagnosis but the Service Coordinator must then use the appropriate Eligibility Code (E05, E06, or E11) on the PA35.

Q4. Must the Service Coordinator have written proof of the diagnosis of the child? Is the physician prescription sufficient for documentation?

A4. Yes, written documentation of the eligible diagnosis for children is still required. A written confirmation of eligible diagnosis by a physician is sufficient to proceed with Assessments. A Service Coordinator must not assume a diagnosis but must work with the family and medical professional to obtain the necessary documentation.

Annual Redetermination of Eligibility

Q5. Do we always use E12 at Annual Redetermination? If the child is eligible based on an existing medically diagnosed physical or mental condition, such as when he/she has Down Syndrome, should we use E02?

A5. For a child who enters under E02 (qualifying medical condition), unless that medical diagnosis is no longer valid, the child remains eligible under E02 at annual(s). E12 is only to be used when the child no longer meets current eligibility criteria at their annual redetermination AND the child meets the criteria of eligibility listed under Chapter 9.9.

Q6. At annual, if a child continues with early intervention services, must the team decrease their frequency, intensity or duration of services or do services need to differ in some way?

A6. If at annual, a child has less than a 30% delay and the team determines that the child continues to need intervention in order to support "continuing developmental progress", the child may still be eligible for the system. In this case, E12 should be used as the eligibility code and the team needs to include information in their reports about why continued services are needed. E12 should not be used in instances where the percent of delay is 30% or greater. It is anticipated that as children's developmental needs and family's support needs change, services will be altered to reflect these changes. This decision would be based on the needs of the child/family and their IFSP outcomes at the annual or any update.

Forms

Q9. Do we still complete the CFC Parental Consent and Ability to Decline Services for the Intake steps of the Routines Based Interview, ASQ:SE and CFC Intake/Social History Summary Sheet? Does a parent/caretaker have the ability to decline any of those?

A9. The CFC can only do the RBI (Family-directed Assessment) or the ASQ:SE if parent/caregiver consents. The *CFC Parental Consent and Ability to Decline Services* is the form used to document the family's consent. The *Intake/Social History Summary* does not require consent and should be completed using the information available.

Q10. When will the new IFSP be available?

A10. No definitive time-frame is known at this time.

Q11. For a child determined eligible based on existing information and only needing assessments performed, does the Assessor have to list percentages/levels of delay on the report?

A11. For children who are eligible based on medical diagnosis or at risk conditions, percentage of delay information (age equivalencies/ percent delay) is desired, but not required. For a child eligible based on previously-performed evaluations indicating a department-approved level of delay, the appropriate level of delay must be listed as it would be known through the existing reports.

Q12. What will happen if a SC sees that a provider does not use an approved tool?

A12. We encourage CFCs to address this proactively by communicating with their evaluator provider community. Ensure that providers are aware of the provider notice from August 2015 and the updated link in the manual and on the DHS website at http://www.dhs.state.il.us/page.aspx?item=79984 , especially if the provider uses a tool that will no longer be approved as of February 1, 2016. If a provider uses an unapproved tool after that date, their report will need to be returned and an approved tool will need to be administered.

EA vs AS Defined

Q13. What is the major difference between Evaluation/Assessment and Assessment (Tools, Pay Rate)? Is there any documentation to define the difference(s)?
A13. The primary difference between Evaluation and Assessment is whether you have to answer the question of eligibility for the Early Intervention program. The differences are defined on slides 29-32 and 42-44 in the Evaluation/Assessment webinar as well as listed in the manual in Chapter 9. There is no difference in reimbursement rate. The approved tools can be used for either evaluation or assessment unless indicated otherwise on the tool listing.

Multidisciplinary Eligibility Determination

Q14. If a child with a diagnosed hearing loss is referred, would the DTH provider have to have an Evaluator credential in order to perform an assessment? Would the DTH ongoing service provider be able to do the annual redetermination of eligibility?

A14. For a child with a diagnosed hearing loss, or any child who needs to have eligibility determined, only credentialed evaluators may complete <u>initial</u> evaluations. <u>Initial</u> assessments must also be completed by credentialed evaluators. At the annual, the direct service provider can perform the Assessment to continue eligibility even if they are not an evaluator-credentialed provider.

Q15. Why must 2 providers complete an assessment if we have a child with an eligible diagnosis such as Down Syndrome?

A15. Per federal regulations and state rules, a multidisciplinary assessment is required.

Q16. If one provider shows a 30% delay on their evaluation and the other doesn't, would that child be eligible as E01 or E03? Do both providers need to show a 30% on their evaluations for it to be an E01? Also, on the PA35, what should SCs enter in the system as the eligibility reason-E01 or E03 if the Evaluation/Assessment results differ?

A16. The hierarchy of eligibility determination is found in Chapter 9.1.
- For children who receive Evaluation/Assessment, a child is eligible if a delay of 30% or greater exists and the SC should choose E01 as the eligibility code used.
- For children who enter EI with an automatic eligibility based on a medical diagnosis and receive an Assessment, the SC should choose E02.
- For children who receive Evaluation/Assessment but the child does not show a 30% or more delay, AND providers feel that their tools do not accurately represent the child's actual level of delay, after the team discussion and consensus, the SC would use E03.

Reports from the multidisciplinary team do not need to match each other's. Providers do not need to change their reports as long as they are accurate based on what they found through the evaluation/assessment process. Documentation of eligibility consensus must be entered in the Service Coordinator's case notes and the correct E code should be entered in Cornerstone.

Q17. When do providers use further assessment to determine eligibility? When the DT has no delay but PT has maybe 50%? Is this right?

A17. In this example, further evaluation would not likely be needed to determine eligibility. It points to an eligible level of delay in the physical domain. If the evaluations that have been completed do not address family/team concerns, additional assessments could be warranted to determine additional support/service needs.

Q18. If a child has been evaluated by two disciplines, but the parent has concerns about another area and would like to have another assessment, is that going to be authorized as an assessment or evaluation?

A18. An initial evaluation completed by two disciplines should cover all five domains of development. If it is determined that a more extensive look at a domain needs to be completed in order to determine strengths/needs and/or to inform IFSP planning, how it is authorized would be based on the findings of the initial two evaluators and/or the timing of the additional provider's information. For instance, if the original two evaluators provide information to support the child's eligibility, the third provider could be issued an AS authorization. If it is determined that the additional information is critical to the eligibility discussion, then an EA authorization would be more appropriate.

Q19. Are you saying that for a child who is eligible based on physical/mental condition or at risk conditions, we will not need to assess functional levels for each of the 5 domains?

A19. To clarify "functional levels", here is the definition from Chapter 9.3.2: Assessment of the child shall include: a review of the results of the evaluations; personal observations of the child; and identification of the child's needs in each of the developmental areas (cognitive, physical, communication, social or emotional, and adaptive development).
Identifying the child's needs in each of the developmental areas will require some assessment of the child's current functioning. When performing only an assessment, documenting age equivalencies in each domain is desired, but not required.

Q20. If a child is found eligible and then the direct service providers believe another discipline would be helpful, must we have an evaluator credentialed provider provide the assessment?

A20. Initial evaluations to determine initial eligibility and Initial assessments for initial IFSP development as well as initial assessment to determine the need for a new service still require the use of an evaluator credentialed provider. A memorandum from DHS with instructions on using Cornerstone to assist the SC in choosing the correctly credentialed provider will be available prior to December 1, 2015.

Cornerstone Activities

Q21. If you have a child with an eligible medical diagnosis, can you write an IFSP without completing evaluations? You said you can complete Assessments, not evaluations. In the past the Cornerstone system would only allow you to use EA option prior to entering the eligibility date in the PA35.

A21. You can hold and create an IFSP on a child who has eligibility determined through a medical diagnosis without authorizing an Evaluation. The Cornerstone system was adjusted to allow AS authorizations prior to the IFSP to comply with the updated manual and practice of Evaluation and Assessment. A Service Coordinator can also enter an eligibility date and reason on PA 35 as soon as the eligibility is established based on the date the documentation proving eligibility was received/reviewed. Assessments would be completed prior to IFSP development. The IFSP date can be different than the date eligibility was determined.

Q22. If an AS authorization is used instead of EA should we re-authorize the provider?

A22. Service coordinators should produce correct authorizations based on whether or not eligibility still needs to be determined. Correct use of these codes is expected with implementation of the updated manual. As in other instances, follow data correction process to fix any incorrect authorizations.

Q23. Will the AS03 look different since it currently has % of delay and we may not get these percentages with assessments?

A23. It may look different as you cannot enter information that you do not have. The majority of information on the ASO3, however, is contained in the narrative sections and should be completed with information gathered through the assessment process.

Q24. Currently we cannot edit the PA35 eligibility or dates

A24. You should not need to edit the eligibility or dates; you can, however, add dates for Eligibility Determination and dates for IFSP at different times and using different dates.

Q25. If you start the PA35 once you know about the diagnosis, how would the meeting authorization then work?

A25. You should enter the correct Eligibility code based on the reason for eligibility. If an eligible physical/mental/at risk condition exists, generate AS authorizations to Evaluator-

Credentialed therapists. Once the Initial Assessments are completed and the Evaluation/Assessment Report format completed and shared, hold the IFSP meeting and create IM authorizations to reflect actual meeting dates. Finally, add the IFSP meeting dates into the PA35.

Q26. What diagnosis should be used if a child is NOT eligible?

A26. No diagnosis is required for children who are not eligible.

Q27. I may be wrong, but I don't think you can save the PA35 without a percentage of delay. If that is entered before assessments for medically eligible children, how could that screen be saved?

A27. You can enter a zero and update if necessary. Cornerstone was adjusted to allow edits of the percentage of delay as well as the Eligibility Determination Code.

Q28. When providers complete their evaluations the same day as the meeting can they bill for the assessment using their E/A authorization instead of a new assessment authorization being issued?

A28. Providers should be given an EA authorization for the entire process of evaluation and assessment time-regardless of the meeting date/timing. Once eligibility has been established, an IFSP meeting authorization should cover the time spent developing the IFSP.

Q29. Please confirm that for annual redetermination that we should use EA authorizations if eligibility needs to be redetermined (no eligible physical/mental condition exists). At an Annual should we use an EA authorization and will Cornerstone be updated to allow this?

A29. Cornerstone will soon be updated to allow the EA authorization for the process of initial eligibility as well as required annual redetermination of eligibility. The AS authorization is utilized only if a child has a physical/medical condition or the parent has a diagnosis that meets our eligibility criteria and only needs an assessment to determine unique strengths and needs to drive the outcomes for the IFSP. Both EA and AS authorizations are available for use before initial IFSP and annual IFSP creation. The practice of using the ongoing direct service provider to perform the annual redetermination of eligibility has not changed. The Bureau is currently working with Cornerstone on a mechanism that would allow the ongoing service provider, to receive the appropriate authorization.

Q30. If we have to use EA authorizations at annual when a child does not meet eligibility through existing documentation of a medical diagnosis, then would a credentialed evaluator be needed to complete the annual evaluations?

A30. There are no plans to change the process and require an Evaluator-Credentialed provider to complete annual redeterminations of eligibility. The policy of the ongoing direct service provider performing the annual redetermination of eligibility should continue but the SC should authorize that provider for performing an EA process of evaluation/assessment for annual redetermination of eligibility in Cornerstone as soon as the updates are finalized.

Ineligible

Q31. If the child's eligibility for the system is unclear based on evaluation/assessment reports and the family and team members need to meet to discuss findings, clarify questions the family might have about eligibility (or ineligibility), and plan for other resources outside of early intervention they may want to obtain, can the team receive authorization for their time to discuss this? How do we pay providers for their time discussing child's needs if the child is determined ineligible?

A31. Team findings and eligibility discussions are considered part of the EA authorizations as ineligible children will not have IFSPs developed and therefore IFSP meeting authorizations are inappropriate. Additional time can be requested if this discussion requires the use of more time than has been authorized for evaluation/assessment activities. The SC would adjust the authorization to incorporate the needs of the team members. Providers should be reminded that they should only bill the amount of time used and be able to support their time through proper documentation.

Q32: If a child is not eligible, when should the SC close the case?

A32: A SC must close the case as soon as possible after it is determined that the child is not eligible, but no sooner than the day <u>after</u> all team members have performed their evaluation/assessments or they will risk having a provider who cannot be reimbursed for the services performed.

Follow-up Needs

Q33. At the CFC manager's meeting, we discussed having the Waiver of Prior Written Notice changed to take out the bottom section (If INELIGIBLE), as there wouldn't be an IFSP meeting. Is that change still going to happen?

A33. DHS is still checking on this.

Q34. Do you fear that an increase in clinical opinion will start?

A34. Clinical opinion is an integral part of all eligibility decisions. As we discussed, it impacts many aspects of evaluation and assessment. The updated regulations emphasize the importance of clinical opinion for eligibility. In terms of our eligibility codes, clinical opinion should continue to be used as teams consider whether or not their tools are good indicators of an individual child's development. If you are asking whether teams will need to use their specialized skills and expertise rather than isolated scores on tools in order to understand a child's domain level performance, we believe that answer is "yes".

Domains vs Subdomains

Q35. Since we have gotten into the practice of determining eligibility based on developmental delays in sub domains (gross motor, fine motor, expressive, receptive language) and some providers even use sub-sub domains such as sensory or locomotion/stationary skills, what might the eligibility discussion look like in an example where a child has no delays other than a 30% delay in expressive language development?

A35. The child's individual strengths and needs should be discussed, always. Results obtained from evaluation tools used should also be discussed. If the tool provides an overall domain

score/information, this should be taken into consideration when determining percentage of delay, as well as results from additional tools used. Attempts to gain an overall picture of the child's developmental status at this point in time should be made along with additional observations, parental input, etc. In addition, the team, in this example, would need to consider how a delay in the particular subdomain (expressive language) is impacting the child's overall communication and his/her interaction with the environment. What concerns have been identified about the child's communication skills? Other things to consider might be, how well does the tool reflect the child's actual developmental status? How is the delay impacting the child's functioning, e.g. can he/she get his/her needs met? Is the child frustrated with communication attempts? Has the child's behavior changed as developmental expectations have increased? The discussion should continue to center around the needs of the individual child and family.

Q36. What is the difference in the social or emotional domain, do providers need to do anything different in reports?

A36. The primary change to the name of the domain is in the removal of the forward slash between social/emotional to recognize that these areas represent related, but distinct, skill sets. While emotional development can certainly facilitate social development, they are not identical skill sets. Providers evaluating/assessing this domain should provide information about the child's functioning in regard to both social and emotional skills.

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