



TECSNews

For the Allied eHealth Resource Network

January 2007

Special points of interest:

- Family-centered service provision – what our fields say about it
- OSEP outcomes measures and provider roles
- Information for providers— documentation, contracts, IDEA Part C regulations
- A therapist’s perspective on providing services

A Change in Focus to Family-centered (FC) Services — what our fields say about it

Introduction

IDEA has “...challenged the service delivery system to move from a focus on the child who had a disability to a focus on the child within a family unit” (Polmanteer, 2000). Federally mandated family-centered service delivery is based on family–systems and ecological theories of child development (Hammer, 1998).

Together these theories view the child as part of a family system and as best understood in the context of family, community, and culture. *So the beneficiary of IDEA/C services is still the child, but the recipient of services includes the family, and the plan of “intervention” is based on both child and family needs* (Hammer, 1998; Brofenbrenner, 1979; Hanft, 2004).

It is important to know that family-centered (FC) services should be reflected in reporting of OSEP outcomes and IFSP service documentation. See pages 4 & 6 for more info.

An FC framework has also *broadly* permeated the way education and healthcare view early intervention (EI) service delivery. Example: The Committee on Children with Disabilities 2001 and the current “Role of the Pediatrician in Family-Centered Early Intervention Services” state that health and developmental services have “...evolved from a child-centered, traditional, ‘medical’ model to a family-centered ‘developmental’ model.”

What does this mean for our service delivery?

FC practices versus child-centered treatment programs have been defined and supported in recent years, resulting in many professionals who are presently learning about methods for delivering family-centered intervention (Brown, 2005). The Division

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About this Issue

This is the third issue of a quarterly newsletter for allied health professionals who provide Part C services to children 0-3 and their families! It is part of an overall effort to give accurate and useable information, resources, and support to allied health providers. This issue features the topic you wanted to learn most about in the Provider Survey (see last newsletter)— “*family-centered*” (FC) *service provision*. FC services are also important for *child and family outcomes measures* required by IDEA, and information regarding *your role* in this process is provided. Information about the 2004 IDEA Part C regulations and BN contract requirements are also included!

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Family-centered Services for the Child and Family

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for Early Childhood (DEC) of the Council for Exceptional Children (CEC) has identified recommended practices for early childhood services including a family-centered focus. These practice indicators "...were validated by parents, providers, and higher education personnel" and "...have become benchmarks for quality services in the 1990s and for the next century (Odom, 1996; Polmanteer, 2000).

Recommended practices for beginning to include family-centered services—

- ◇ Have ongoing discussions with the family, from evaluation/assessment throughout service delivery; for example, together determine the family's priorities and concerns related to their child's development, and collaboratively select and work on "meaningful, achievable functional goals" for treatment plans (Randall, 2000).
- ◇ Involve the family as an equal partner and "core of an early intervention team" (Hanft, 2004). Family participation, *to whatever level is comfortable for families*, should occur in assessment of the child's strengths and needs, and in IFSP service delivery. Providers' points of view

- ☑ **To learn more about recommended practices, log onto the TECS website: <http://uscm.med.sc.edu/tecs/>**
- ☑ **To learn about IDEA 2004 for Part C, log on to the TECS website (<http://uscm.med.sc.edu/tecs/>), or www.ed.gov/offices/osers/idea**
- ☑ **To learn about the revised policies for SC, log on to www.scdhec.net/babynet (click on Policy Manual and Forms)**

of developmentally appropriate methods merges with the family's point of view, and these are used to support goals and intervention plans for their child (Polmanteer, 2000; Briggs, 1998).

- ◇ Teach or coach families methods to effectively and comfortably facilitate their child's development (IDEA/C) (APTA 2004). IDEA/C specifies that funds for children eligible for Part C must be used to enhance the family's capacity to meet the developmental needs of their child— so the family becomes the consumer yet the impact is still on the child. This includes collaboratively designing intervention plans that help family members facilitate their child's participation and learning as part of their daily routines and activities (Hanft, 2004; Polmanteer, 2000).
- ◇ Develop IFSP goals that reflect "...changes the family wants for itself or for its child who has a disability" (McGonigel, 1988). Both child and family goals should be included on the IFSP, and they should reflect the family's resources, priorities, and concerns (Noonan, 2006; Turbiville, 1996).
- ◇ Figure out ways for team members to support/collaborate with one another (to whatever level possible) so that services are integrated and consistent (Hanft, 2004).
- ◇ Have, and document, meaningful and understandable communication with family members that promote a provider-family partnership (McWilliam, 1998). For example, collaboration can be observed on the IFSP, such as in the description of the child's levels of functioning (Polmanteer, 2000) and in IDEA child outcomes documentation (see page 4). We can provide families with choices "...that defer to their priorities and concerns" (Noonan, 2006) and with information that families need to make informed decisions (Noon, 2006; Hanft, 2004).

References & Resources on next page.

References and Resources on Family-centered Service Provision from Various Disciplines

- American Academy of Pediatrics, Committee on children with Disabilities, PEDIATRICS, Vol. 107 No. 5, May 2001.
- American Speech-Language-Hearing Association (1989). Communication-Based Services for Infants, Toddlers, and Their Families. Rockville, MD: Author.
- American Speech-Language-Hearing Association (2004), Preferred Practice Patterns for the Profession of Speech-Language Pathology, #11 Communication Assessment – Infants and Toddlers and #12 “Communication Intervention—Infants and Toddlers.”
- American Physical Therapy Association, Section on Pediatrics, <http://www.pediatricapta.org>, Practice Committee of the Section on Pediatrics (2004). Early intervention: physical therapy under IDEA, fact sheet.
- Briggs, M. (1998). Families talk: Building partnerships for communicative change. Topics in Language Disorders, 18.
- Brofenbrenner, U. (1979). Ecology of human development. Cambridge, MA: Harvard University Press.
- Brown, Stredler A. (2005). The art and science of home visits, The ASHA Leader, Jan. 18, 2005, pp. 6-7, 15.
- Hammer C.S. (1998). Viewpoint: Toward a “Thick Description” of Families: Using Ethnography to Overcome the Obstacles to Providing Family-Centered Early Intervention Services.
- Hanft, B.E., & Rhodes, D. (2004). Occupational therapy in Community-Based Early Intervention Settings, AOTA Continuing Education Article.
- Hanft, B. (1988). The Changing Environment of Early Intervention Services: Implications for Practice. American Journal of Occupational Therapy, 42(11).
- McGonigel M., & Garland, C. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. Infants and Young Children, 1.
- McWilliam, R. A., Ferguson, A., Harbin, G., Porter, P., Munn, D., & Vanidviere, P. (1998). The family-centeredness of individualized family service plans. Topics in Early Childhood Special Education, 18(2).
- Noonan, M.J., & McCormick, L. (2006). Young children with Disabilities in Natural Environments—Methods and Procedures. Baltimore, Md.: Paul Brookes Publishing Co.
- Odom, S & McLean, M. (Eds.), (1996). Early intervention/early childhood special education: Recommended practices. Austin, TX: PRO-ED
- Polmanteer, K. & Turbiville, V. (2000). Family-Responsive Individualized Family Service Plans for Speech-Language Pathologists, Language, Speech, and Hearing Services in Schools, 31, 4-14.
- Randall, KE, McEwen, IR, (2000), “Writing Patient-Centered Functional Goals,” Physical Therapy, Vol. 80, Number 12, December, 2000.
- Turbiville, V., Turnbull, A.P., Garland, C. W., & Lee, I.M. (1996). Development and implementation of IFSPs and IEPs: Opportunities for empowerment. In S. Odom & M. McLean (Eds.), Early intervention/early childhood special education: Recommended practices. Austin, TX: PRO-ED.

Please submit your ideas or articles for the newsletter!!!

Email Lily Nalty at NaltyL@cdd.sc.edu

Provider Participation in the Outcomes Measures Process, by Lesly Wilson, PhD, OTR/L, Evaluation Research Specialist

The IDEA Outcomes

The 2004 Reauthorization of IDEA Part C legislation requires states to move toward a higher level of accountability for early intervention service systems. For this purpose, the Office of Special Education Programs (OSEP) established *child and family outcomes* for all states to implement within their systems. South Carolina's early intervention system, BabyNet, began implementation of these requirements in 2006 which, as required, will be ongoing and involve all providers within the BabyNet system.

There are three OSEP-developed child outcomes in Part C of IDEA. These measure the development of children in the BabyNet system relative to that of normally developing same-age peers. The three **child outcomes** address each child's demonstration of:

1. positive social relationships,
2. acquiring and using knowledge and skills,
3. taking appropriate action to meet their needs.

There are also three Part C family outcomes, which measure the family's view of help received through the BabyNet system. The following **family outcomes** focus on families:

1. knowing their rights,
2. effectively communicating their children's needs,
3. helping their children develop and learn.

The Role of Therapists in the Outcomes Process

It is important to know that all providers must have an active role in the *child outcomes* requirements; however, neither providers nor service coordinators will participate in the *family outcomes* portion of these requirements. Team for Early Childhood Solutions (TECS) has developed an online training required by DHEC for *all* providers, which provides an overview of the South Carolina *Child Outcomes* process. It is

available at <http://breeze.sc.edu/p82299978/> or through the TECS website <http://uscm.med.sc.edu/tecs/>, *Child Outcomes* link.

Provider Input: The *Child Outcomes Summary Form* (COSF) is used to capture provider input at the child's exit from Part C services. Each provider working with a child and family completes a COSF and provides a rating for each of the three child outcome areas relevant to the provider's services. It is important for therapy providers completing discipline-specific assessments (i.e., OT, SLP, & PT) to include family input and involvement on COSF documentation. Copies of the COSF can be found at the TECS website <http://uscm.med.sc.edu/tecs/>, *Child Outcomes* link.

When completing the COSF, it is also necessary for providers to be familiar with the Early Childhood Outcomes Center (ECO) rating scale and Decision Tree. Copies of the ECO rating scale with definitions and the Decision Tree can be found on TECS website <http://uscm.med.sc.edu/tecs/>, *Child Outcomes* link.

Provider-Service Coordinator Communication: Providers are asked to continue good communications with service coordinators during the COSF and rating process. Specifically, there should be continued communication regarding receipt of the COSF, interpretation of COSF documentation, and interpretation of ECO rating between therapy providers and service coordinators. The individual COSF and ECO ratings provided by therapy providers are synthesized by service coordinators in order to determine an IFSP team consensus ECO rating for each *child outcome*.

For additional training and resources, link to: <http://uscm.med.sc.edu/tecs/childoutcomesinfo.htm>.

For further information regarding child outcomes, contact Dr. Lesly Wilson, OTR/L at lwilson@cdd.sc.edu or the TECS office at (803) 935-5227.

Provider Participation in Outcomes Training, by Lesly Wilson, PhD, OTR/L, Evaluation Research Specialist

TECS launched the Online Child Outcomes Training in July 2006 and a snapshot of the online training data was taken on 12/12/06. The snapshot provided valuable information regarding which BabyNet personnel/contractors had completed the training, how they felt about the online training mode, and their level of understanding of the three Child Outcomes as well as the SC Child Outcomes Process. Some of these results are described below.

A total of 288 BabyNet personnel/contractors had participated in the online training, of which 48 were allied health providers (i.e. OT n= 11; PT n= 7; SLP n= 30). OTs represented 23%; PTs represented 15% and SLPs represented 62% (Figure 1) of the total number of allied health providers completing the training by December 12, 2006. Of this group of providers, the largest number were located within Region 2, followed by Region 3, with all other regions well behind in numbers of allied health providers completing the Online Child Outcomes Training. Regions 1, 4, and 5 had no participation of OT, PT, or SLP providers in the Online Child Outcomes Training. See Figure 2.

The number of allied health providers completing the online training was then compared to the total number of credentialed allied health providers, per the TECS credential database (Figure 3). The TECS database indicated 438 as the total number of credentialed allied health providers, consisting of 122 OT, 98 PT, and 218 SLP providers. 390 providers must still complete the training as of this publication.

All allied health providers will be expected to participate in the SC Child Outcomes Process as early as late February 2007. Training can be accessed at <http://breeze.sc.edu/p82299978/> or through the TECS website.

Figure 1

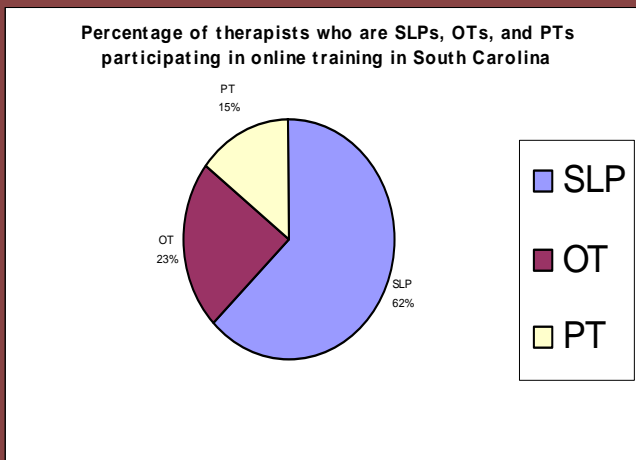


Figure 2

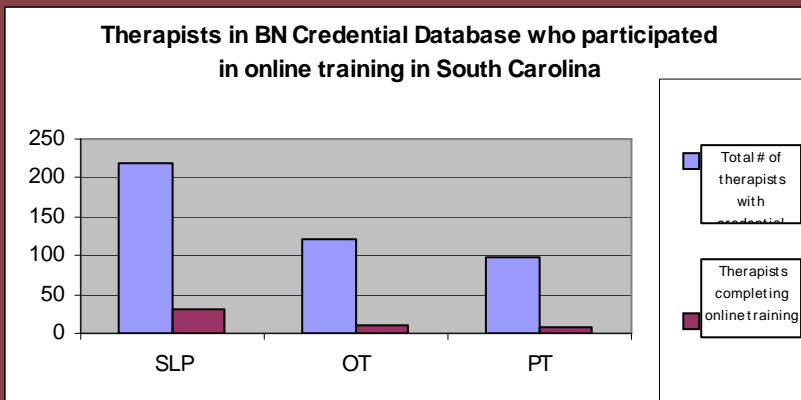
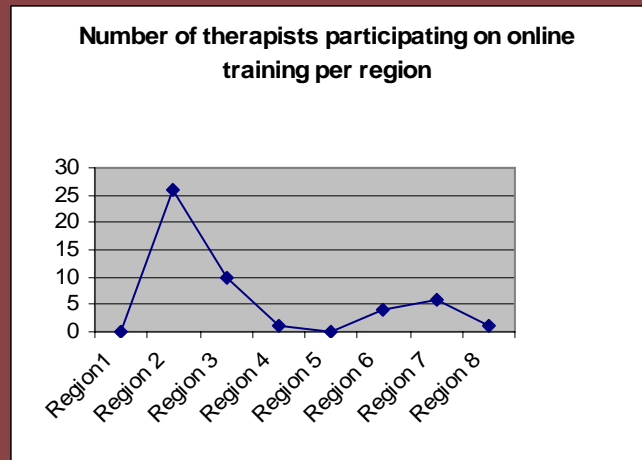


Figure 3

Charts and graphs prepared by Libby Horton

Important Information for Providers— Documentation for Outcomes Data Reporting, Evaluations/Assessments, and other IFSP Services

Evaluation/assessment information that involves family-centeredness, collaborative methods, and natural environments can be reported and gathered in a number of ways, including from:

- family/caregiver participation in standardized or criterion-referenced tests, if they are given, with results reported as obtained via family participation; e.g., the family/caregiver administers an item, the family is present during an evaluation for interpretation or input, etc.
- “arena”- type testing formats in which family members, the child and other professionals participate by observing, asking questions such as “can you show us how you get your child to...., could you feed your child and show us what you have tried that works...”, etc.
- judgment-based assessments such as observations reported of the child in various contexts (e.g., play, bath time); information can be used from observation checklists/interviews which identify the presence/absence of certain behaviors/skills.
- samples of the child’s natural and elicited behaviors and responses during play and other activities, across settings; these documented observations can include portfolio formats if available, which are typically collected over time.
- testing in familiar contexts; e.g., testing that includes the child involved with familiar toys, books, foods, etc.; familiar people in the assessment; typical routines such as play-social routines, feeding routines; usual settings.
- ecobehavioral or ecological evaluations/assessments during specific activities, such as observation of a specific problematic situation
- other current testing; consider all discipline-specific assessment information.

For references and additional information, log onto <http://uscm.med.sc.edu/tecs/>, link to TECS Projects and Allied eHealth Network.

Data that should be reported:

- ◆ Data should reflect that evaluation/assessment was conducted in a “family-directed” manner (CFR 303.322).
- ◆ Evaluations/assessments must include “informed clinical opinion” (CFR 303.300), or ICO, which involves the “... use of qualitative and quantitative information in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention” (Shackelford, 2002; Shackelford, 2004). ICO is intended to give a holistic picture of the child’s abilities and needs within his/her natural environment ; ICO activities are completed by personnel with “... appropriate training, previous experience with evaluation and assessment, sensitivity to cultural needs, and the ability to elicit and include family perceptions...” and are considered a “...necessary safeguard against eligibility determination (initial and ongoing) based upon isolated information or test scores alone” (Shackelford, 2002).
- ◆ Evaluations/assessments should include activities conducted in contexts that are familiar to the child; this could involve ICO activities such as those listed in the above text box . These must include information gathered from multiple sources as those listed above. (Sandall, 2005) CBA crosswalks should serve as “reference points” to guide the type of data that can be reported for each OSEP outcome.

For references/additional information, log onto <http://uscm.med.sc.edu/tecs/>, link to TECS Projects, Allied eHealth Network.

Important Information about IDEA 2004, by Kristie Musick, Director, TECS

In December 2004, re-authorization of the Individuals with Disabilities Education Act (IDEA) was signed into law. While specific regulations for implementation of *Part C for infants and toddlers* are still pending, the changes in the law became effective on July 1, 2005. It is anticipated that corresponding changes to BabyNet state policy will take place once the new regulations are finalized. Current BabyNet policies can be found at: <http://www.scdhec.com/health/mch/cshcn/programs/babynet/policy.htm>.

Key Changes in IDEA 2004 for Part C

Monitoring, Technical Assistance and Enforcement § 616

- Adds requirement for public reporting for Part C State Performance Plan (SPP). To see South Carolina's current SPP, go to <http://www.scdhec.com/health/mch/cshcn/programs/babynet/index.htm>.
- Adds requirement for collection and reporting of outcomes data for families and children participating in Part C services.

Target Populations & Eligibility §§ 631, 634, 637

- Adds infants and toddlers who are homeless, in foster care, or are wards of the state (either as the result of substantiated child maltreatment and/or identified as affected by illegal substance abuse, or withdrawal from prenatal drug exposure) as families and children who must be included in provision of Part C activities (child find, referral, screening, evaluation), and, if eligible, must receive services in the Individualized Family Service Plan (IFSP).

Definitions §§ 632, 635

- Adds that services must be based on the developmental needs of the child *as identified by the IFSP team*.
- Adds sign language and cued language services to definition of speech-language pathology and audiology services.
- Adds developmental screening as a service.
- Adds ophthalmologists and optometrists to definition of vision specialists.
- Changes Nutritionist to Registered Dietitian in list of qualified personnel.
- *At the State's discretion*, allows children who have received services under Part C AND who are eligible for Part B to continue receipt of IDEA services under Part C until age 5.

Requirements for Statewide System §§ 635, 636

- Requires States use a 'rigorous' definition of the term 'developmental delay' in establishment of Part C eligibility.
- Adds that the public awareness program for States' Part B & C services must include components specifically for parents of premature infants, or infants with other physical risk factors associated with learning or developmental complications, procedures for assisting hospitals and physicians for dissemination of PA information to these and other groups.
- Requires that provision of IFSP services be grounded in scientifically-based/peer-reviewed research, and evidence-based practices.
- Adds training in use of evidence-based practices in transition from Part C and social-emotional development to the requirements for the Comprehensive System of Personnel Development (CSPD).
- Amends the provision of services in natural environments to state 'the provision of early intervention services...occur in a setting other than a natural environment that is most appropriate, as determined by the parent and [other members of] the IFSP team, only when early intervention cannot be achieved satisfactorily...in a natural environment.'

IFSP §§ 636, 637

- Adds that the IFSP must include a description of appropriate transition services, and the transition conference may be held not more than 9 months from the child's third birthday.
- Adds that the IFSP must include a statement of measurable results expected to be achieved through provision of Part C and other services.
- Adds that IFSP goals must include pre-literacy and language skills.
- Adds that IFSP goals must include projected dates for initiation of services and length, duration, and frequency of services.

State Assurances & Application § 637

- Adds requirement that States describe collaborative efforts between State Part C early intervention systems, State Part B Preschool Programs, Early Head Start, Head Start, and early care education providers relative to transition at age 3.

Resources:

IDEA Infant & Toddler Coordinator Association: <http://www.ideainfanttoddler.org>

National Association of State Directors of Special Education (NASDE): <http://www.nasdse.org/index.cfm>

National Early Childhood Technical Assistance Center (NECTAC): <http://www.nectac.org/>

News for you — More Information and Resources!

Providing Services in Child Care Contexts, by Suzan Albright, M.Ed.

In order to promote children's development within "home, day care centers, or other community settings" (54 CFR 119 303.12), a primary focus for providers of IDEA/C services is to identify potential opportunities for infants and toddlers to learn and practice skills/behaviors. We know that recommended practice guidelines also indicate that interventions should be embedded within routines, activities and places (RAPs) that are part of the child's daily experience, and that interventions should involve the family and their resources, priorities, and concerns (Noonan, 2006; Hanft, 2004).

One way to meet these needs is to partner with the child care provider (early care educator) in child care settings. Here are some things to consider when offering services in daycare settings:

A variety of "*naturally-occurring*" routines take place at daycares. These experiences can be used to address development in all domains and can be repeated in home settings. For example, routines for infants and toddler groups typically include transitions (e.g. arrival, shifts between activities, and departure) snack time, naps, and regular hygienic and housekeeping practices (e.g., diapering, toileting, clean-up, and hand washing) (Craig, 1997; Goldbeck, 1997). Within these routines, a wide variety of social-emotional, adaptive, communication, and motor behaviors can be learned and practiced (Horn, 2001).

Planned activities in child care often include such activities as music (singing and making sounds with simple rhythm instruments), early literacy activities (e.g. listening to stories, looking at pictures, handling books), and crafts (e.g. exploring materials of various colors, textures, and tastes).

Child care contexts include a variety of indoor *places*, such as floor spaces, table areas, and open areas for large toy play; as well as outdoor places such as grassy areas, swing and slide areas, sidewalks, and wading pools. Each of these present opportunities for embedding activities to promote IFSP goals for development in communication, cognition, fine and gross motor development and social interaction.

See next page for a therapist's perspective on providing services in a daycare setting.

Collaborating with Daycare Providers (Early Care Educators):

Early care educators are uniquely positioned to observe children over extended periods of time, and across a range of routines, activities and places throughout the day. The early care educator usually knows how a child typically reacts to new experiences, what a child prefers or dislikes, when the child's "best times of day" are, and what is happening in the child care context or the child's life that may affect learning and behavior. Sharing this kind of information can facilitate the planning of intervention across RAPs, and provide useful insights for assessment and monitoring purposes as well.

Even early care educators who are well-qualified and experienced with typically developing children may lack the knowledge and confidence to meet the special needs of children with disabilities (Dinnebeil, 1998; Golbeck, 1997). Research on early intervention/community child care collaboration has demonstrated that benefits of such collaboration may include improvement in caregiver intervention skills and improvement in child care environment (Oltmans, 1986; Kontos, 1988; Bruder, 1993). Early interventionists can support caregivers' efforts by sharing their expertise on meeting the special needs of children. For example, in collaborative situations, the interventionist may explain how to use strategies such as prompts, positioning devices, alternative communication systems, and balanced turn-taking. When needed, the intervention provider can assist with accessing or making assistive technology devices and using them within the context of the child care program.

Partnering with early care educators provides opportunity to capitalize on experiences with children who will potentially be classmates, teammates, friends, and fellow citizens; it means "starting in the mainstream" (Safford, 1989) of their own communities, and not having to apply for membership later in life.

For additional information, references, or resources, please contact Suzan Albright at suzanalbright@bellsouth.net.

A Therapist's Perspective on Involving Daycare Staff and Activities in IFSP Interventions, by Loretta Jones, M.A., CCC-SLP

***Although the following article is specific to speech-language therapy, it has applications for other disciplines. We invited the author to share her experience working with three children at a daycare setting, integrating individualized interventions using a naturalistic group-based model, which meets federal mandates of natural environments, family-centeredness, and the therapist's role as consultant/coach. Loretta Jones works in the public schools and private practice. The following is her story. . .*

It can sometimes be challenging to figure out ways to implement developmentally appropriate methods, facilitate family/caregiver participation, and include what the family/caregiver views as important. Young children are not always ready to learn the same activities as their age peers with mild or no disabilities, and caregivers can perceive requests for their participation on IFSP goals as more things for them to do.

One way I have found to individualize intervention and still involve caregiver-preferred activities and participation at a daycare setting is to think of age-appropriate or everyday activities as a context for instruction (from a naturalistic curriculum model) — something that therapists have already frequently done. For example, we know that peer groups provide opportunities for children with disabilities to learn to play and socialize. These situations allow us to provide needed interventions and to coach others to facilitate skill development in functional everyday activities.

Here is my story:

I provide speech-language services at a daycare setting for 3 children who were assessed and found to have various levels of speech, language, and pragmatic language (social-interactive language) delays and disorders. I began my treatment planning by observing the typical activities of all of the children and gathering information from the family and daycare staff to determine their perceived needs and preferences. We selected 3 of the usual activities, preferred by parents and caregivers, that would allow each of the children to develop and practice their speech and language skills (story time, song time, games).

These activities were first redesigned to allow the 3 children enrolled in therapy to learn and practice skills related

to their social language and speech needs. After the daycare staff and I became comfortable with the new strategies, we redesigned the activities so that all of the children (including those not enrolled in therapy) could take part more effectively together (i.e., “universal design” for activities). I spent a minimum of 1.5 hours at the daycare, focusing on each child for 30 minutes. Daycare staff and family have chosen to use these strategies on their own and in other activities, and we found that the social development strategies were helpful for many of the children not enrolled in therapy.

My group-based individualized interventions are primarily designed for children having difficulties communicating and playing with peers, and also for children whose parents feel are have difficulty thriving socially. Specifically, I have found it easy to work on such skills as ways to initiate, maintain and end interactions, generating/maintaining appropriate topics, understanding and appropriately using new words and communicative intents, practicing early literacy skills, and understanding and using non-verbal communication effectively. I integrate scripting and modeling of appropriate language behaviors through various pre-planned routines. The groups have also been a helpful context for functional assessments, referrals, consultation, and transition preparation. The end goal is for each child to continue to generalize these learned new social skills to their home and other settings.

Parents of the children enrolled in therapy have reported that they like the program because of the flexibility with scheduling that does not require them to take time off from work to carry their child to a separate facility and because it means that their children learn while interacting as other children would. Parents of the children not enrolled in therapy like the added language and social interaction focus. For the daycare setting, this is a marketing feature that separates them from other daycare centers. Who wouldn't want their child to take part in activities specifically designed to maximize social development?

Contact the author at (803)603-2252 for more information.

Information for Providers from Dr. Debra McCoy, BabyNet Provider Relations

As you may or may not be aware, Robin Morris and I have been traveling around the state meeting with local BN Teams and Contracted Providers to provide updates on the new eligibility determination process and contract requirements. It has been a pleasure meeting so many of you. We have visited all Regions except Regions 1, 2 and 3. If we have not visited your region, we will be doing so in upcoming months (meeting dates and times to be announced). Here are some of the issues we have discussed.

BabyNet contracts: As a contracted provider, it is important that you understand your responsibilities under the BabyNet contract. The contract between you and DHEC BabyNet requires that you:

- Maintain your status as a SC DHHS Medicaid Provider.
- Conform with all BabyNet Provider guidelines and eligibility requirements listed in the BabyNet Policy and Procedure Manual in effect at the time of services, and all state credentialing and license requirements. The policy and procedure manual can be downloaded from www.scdhec.net/babynet.
- Apply for and obtain the Infant Toddler Credential through TECS. Interpreters must submit the application and complete the Orientation Module only. For more information about the Infant Toddler Credential, visit <http://uscm.med.sc.edu/tecs/>.
- Obtain prior authorizations from DHEC's BabyNet Program for services in accordance with the BabyNet Policy and Procedure Manual in effect at this time of service.
- Provide services to eligible children in accordance with IDEA Part C law and regulations, the BabyNet Policy and Procedure Manual in effect at the time of services, and all other applicable federal, state and local laws.
- Request BabyNet reimbursement as appropriate for: services required to determine eligibility; and/or services included in the child's current Individualized Family Service Plan (IFSP). Please note that your service must be listed on a current IFSP for you to receive an authorization for reimbursement. BabyNet will not pay if an IFSP is not completed (unless requested from the Service Coordinator).
- Bill the BabyNet program for reimbursement only after all third party sources, including Medicaid, have been exhausted.
- Accept BabyNet reimbursement for services as payment in full.
- Provide quarterly written progress reports to the Service Coordinator for all children served under this contract per BabyNet policy and as requested.
- Permit access to BabyNet client records for the purpose of oversight, audit, review, and inspection by BabyNet, state and/or federal personnel.

If you have any questions or concerns regarding the contract requirements or your responsibilities under the contract, feel free to contact me at mccoydm@dhec.sc.gov or MORRISRH@dhec.sc.gov.

BabyNet updates: We are in the process of adding the BabyNet Authorizations (3203s) online. In order to make this possible, we need current information on all Providers including Interpreters. We are requesting you send us your updated information. If you have not submitted your updated information or are not sure if we received it, please e-mail Robin Morris at morrisrh@dhec.sc.gov. You will be required to have an email address once the online 3203s are fully functioning. Please make sure we have a current email address for you. If you are an Interpreter, you will also be required to have an email address.

All Interpreters who have BabyNet contracts with an effective date of July 1, 2006 are required to meet the DHEC Interpreter Qualification. If you have not yet taken the Interpreter Qualification Project testing please remember this test has to be completed by April 30, 2007, for you to remain a contracted provider with BabyNet. If you have already taken this test, please forward us a copy of your Qualification Certificate. You may send this to 1751 Calhoun Street Columbia, SC 29201, to the attention of Robin Morris. If you have a contract dated after July 1, 2007 you have a year from the effective date of your contract to have this test completed and forward us a copy of your Certificate. If you have any questions please feel free to contact the BabyNet office.

Finally, as we have been going around the state, we have been asking the following questions of all Providers:

- Have you seen any improvements in the payment process?
- What are some of the barriers to recruiting and retaining providers for BabyNet?
- What type of training do you feel you need?

We would love to have your feedback on these questions. You can call or e-mail your response to Robin Morris at 803-898-0781 or morrisrh@dhec.sc.gov or to me at 803-898-0591 or mccoydm@dhec.sc.gov. Thanks for all you do for the kids and families of South Carolina. Feel free to call us if you have any questions or concerns.

Sincerely,

Debra M. McCoy, PhD, LMSW

Important Information for Providers

Some Upcoming Workshops

Wednesday, March 7, 2007, **Graphic Symbol Systems: Software for Making Augmentative Communication Displays**, 9:00am – 3:30 pm, Collaborative Training Center, Midlands Center, Columbia; Presenter: Ken Whitley, B.S., M.A., CCC-SLP, Key Technologies, Inc. Cost: \$15.00 payable to Key Technologies at the door. To register, print out the [registration form](#) and fax or mail to Key Technologies. For questions, call KeyTechnologies at 888-433-5303. **The SC Board of Examiners in Speech-Language Pathology has approved this workshop for .5 hours of continuing education for licensed speech language pathologists. Contact for more information: 803-935-5263 or 1-800-915-4522.**

Thursday, March 8, 2007, **EXPLOSION!!! The great expansion of new text-based communication devices**, 9:00am – 3:30 pm, Collaborative Training Center, Midlands Center, Columbia, Presenter: Ken Whitley, B.S., M.A., CCC-SLP, Key Technologies, Inc. To register, print out the [registration form](#) and fax or mail to Key Technologies. For questions, call Key Technologies at 888-433-5303. The SC Board of Examiners in Speech-Language Pathology has approved this workshop for .5 hours of continuing education for licensed speech language pathologists. **Contact for more information: 803-935-5263 or 1-800-915-4522.**

Monday, March 19 - Tuesday, March 20, 2007, **Including All Students in Standards-Based Instruction**, 8:30am - 3:30pm, Collaborative Training Center, Midlands Center, Columbia, Presenter: Pat Satterfield, M.C. E., CREATE, The Center for Research and Expansion of Assistive Technology Excellence, Contact Hours: 11 hours. Registration: Fee for this two-day session will be \$75 per participant. Please register by calling Dunamis, Inc at 800-828-2443. When registering, please indicate the functional level of the students whom you are teaching. Appropriate AT programs for creating activities will be chosen on the basis of registration information. **Contact for more information: 803-935-5263 or 1-800-915-4522.**

Thursday, March 29, 2007, **South Carolina Assistive Technology EXPO 2007**, 9am—4pm, Columbia Metropolitan Convention Center, free and open to the public, no pre-registration necessary. Exhibits and workshops about the latest assistive technology for people with disabilities and age-related limitations, continuing education for OT, PT, SLP, Infant/Toddler, and Social Work will be offered for some workshops. **Contact for more information: 803-935-5263 or 1-800-915-4522.**

Saturday, March 31, 2007, **Family Connections of South Carolina Annual Conference, Of Hopes and Dreams Conference XIII.** Contact for information: **803-252-0914 or 864-993-6162. Ask about other workshops planned for 2007.**



Please submit your ideas or articles for the newsletter!!!

Email Lily Nalty at NaltyL@cdd.sc.edu



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TECS is contracted by the IDEA Part C lead agency (DHEC-BabyNet) to provide a comprehensive statewide system for personnel development and technical assistance.

If you need a paper copy of the newsletter or have any questions about this newsletter, please contact Leah Perry at 803-935-5227.

Lily Nalty, M.A., CCC-SLP

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