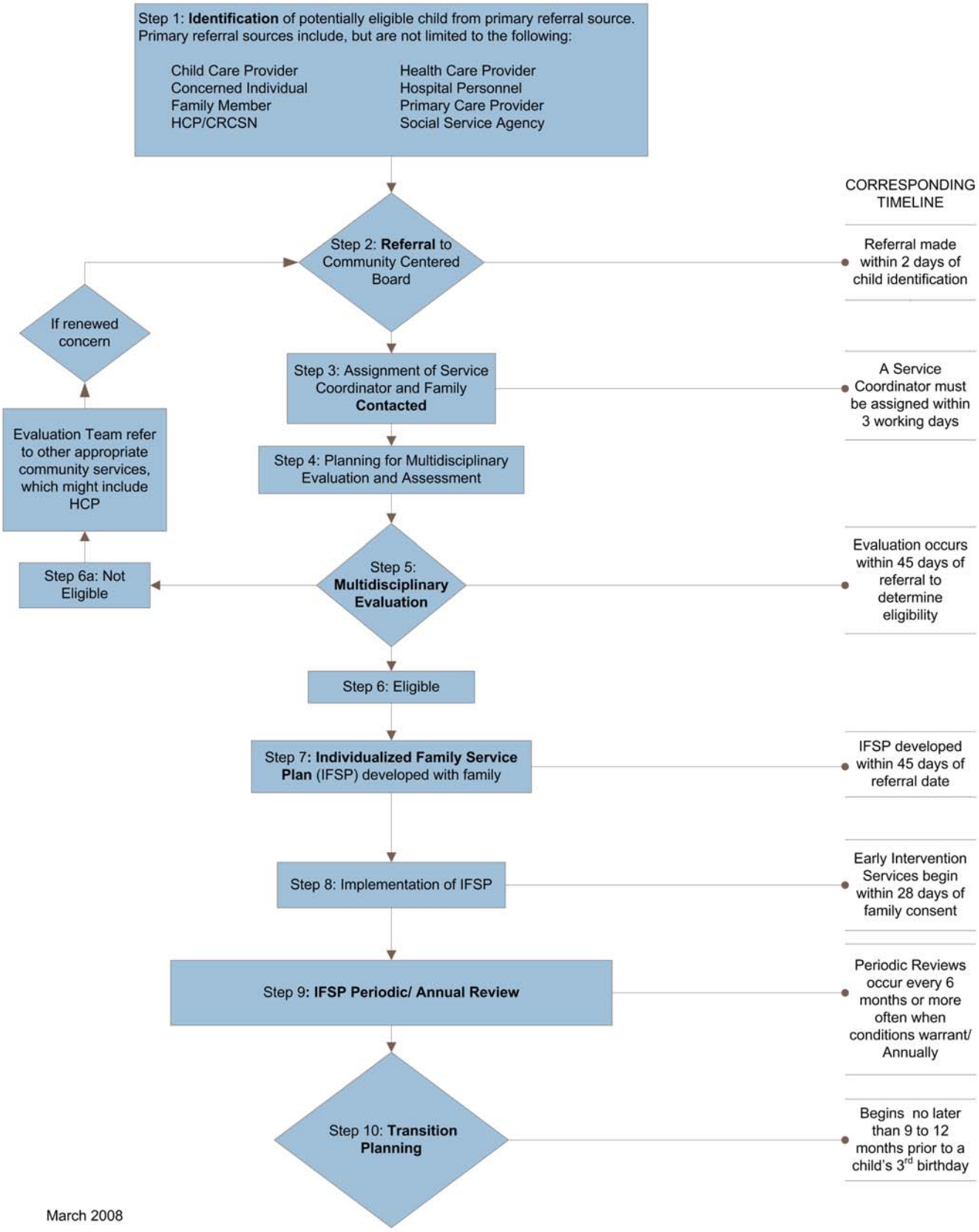
HCP Collaboration within the Early Intervention System: Identification to Transition

Overview of the Early Intervention Processes

(see following pages for descriptions)



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The *Overview of the Early Intervention Processes* algorithm depicts the potential for involvement of HCP throughout the processes and procedures within the Early Intervention System. The following descriptions of the Early Intervention System processes provide the detail about each step, and the potential role of HCP.

Description of Early Intervention System Process	Potential HCP Role During Early Intervention Process
Step 1: Identification of Potentially Eligible Child	
An infant or toddler is identified as potentially eligible for early intervention services due to: ❖ A suspected significant developmental delay in one or more developmental area(s): cognitive, adaptive, communication, social/emotional, and/or physical (including vision, hearing) ❖ A diagnosed physical or mental condition that has a high probability of resulting in a significant developmental delay – (see established condition database in the referral section of the Early Childhood Connections website (www.earlychildhoodconnections.org) An infant or toddler should be referred to a Community Centered Board when: ❖ A parent or other referral source has concerns or suspicions about a child's development, either through observation or by conducting a developmental screening. ❖ A child is diagnosed with a physical or mental condition that has a high probability of resulting in significant developmental delay. A listing can be found at www.earlychildhoodconnections.org.	Note: Prior to identification, HCP may provide information to families about community resources for developmental screening when there is a question about development. HCP identifies a potentially eligible child, either because of a developmental concern, or because a child has been diagnosed with a physical or mental condition with a high probability of resulting in developmental delay. HCP may obtain health/medical history from the family. HCP assures that the child and family has a medical home, or connects them with one if needed.
Step 2: Referral to Community Centered Board	
A referral to the early intervention program at a **Community Centered Board** should be made within 2 working days of the time a professional "identifies" a concern about a child's development. The referral source (physician, health care provider, public health nurse, family member, home visitor, child care provider, etc.) notifies the Community Centered Board for the city or county in which the family of the potentially eligible child resides. The information needed for the referral includes: ➢ Child's name, gender, and date of birth ➢ Name, address, and telephone number of the parent or legal guardian ➢ Reason for referral (child has a suspected or confirmed significant developmental delay or disability, child has one of the established conditions as outlined on the established condition database) ➢ Name of referring party and telephone number A referral may be made for the family or provide contact information to the family. There is toll free line (1-888-777-4041), or a directory, along with a database that is searchable by county, city, or zip code located on the Early Childhood Connections website within the state and local contacts section (www.earlychildhoodconnections.org). The transmittal of confidential information, such as the	With parental consent, HCP refers the potentially eligible child in writing or via phone call within two working days and provides necessary information for contact to be made with the family. Consent may be given verbally and documented in the HCP record.

nature of the child's condition, requires written parent consent. The early intervention referral form is HIPAA compliant and was created to streamline the process of information sharing. This form is available in Spanish and English and is posted on the Early Childhood Connections website within the documents section, state approved forms sub link. For the purposes of the referral form, the term "qualified health professional" includes physicians and physician extenders (i.e., physician assistants, nurse practitioners, and child health associates), registered nurses, occupational therapists, physical therapists, speech-language pathologists, psychologists, audiologists, and optometrists. Licensed clinical social workers and Masters of Social Work are also included because of their role as part of the primary care team within a hospital or other health care setting. When the DC: 0-3R is used to make a diagnosis, an individual with a mental health degree and licensure who has completed the 2-day DC: 0-3R training is included. When qualified medical or health personnel make a referral of a child because of a diagnosed physical or mental condition known to have a high probability of resulting in significant delays in development, the following information should also be provided: ❖ name of the established condition; ❖ name of the qualified health professional; and ❖ health care facility/agency who was the source of the referral. A service coordinator is assigned within 3 working days after referral to the early intervention system. When the referral was made by a Level III NICU in the Denver-metro area, the designated NICU Liaison works in collaboration with the family's local CCB service coordinator to support the family during their infant's inpatient stay.	
Step 3: Assignment of Service Coordinator and Family Contact	
Contact with the family and the assignment of a service coordinator is made within three working days. This initial contact is initiated by someone working in the EI system (a local EI intake person, service coordinator, NICU Liaison, a local administrative unit staff person (Child Find), etc.). The family is informed of the Individuals with Disabilities Education Improvement Act (IDEA) and of the entitlements under Part C. The process of gathering and giving information to and from a family begins, answering questions that they might have about their child's development, and explaining the next steps in the process, including the other system partners who will be involved. If a parent elects not to continue to have a multidisciplinary evaluation for eligibility determination, the process stops here. A parent could elect to re-enter in the future. With parental consent, local CCB will notify HCP of children who have been referred with medical or health concerns and/or when the child does not have a Primary Health Care Provider (Medical Home).	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Offering information about the child's medical condition and how it may impact the child's development; and, • Obtaining medical records. NOTE: HCP consultation is based upon local HCP office capacity.

Step 4: Planning for the Multidisciplinary Evaluation and Assessment	
This stage of the process begins with planning for the evaluation and assessment process. A family is provided information and answers to questions regarding the entitled multidisciplinary evaluation and assessment. The family assists in planning the evaluation with the service coordinator and evaluation team. The parent or legal guardian must give written consent for the evaluation, and for sharing any information with other EI partners who will be involved in the evaluation and assessment process. Health related information about the child that will be useful in planning the evaluation should begin to be gathered. Pertinent records related to the child's current health status and medical history should be requested so that appropriate members of the evaluation team can review them. The child's primary health provider should be notified of the child's referral for early intervention services. Early Intervention staff should invite pediatric health care clinicians to participate in the assessment. Invitations should be as far in advance as possible, with the understanding that most clinicians will not be able to attend. However, participation in the form of phone conference or written correspondence should be requested. Examples of written correspondence could include a health summary or pertinent copies of health records. The health summary could be a standardized form developed by the early intervention program and completed by the clinician.	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Requesting pertinent health related information about the child; • Reviewing health status and medical records and implications for evaluation and assessment needs; and, • Contacting the child's primary health provider to discuss the child's health status or medical history in order to provide consultation to the IFSP team.
Step 5: Multidisciplinary Evaluation	
Evaluation refers to the process used to determine a child's current levels of developmental in five developmental domains and to gain information about the child in order to determine eligibility for early intervention services and develop a plan to help the family support their child's learning and development. Whenever health or medical concerns become evident that were not previously known, the child's primary pediatric health care clinician should be notified (with parental consent) to the need for possible additional medical evaluations (e.g., in cases of suspected autism or cerebral palsy). Additionally, early intervention staff should clearly state in written reports any significant developmental delays. The pediatric health care clinician should be able to understand whether or not the child has global delays (significant delays in two or more of the following: gross/fine motor, speech/language, cognition, social/personal, and activities of daily living).[1]	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; and, • Attending evaluation and assessment to interpret medical or health information to inform the evaluation and eligibility process.

[1] http://www.neurology.org/cgi/reprint/60/3/367.pdf
http://aan.com/professionals/practice/guidelines/guideline_summaries/Global_Devlopmental_Delay_Patients.pdf

Step 6 and Step 6a: Eligibility Determination	
At this stage of the process, a decision is made by the multidisciplinary eligibility team about eligibility for early intervention services. Eligibility may be determined when a child has a diagnosed physical or mental condition with a high probability of resulting in significant developmental delay, or because the child is exhibiting a significant delay in one or more developmental domains: cognitive, adaptive, communication, social/emotional, and/or physical (including vision, hearing). Step 6a. If a child is determined not eligible for early intervention services, the child and family should be present with other appropriate service options, if needed.	While HCP may be involved in eligibility determination as a member of the multidisciplinary eligibility team, this is not required. HCP may provide information (e.g. interpretation of medical or health information; likely impact of condition on development, etc.) to assist the evaluation team with the eligibility decision. HCP may be able to provide care coordination for children who have been determined not eligible for early intervention services depending upon local HCP office capacity or other existing community resources.
Step 7:Initial Individualized Family Service Plan (IFSP) Developed with Family	
At this stage of the process, information is gathered to identify a family's concerns, resources and priorities, their child's developmental strengths and needs, and develop a plan of action, which includes functional outcomes and related strategies, necessary supports and services and how those will be provided to the child and family. This plan is developed through a multidisciplinary team process.	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Attending the initial IFSP meeting to provide information about the impact of the child's health on the child and family's daily routines and activities; and, • Sharing information about the long term implications of the child's health for the discussion about the family's concerns and priorities.
Step 8: Implementation of IFSP	
At this stage of the process, the supports and services that are identified in the IFSP are implemented. Infants and toddlers must receive any identified early intervention services identified on the IFSP within 28 days from the day the parent(s) or legal guardian gives their consent for services.	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Collaboration among the child's primary care provider, specialty care providers, and the family to ensure identified health needs are being met; and, • Facilitating communication with home care agencies, other health agencies, and early intervention providers, as needed.
Step 9: IFSP Periodic/Annual Review	
During this stage, progress toward identified outcomes is monitored, and periodic reviews of all components (including any new developmental or medical evaluations or assessments) of the IFSP take place. When appropriate, new health information may be an instance, which merits a review of the plan.	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Assisting with the identification of appropriate transition steps and services to Preschool Special Education Services (as defined within Part B of IDEA) or other community resources when a child with medical needs is transitioning out of the EI system; • Providing information about the long term implications of the child's health and implications for transitional planning; and, • Providing health care coordination for child and family.

Step 10: Transition Planning	
At this stage of the process, transition planning begins 9-12 months prior to a child's third birthday. The early intervention program must insure that all children exiting receive timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including: • IFSPs with transition steps and services; • Notification to the local education agency, if a child is potentially eligible for Preschool Special Education Services (as defined within Part B of IDEA); and, • Transition conference, if a child is potentially eligible for Preschool Special Education Services (as defined within Part B of IDEA). This plan insures a smooth transition for the child and family from early intervention services to the next stage for that family on or before the child's third birthday.	HCP may consult with the family's service coordinator to determine the need for public health involvement, which may include: • Contacting the family; • Assisting with planning for a smooth transition to Preschool Special Education Services (Part B of IDEA) or other community resources when a child with medical needs is transitioning out of early intervention services; • Providing information about the long-term implications of the child's health; and, • Providing health care coordination for child and family.