



A Message from the Director Quality

Vol. 5, No. 1 — November 2019

Why is providing high quality early intervention services important?

Quality is important for many reasons, but first and foremost is the children and families we serve. High quality services can not only help reduce the incidence of future problems or worsening delays but can also change a child's developmental trajectory. High quality services improve outcomes for children, families, and whole communities.

In Early Childhood Intervention (ECI), quality is measured across the full realm of services. Texas ECI has adopted the Seven Key Principles as our foundation to ensure the highest quality of early intervention and practice guidelines for providers across the state.

The State Office Quality Assurance team works to assist contractors in meeting standards that ensure the developmental needs of children are being met and that necessary supports are being provided to assist family members and caregivers.

Thank you for your commitment to the quality of these critical services across the state. Our families deserve your best!



Dana McGrath
ECI Director

In this issue:

The History of Quality Assurance in ECI	2
Meet the QA Team.....	3-4
Considering Moving to Qualitative Determination of Delay.....	5
Effectively Planning Frequency and Intensity of Service Tip Sheet	6
Towards Improved Program Performance and Best Practices	7
Let's Talk About Quality Assurance Desk Reviews.....	8

The History of Quality Assurance in ECI

6 BIG changes

September 2011 was a time of huge change for Texas Early Childhood Intervention (ECI).

- The Batelle Developmental Inventory, Second Edition became the single tool used for statewide eligibility determination.
- Eligibility criteria were narrowed.
- ECI contractors became responsible for all Medicaid billing.
- The reauthorization of the Individuals with Disability Education Act (IDEA) meant new federal regulations had recently gone into effect.
- The ECI Standards Manual was discontinued.
- All state requirements were moved into the Texas Administrative Code or the ECI contract.

Contractor and State Office Concerns

Understandably, contractor staff had new requirements, skills, and processes to learn and had many questions. State office staff had concerns about how local programs could effectively implement so many changes all at once and wanted to provide as much information and assistance as possible.

Creation of the Quality Assurance (QA) Team

The Quality Assurance (QA) Team was created to assist programs in providing IDEA Part C services that meet the needs of children and families, while complying with federal, state, and Medicaid requirements.

The QA process was designed to complement, rather than duplicate, compliance efforts at the state office, and to view services from the perspective of clinicians and other EI practitioners. From the very beginning, QA visits and desk reviews have never cited findings, and have always focused on quality and best practice, as well as the requirements.

Initially, the QA team consisted of two staff people. The response from contractors that received QA reviews was overwhelmingly positive, and other contractors began to request QA visits. As a result, the QA team was increased to three, and then later four, people.

Currently, the QA team includes three licensed therapists and one team member with experience providing EI services both as an early intervention specialist and service coordinator. The QA process has been amended and refined over the years, but the original purpose of assisting contractors in providing effective services that meet state, federal and Medicaid requirements has not changed.

Meet Your QA Team



Meet the QA Team



Mary Alice Alvarez

**Speech-Language Therapist
Joined ECI State Office — 2018**

Mary Alice Alvarez

University of Texas at Austin
Degree in Communication Sciences and Disorders

She is a speech-language pathologist by training and first fell in love with early childhood intervention during her student practicum. Upon completing her Clinical Fellowship, she was able to begin working in ECI, where she enjoyed traveling to rural counties to serve infants and toddlers with communication and feeding needs.

After taking a break to raise her three sons, now 20, 17, and 17, she returned to the field of speech therapy at a small Medicaid waiver program which served infants and toddlers with mild to moderate developmental delays. When funding for the program was not renewed, she was excited to join the Quality Assurance team at the ECI state office.

She lives in southwest Austin with her husband, 3 sons, 2 dogs, and a cockatiel.

Carol Baisdon

University of Texas Medical Branch
Degree in Occupational Therapy

She has worked as an occupational therapist in acute care, long term care, schools (Part B), home health pediatrics and in-patient rehabilitation centers.

She has served as the Prospective Payment System coordinator for Medicare reimbursement of Part A and B therapy services for various hospital-based rehabilitation centers.

She owned her own therapy contracting company, as well as an outpatient therapy clinic providing occupational, physical, and speech therapy services in Texas and New Mexico.

Prior to joining ECI, she worked as a faculty member teaching pediatrics, neuroanatomy, and served as the clinical fieldwork coordinator for the Certified Occupational Therapy Assistant Program at Anamarc College in El Paso, Texas.



Carol Baisdon

**Occupational Therapist Registered
Joined ECI State Office — 2014**

Meet the QA Team



Sandra Cavazos

**Quality Assurance Specialist
Joined ECI State Office — 2013**

Sandra Cavazos

University of Texas at Austin — Degree in
Child Development and Family Relationships

She started her ECI journey in 2003 working as an Early Intervention Specialist with Any Baby Can. After 10 years in that position, she was hired at the ECI state office as the Family Liaison.

She then was selected into the Performance and Oversight team as a Performance Manager. With more than 16 years of experience with ECI, Sandra now provides support and technical assistance to ECI programs as a Quality Assurance Specialist.

She is dedicated to supporting ECI programs in their provision of quality services to families and looks forward to visiting your program one day.

Carol Elskes

University of Texas Medical Branch
Degree in Occupational Therapy

She has been practicing as a pediatric OT for over 35 years in settings such as hospitals, school systems, home health, outpatient clinics, and, her favorite, ECI.

In ECI, she saw how effective her services could be when delivered in an environment familiar to the child, and how empowered her families felt when they developed the skills necessary to help their child succeed and grow.

She is passionate about supporting and promoting excellence in our ECI programs throughout the state.



Carol Elskes

**Occupational Therapist
Joined ECI State Office — 2016**

Considering Moving to Qualitative Determination of Delay

The HHS ECI Quality Assurance team often receives questions pertaining to Qualitative Determination of Developmental Delay (QDD). Although this article is not intended to cover all the requirements regarding when to implement or document QDD, it will provide some examples of when a team might want to consider moving to QDD.

Remember, these are [examples](#)—only the team completing the evaluation, which must include an LPHA knowledgeable in the area of concern, can make the decision to move to QDD, and clinical opinion must guide this decision.

The team must document in the child's record why they are moving to QDD, in both clinical and functional terms. QDD eligibility is only in effect for six months, so the team must also inform the parents that the program will re-determine eligibility within six months.

Remember, for a child with a chronological or adjusted age of 0 months, the team does not need to administer any formal evaluation tool, and the LPHA with expertise in the area of concern along with the other team members, will determine eligibility based on clinical opinion.

For a child with a chronological or adjusted age of one or two months, the team must administer the BDI-2, but the Hawaii Early Learning Profile (HELP) is not required if the team decides to move to QDD. The team, including the LPHA with expertise in the area of concern, will use clinical opinion to determine if the child is eligible by QDD.

For more information about QDD, please refer to [TAC §108.821 \(2\)\(A\) and \(B\)*](#) or to the QDD series located on the ECI website under Archived Webinars as well as *Making It Work for Therapists* located on the ECI website under [ECI Training and Technical Assistance](#).

Examples

The team may want to consider moving to QDD for:

- A child who scored at age level on the BDI-2:
 - ~ Who is not bearing weight when standing
 - ~ Whose speech is difficult to understand
 - ~ Who uses only one arm and/or hand
 - ~ With unusual social and/or repetitive play patterns
 - ~ When frequent and prolonged tantrums are reported
 - ~ With resistance to eye contact
 - ~ Who chokes or gags when eating
- A child who presents with patterns of mild delays consistent with autism AND there are "red flags" regarding the child's development.
- A child with severe attention difficulties or who refuses to complete many BDI-2 test items.
- A child who exhibits extremely low muscle tone or high muscle tone that affects the child's quality of movements or function.
- A child who shakes or has a tremor during his/her movements that affects the child's quality of movements or function.
- A child who is unable to hold his/her head upright or in midline and/or shows a definite side preference.
- A child who does not show a qualifying delay in any area but shows more than 15% delay in two or more areas and the team is concerned about aspects of the child's development.
- A child who shows an "almost" qualifying delay (20-24%, or 20-32% in Expressive Communication) in one or more areas and the team is concerned about aspects of the child's development.
- A child who does not show a qualifying delay in any area, but the pattern of delays in communication, peer interaction and/or cognition are a concern.

* Title 40 Texas Administrative Code Part 2, Chapter 108, §108.821 Qualitative Determination of Developmental Delay (QDD) states:

"(1) When a child's adjusted age is 0 months, administration of the standardized tool or another protocol is not required. The interdisciplinary team, which must include an LPHA knowledgeable in the area of concern, must describe clinical findings and how those findings significantly interfere with the child's functional abilities. (2) When the evaluation results, which are measured using the standardized tool designated by HHSC ECI, do not accurately reflect the child's development

or ability to function in the natural environment, the interdisciplinary team, documents this information in the child's record and proceeds to a qualitative determination of developmental delay. (A) For a child with an adjusted or chronological age of greater than 0 months but less than 3 months, the interdisciplinary team, which must include an LPHA knowledgeable in the area of concern, qualitatively determines developmental delay by describing clinical findings and how those findings significantly

interfere with the child's functional abilities. (B) For a child with an adjusted or chronological age of at least 3 months, the interdisciplinary team, which must include an LPHA knowledgeable in the area of concern, must use the supplemental protocol designated by HHSC ECI to qualitatively determine developmental delay. The developmental domains and sub-domains that can be used for qualitative determination of delay are established by HHSC ECI."

Effectively Planning Frequency and Intensity of Service

Tip Sheet

7 Key Principles

Take every opportunity to explain the mission and **key principles** of early intervention during first contacts with families (e.g., in an initial phone call, at intake, on the first service visit) to help families understand how EI works. Help them understand their central role in intervention.

IFSP

During the development of the IFSP, discuss as a team both what the ECI professionals recommend and what will work for the family. Discuss the child's outcomes and how the professionals will help the **family achieve the outcomes**.

During the IFSP, emphasize that the primary role of every service provider is not to provide "hands on therapy" but to **work with, teach and coach caregivers**. Explain that infants and toddlers learn best through everyday experiences and interactions with familiar people.

Help the family understand the role of each service provider and how the recommendations for services are based on the **child's and family's strengths, needs, priorities and outcomes**.

Remember, "There is no team decision without the family".

Frequency & Intensity

Encourage the **family to ask questions** regarding the services and recommendations for frequency and intensity. Avoid asking a family member how often they want services without an explanation of the professionals' recommendations. This does not allow the family member to make an informed decision, and diminishes the clinical judgment of professional team members.

When recommending frequency and intensity, remember that some families may have a greater comfort level in implementing strategies recommended, whereas others may need additional time and support before **gaining the confidence** to implement strategies and recommendations independently.

Many teams get stuck recommending the same intensity and frequency (for example, 2x month SST and 2x month Speech, 45 minutes each session) for the majority of families. Make recommendations based the **child's needs and outcomes** and how much support the family will need to address those needs and outcomes in their everyday routines.

Individualize all aspects of intervention to the needs of the child and family.

Service

Severity of delay isn't always an indicator for how much service is needed. For example, if rapid progress is expected for a child with moderate delays, a **parent may need more support** to implement rapidly changing strategies.

Consider front loading services, especially when a **child and family's needs, priorities** and risk factors may call for more intensive treatment in the beginning. The tapering of service can be planned in the initial IFSP. For example, OT can be planned at twice a week for two months, and 4 times a month for the remaining 10 months in the year.

Begin planning by considering one visit a week (or 4 times per month) from the most appropriate provider. Adjust to increase or decrease service to meet the unique and individual needs and priorities of the child and family. Add other services if the team determines they are needed to help the **child achieve outcomes**.

It isn't necessary, or recommended, to plan one service per outcome. **ECI providers are knowledgeable** about development across domains. For example, a PT who is helping the family address serious motor issues may also be able to provide support for a speech/language stimulation outcome. The SLP or EIS could then visit on a monthly basis for consultation to the family and the PT.

Reference – Division for Early Childhood (DEC); Tip Sheet – Effectively Managing Frequency and Intensity. (2015, August 5). Retrieved August 12, 2015, from [http://dec.membershipsoftware.org/files/Tip Sheet EI SIG Frequency and Intensity.pdf](http://dec.membershipsoftware.org/files/Tip%20Sheet%20EI%20SIG%20Frequency%20and%20Intensity.pdf)

Towards Improved Program Performance and Best Practices

The QA team, through record reviews and on-site quality assurance visits, recommends the following efficiencies to maximize program performance and best practices. Note: The programs we have encountered with the strongest management oversight tend to have higher average delivered service hours and overall program efficiencies.



Staff

Have a **productivity standard** and enforce it. Review staff schedules to ensure they are maximizing their time efficiently and, in staff meetings, recognize those who consistently meet their productivity standards (we recommend at least 65% of an employee's time be spent completing service delivery, evaluations, Individualized Family Service Plans (IFSPs) or service coordination/case management).

Consider **four hours per month, per child**, as a starting point for planning and provide ongoing monitoring to ensure appropriate and individualized service planning.

Eliminate "paper work" hours or "documentation days" (most documentation can and should be completed during the visit).

Consider implementing **groups**.

Periodically review IFSP goals, strategies, and service delivery notes to ensure therapists are not providing a service that could be **provided by an EIS**.

Consider assigning service providers to **designated geographical areas** (such as by zip code).

Billing

Billing as **quickly as possible** to meet timelines and be able to file disputes within the timelines.

When the service coordinator is also the service provider, ensure all allowable **TCM activities are captured and billed**.

Service Delivery

Have a system in place to **monitor no shows** and establish a no-show policy if one does not exist currently and follow it (make sure to discharge those families from TKIDS so their average delivered hours are not pulled down by these cases).

Implement a procedure in which staff **confirms appointments** a day in advance, plan visits with families on a monthly basis and provide families with a calendar. Staff should not leave the home without knowing when their next visit is scheduled.

Consider **one-hour visits** for most visits to ensure there is enough time for the coaching process and concurrent documentation.

Ensure the IFSPs reflect the **actual amount of the time** the providers are spending with the families (if a provider is consistently spending one hour with the family and the IFSP lists only 45 minutes, change the IFSP with the family's consent).

Qualifying Children

For children with a **qualifying medical diagnosis**, remind staff that administering the BDI-2 is not required. Staff may choose another standardized tool if their practice act or billing requirements mandate this.

Consider utilizing **developmental screenings** for Child Protective Services (CPS) and other children with no specific concerns.

Consider eliminating designated service coordinators. Consider using **eligibility determination teams**. Eliminate the in-person, intake visit.

Monitor for **appropriate referrals**. Reach out to referral sources who consistently make inappropriate referrals.

Let's Talk About Quality Assurance Desk Reviews

In fiscal year 2019, the QA team completed a series of desk reviews focused on Case Management (CM) and Targeted Case Management (TCM). The purpose of the desk reviews was to provide ECI contractors with feedback regarding areas of strength as well as identify any concerns. In addition, the QA team recommended resources and training based on the desk review results. Thirty-two desk reviews were completed from September 2018 to August 2019.

Top Concerns

The service coordinator (SC) did not probe for additional needs, thus potentially missing family and child needs that could lead to opportunities for TCM.

The SC did not use the "SC" credential. Either the CM note was not signed with any credential, or the Early Intervention Specialist (EIS) credential was used when signing or referring to the SC in the body of the CM note.

Documentation for events coded as TCM did not support the time billed. For example, if the SC billed for an hour of TCM and only documented she gave the parent a handout, the documentation would not support the time billed.

Training Recommendations

Provide guidance to staff on how to probe for additional information when discussing things such as current needs, upcoming medical and other appointments, the child's progress, or outside therapy providers.

Train SCs, including those with dual credentials, to use the appropriate credential (SC or SC/EIS) when signing and documenting service coordination, case management, and targeted case management activities, so as to provide clear assurance that services are provided by qualified staff as specified in 40 TAC §108.315. This additional training will help avoid confusion for auditors and possible recoupment of funds.

Train SCs on how to document in enough detail to support the duration of time billed for providing a given service.

Training Resources

Refer to the [ECI Case Management Checklist webinar](#), the [Case Management Checklist](#), and the [questions and answers from the webinar](#) for guidance in determining whether various activities are classified as Service Coordination, CM, or TCM, and tips on documenting TCM to decrease chances of recoupment.

Refer to the ["Service Coordinator/Case Management Resources"](#) page which provides service coordinators with information and tools on service coordination, case management and targeted case management.

[Chapter 3.2 of the ECI Reimbursement Guide \(Case Management\)](#), located in the Third-Party Billing document library on the ECI Extranet, describes activities that can and cannot be considered CM or billed as TCM.

The [Case Management Monitoring Training Module](#) (in the Case Management document library on the ECI Extranet) provides information on the monitoring aspect of ECI Case Management.

The [CM-TCM folder](#) of the Quality Assurance document library, on the ECI Extranet, contains guidance about documenting TCM activities, including sample TCM progress notes, examples of TCM, and "Don'ts and Dos" for TCM documentation.

The [Family Centered Case Management module](#) is an in-depth training resource intended to prepare providers to serve as SCs in Texas ECI.

FY20 Desk Review — Coaching Focus

The QA team will be conducting FY20 desk reviews on service delivery documentation with a focus on the key components of the coaching approach. It is our hope that through these targeted desk reviews we can support ECI contractors as they begin to implement the rollout of the evidenced-based practice of coaching.



We welcome your input!

Email your feedback, suggestions or questions related to the newsletter to eci.connection@hhsc.state.tx.us. Messages to the *ECI Connection* mailbox should pertain only to the newsletter.