

STATE ICC

Committee

- ☐ Committee of the Whole
- ☐ Quality Assurance
- ☐ Public Awareness
- ☒ Health Systems
- ☐ Family Support
- ☐ Bylaws

Item

- ☒ Action
- ☐ Consent
- ☐ Discussion
- ☐ Information

APPROVED

Date: September 25, 1997
To: ICC Members
From: Health Systems Committee

Title: Enhancement of the review of health status in the IFSP/records review component of the site review/monitoring visit

Background/Discussion

A child's health status and developmental state are inexorably linked. For many children, the developmental support and intervention strategy must be designed and implemented in the context of the child's current and changing health status. This is particularly true for infants and toddlers because they are undergoing dynamic and life shaping physiological and developmental changes. The development of an IFSP without reasonable documentation and review of health/medical information may result in the implementation of developmental supports and services that are ineffective and even counterproductive. The Health Systems Committee(HSC) and ICC have endorsed the following definition of health status as a component of both assessment and the IFSP process generally: *Health status means a description of the physical and mental condition of an infant or toddler. Health status shall include, but not be limited to, current diagnosis, medications, required regular medical procedures, current medical supplies and technological devices, primary and specialty care providers, nutrition, dental health and immunization status.*

The HSC is seeking to ensure that Early Start agencies are responsive to the health/medical context of each infant and toddler served. The site review/monitoring visit is the primary mechanism available to identify how effectively Early Start agencies collect, document and integrate this essential information.

Recommendation

- 1) The Health Systems Committee requests that the ICC recommend to the Department of Developmental Services (DDS) and California Department of Education (CDE) that the IFSP/records review component of all site reviews/monitoring visits include a comprehensive review for the presence of health status information including assessment of the effectiveness with which health status information is integrated into service planning and delivery. The recommended review of health status in the IFSP should include a review for the presence of all elements specified in the definition of health status previously endorsed by the ICC (action of 9/96) including nutrition and dental status.
- 2) The Health Systems Committee also requests that the ICC recommend to DDS and CDE that the IFSP/records review component of the site review/monitoring visits include a sampling of randomly selected client records of sufficient size to minimize sample bias and accurately reflect the standards applied by the agency being reviewed. Site review/monitoring teams should include members with the appropriate expertise and/or training to support the review of a representative sampling of client records.
- 3) The Health Systems Committee also requests that the ICC recommend to DDS and CDE that the IFSP/records review component of the site review/monitoring visits be conducted by both state and local program representatives with the expertise and/or training to assess the appropriate documentation and utilization of health status information in the IFSP.

Possible Action

- 1) Approve recommendations 1, 2 and 3.
- 2) Approve any single recommendation or any two combined.
- 3) Modify and approve any single or combined recommendations.
- 4) Reject all recommendations.

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APPROVED

Date: September 25, 1997
To: ICC Members
From: Health Systems Committee

Title: Technical assistance document: Cleft Lip/Palate

Background/Discussion

In May 1997, the ICC voted to approve a recommendation clarifying that children with cleft lip/palate who are referred to the Early Start program should not be considered to have a low incidence disability. Many of these children are eligible for Early Start Services and the Health Systems Committee(HSC) has developed a technical assistance document detailing additional considerations applicable to children with cleft lip/palate. It is the goal of the HSC to ensure that Early Start agencies are informed of, and respond appropriately to, the needs of these children.

Recommendation

The Health Systems Committee requests that the ICC recommend to the Department of Developmental Services and the California Department of Education that the attached technical assistance document be adapted for use by Early Start agencies and that all regional centers, LEAs/SELPA's, and Family Resource Centers/Networks be provided this information.

Possible Action

- 1) Approve the recommendation.
- 3) Modify and approve the recommendation.
- 4) Reject the recommendation.

EARLY START REFERRAL FOR CHILDREN WITH CLEFT LIP/PALATE

Should children with cleft lip/palate be referred to EARLY START?

Cleft lip/palate is not a solely low incidence disability (1) but is considered an anatomical anomaly with varying degrees of severity that may result in communication delays and may be accompanied by other disabilities.

Many infants and children with cleft lip/palate will develop normally and do not require special education services. In early childhood a child may need and be eligible for services from Early Start and/or the California Children Services' (CCS) craniofacial center teams which are an essential source of expertise in treatment. A delay in communication development, adaptive development or social or emotional development may already be present or the child may be at risk for these delays and referral to Early Start should be considered.

Infants and toddlers may be appropriately considered for the Early Start program if they have communication delays, physical delays, adaptive delays, social or emotional delays or cognitive delays; or have a diagnosis of an established risk condition or may be considered at risk for a developmental delay. An infant or toddler, with cleft lip/palate who is suspected to have the above delays, should be referred to Early Start for assessment. Infants or toddlers with cleft lip/palate may also have genetic factors, difficulties in feeding/nutrition, hearing, breathing, communication delays or be in need of family support services, and service coordination and may benefit from early intervention services. It is not uncommon for young children with cleft lip/palate to have social/emotional problems in relationships with their families. Service coordination in Early Start is important to assist families with multiple medical appointments to facilitate interagency cooperation. Infants and toddlers may be served by regional centers or local education agencies (schools) depending on the local interagency agreement and the local education agency's funded capacity.

As children grow older and physical modifications and surgery are implemented, speech therapy may be the only service required. Children with cleft lip /palate may have varying degrees of expressive speech problems and may also have other delays. Often by the age of ten years, speech therapy may no longer be indicated.

In addition, the craniofacial center team of physicians, nutritionists, speech pathologists, occupational therapists and audiologists at various locations generally evaluate children 0-3 years every six months and sometimes more frequently. They can refer to the Early Start Program when family support, developmental assistance and Early Start coordination services are needed. Services related to medical, surgical and genetic needs provided by health care providers and care systems are coordinated by medical case managers. Service coordinators assigned to Early Start infants and toddlers assist families via collaboration with the medical case managers.

Questions regarding appropriate referrals of infants and toddlers with cleft lip/palate for Early Start can best be addressed by communication among the parents, primary care physician, craniofacial center specialist or medical case manager and the local Early Start representative at the regional center or local education agency.

(1) A solely low incidence disability is defined in Early Start as a visual impairment, hearing impairment, severe orthopedic impairment or a combination of those impairments observed in a child who does not have an overall developmental delay which would result in his eligibility for services under the Lanterman Act.

Age (birth to 36 months of age) and
A need for early intervention services and

Presence of Developmental Delay which exists if there is a significant discrepancy between the child's current level of functioning and the expected level of development for his or her age in one or more of the following developmental areas:

Cognitive

Physical: including fine and gross motor; vision; hearing and health status

Communication

Social or emotional

Adaptive or

Established Risk

An established risk condition exists when an infant or toddler has a condition of known etiology which has a high probability of resulting in developmental delay; or

An established risk condition exists when an infant or toddler has a solely low incidence disability or

High Risk for Developmental Disability which exists when an infant or toddler has a combination of two or more of the following factors:

(1) Prematurity of less than 32 weeks gestation and/or low birth weight of less than 1500 grams.

(2) Assisted ventilation for 48 hours or longer during the first 28 days of life.

(3) Small for gestational age: below the third percentile on the National Center for Health Statistics growth charts.

(4) Asphyxia neonatorum associated with a five minute Apgar of 0-5.

(5) Severe and persistent metabolic abnormality, including but not limited to hypoglycemia, acidemia, and hyperbilirubinemia in excess of the usual exchange transfusion level.

(6) Neonatal seizures or febrile seizures during the first three years of life.

(7) Central nervous system lesion or abnormality.

(8) Central nervous system infection.

(9) Biomedical insult including, but not limited to, injury, accident or illness which may seriously or permanently affect developmental outcome.

(10) Multiple congenital anomalies or genetic disorders which may affect developmental outcome.

(11) Prenatal exposure to known teratogens.

(12) Prenatal substance exposure, positive infant neonatal toxicology screen or symptomatic neonatal toxicity or withdrawal.

(13) Clinically significant failure to thrive, including, but not limited to, weight persistently below the third percentile for age on standard growth charts or less than 85% of the ideal weight for age and/or acute weight loss or failure to gain weight with the loss of two or more major percentiles on the growth curve.

(14) Parent who has a developmental disability as defined in Welfare and Institutions Code section 4512(a).

(15) Persistent hypotonia or hypertonia, beyond that otherwise associated with a known diagnostic condition.

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Date: May 29, 1998
To: ICC Members
From: Health Systems Committee

Title: Proposal to extend California's immunization requirements to Early Start Programs providing services to children in group settings

Background/Discussion

In response to new immunization requirements specified in the California Health and Safety Code, the Department of Health Services (DHS), Immunization Branch issued communications to the field advising of changes applicable to children entering kindergarten and those attending child care. Effective August 1997, a hepatitis B series must be implemented for children entering kindergarten and child care and a second dose of measles vaccine must be provided to children entering kindergarten. The immunization requirements in the Health and Safety Code applicable to the child care setting include child care centers, day nurseries, nursery schools, family day care homes and (child) developmental centers.

Early childhood immunizations prevent the spread of potentially fatal contagious childhood diseases. Estimates by DHS indicate that 30 to 40 percent of California's preschool children are not up to date on immunizations. Children from birth to two years are at highest risk of contracting vaccine preventable diseases with serious complications due to under immunization.

In September 1997, the ICC voted to recommend that the lead agency inform all regional centers, LEAs/SELPA's, family resource centers/networks and all facilities providing services to children in a group setting under Early Start of current immunization standards and request that they (voluntarily) take steps to promote compliance with these standards. On April 3, 1998, the Department of Developmental Services issued a written notice to regional centers and family resource centers/networks in response to this recommendation.

While non-licensed facilities providing infant development programs are not specifically required in law to assure that infants and toddlers participating in these programs receive the required immunizations, the members of the Health Systems Committee support the extension of immunization requirements to children served in these group environments. Children in these programs are often brought into close contact with one another for extended periods of time and may experience exposures to childhood diseases in much the same way that children in the child care environment may be exposed.

In order to bring attention to this gap in the current immunization standards, the Health Systems Committee proposes that the ICC request that the lead agency communicate this concern, on behalf of the ICC (and the Department), to the DHS, Immunization Branch and request that DHS, to the extent feasible, take steps to amend statute, regulation and policy to extend current immunization requirements to settings, such as infant development programs, in which young children are brought into close contact in a group environment on a regular basis for extended periods. **If such a remedy is not feasible, DDS, in consultation with the DHS, Immunization Branch, should explore the potential to extend the current immunization requirements to Early Start programs through contractual agreement.**

Recommendation

1) The HSC requests that the ICC recommend to the lead agency that the Department of Health Services (DHS), Immunization Branch be advised of the concerns of the ICC regarding the gap in current

immunization requirements and that this gap may have an adverse effect on children served by the Early Start Program in group environments.

2) The HSC requests that the ICC recommend to the lead agency that DDS request, on behalf of the ICC, that DHS take steps to amend statute regulation and policy to extend current immunization requirements to (publicly funded) settings, such as infant development programs, in which young children are brought into close contact in a group environment on a regular basis for extended periods.

3) The HSC requests that the ICC recommend to the lead agency that DDS, in consultation with the DHS, Immunization Branch, explore the potential to extend current immunization requirements through contractual agreement to Early Start programs providing services to children in group settings.

4) The HSC requests that the ICC recommend to the lead agency that DDS request that the DHS, Immunization Branch provide consultation and technical assistance to Early Start programs seeking to promote compliance with current immunization standards.

Possible Action

- 1) Approve all recommendations
- 2) Approve any single or combined recommendations
- 3) Modify and approve any single or combined recommendations
- 4) Reject all recommendations

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Background/Discussion

A child's health status and developmental state are inexorably linked. For many children, the developmental support and intervention strategy must be designed and implemented in the context of the child's current and changing health status. This is particularly true for infants and toddlers because they are undergoing dynamic and life shaping physiological and developmental changes. The development of an IFSP without reasonable documentation and review of health/medical information may result in the implementation of developmental supports and services that are ineffective and even counterproductive.

The HSC is seeking to ensure that Early Start agencies are responsive to the health/medical context of each infant and toddler served. The site review/monitoring visit is the primary mechanism available to identify how effectively Early Start agencies collect, document and integrate this essential information. Technical assistance in support of this objective should be available and provided as necessary.

Recommendation

- 1) The Health Systems Committee requests that the ICC recommend to the Department of Developmental Services (DDS) and California Department of Education (CDE) that the IFSP/records review component of all site reviews/monitoring visits include a comprehensive review for the presence and integration of health status information.
- 2) The Health Systems Committee requests that the ICC recommend to DDS and CDE that site review/monitoring teams include a licensed health care professional (physician, nurse, physician's assistant) who is able to assess the appropriate documentation and utilization of health status information in the IFSP and in related functions/activities. The team may also include individuals who are trained to assess the appropriate documentation and utilization of health status information and who work in consultation with, and under the supervision of, the team's health care professional.
- 3) The Health Systems Committee requests that the ICC recommend to DDS and CDE that the IFSP/records review component of the site review/monitoring visits be conducted by both state and local program or agency representatives. At minimum, state representatives, not employed by DDS or CDE, and local agency or program representatives who are invited to participate must:
 - A) participate only with the approval of their employing program/agency (or the program/agency with which they are affiliated for this role)

- B) have no conflict of interest or role affecting their ability to objectively review regional center or LEA client records
- C) commit sufficient time to complete related tasks, including completion of any required training
- D) sign an oath of confidentiality before reviewing client records
- E) agree not to disclose review findings outside the scope and context of the site review/monitoring process
- F) respond to direction from DDS and CDE team leaders
- G) conform to the criteria specified in recommendation #3 above.

Possible Action

- 1) Approve all recommendations.
- 2) Modify and approve any single or combined recommendations.
- 3) Reject all recommendations.

HSCACTN4.598

DRAFT

Site Review/Monitoring Visit

Define the health status/records review goals and purpose

Records Review Team Duty Statement

Define the roles and responsibilities of the records review team members.

Composition of the Team

Define the structure of the review team.

1. DDS and CDE Staff as team lead
2. Licensed Health Care Professional:
 - California licensure/certification/registration
 - Physician
 - Registered nurse/public health nurse
 - Nurse practitioner
 - Physician's assistant
3. Trained state and local team members
 - Trained team members work under the direction and supervision of the designated health care professional.

Selection of Team Members

Define the qualifications and desired characteristics of review team members

- Knowledge of Part H/early intervention systems and services
- Knowledge of federal and state statute, regulation and policy relating to Part H/early intervention systems and services.
- Knowledge of medical terminology.
- Ability to recognize medical conditions with significant developmental consequences.
- Ability to recognize the appropriate integration of health status information into services planning and delivery.
- Ability to communicate related concerns to lead health care professionals and DDS/CDE team leaders.
- Ability to work effectively and cooperatively in a team structure.

Training of Team Members

Define the training required to assure that all team members are capable of fulfilling the assigned role (see selection of team members).

- Confidentiality
- Site Review/Monitoring process
- Review tools/documentation system
- Regional center/LEA records systems
- Response to omissions/incorrect application of health status information
- Role of the health care professional and team leaders
- Scope and limitations of role and responsibilities

HSCACTN4.598

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Date: May 29, 1998
To: ICC Members
From: Health Systems Committee

Title: Request for Reform of the Medi-Cal In-Home Nursing Reimbursement System and Rates

Background/Discussion

Many children served by the Early Start Program are Medi-Cal beneficiaries, including many children who are also served by California Children Services (CCS). The early intervention services required for many of these children are often provided/funded by Medi-Cal, including services provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services benefit. Although Medi-Cal/EPSDT fulfills a vital role in the delivery of needed services to children with special health and developmental needs throughout the state, the Medi-Cal/EPSDT system is complex and presents a range of challenges to low income families, many of whom are not prepared to confront the barriers presented. Too often, families with children who are eligible to receive medically necessary services under Medi-Cal/EPSDT Supplemental Services are unable to find a qualified provider to deliver them. **The attached letters exemplify the experiences of families who have come forward to present their concerns.**

Since the formation of the HSC, many individuals, representing children, families, agencies, organizations and other entities, have come forward to express concerns regarding the interface between Medi-Cal/EPSDT and Early Start. Recurring concerns have been expressed regarding barriers to access to a range of services including in-home nursing services (these concerns also generalize to consumers served under the Lanterman Act).

In-home nursing services provide families with and opportunity to keep their child with special needs at home and minimize costs to families and taxpayers associated with institutional care. Many of the children provided in-home nursing services would be required to live in an acute care facility, a subacute care facility or other intermediate care facility if not for these services.

A fundamental obstacle to the effective and timely delivery of needed services is a lack of qualified providers, including in-home nursing services providers, who are willing or able to deliver those services. The lack of providers is due, in large part, to the disincentives created by the low Medi-Cal/EPSDT Supplemental Services rates of reimbursement and delays encountered by providers in receiving reimbursement through the Medi-Cal/EPSDT system. The rates of reimbursement under Medi-Cal have not changed in ten years while the rates of compensation to providers in the private sector have continued to increase. Despite ongoing efforts by the Department of Health Services (DHS) to improve access to Medi-Cal and EPSDT Supplemental Services (e.g., provider training and recruitment, beneficiary education, due process systems), without a more effective and timely Medi-Cal/EPSDT reimbursement system and without more realistic reimbursement rates, eligible children served by Early Start may continue to be denied access to medically necessary services to which they are entitled.

The goal of the Health Systems Committee is to ensure that DHS, including Medi-Cal, is aware of the adverse consequences of the current Medi-Cal/EPSDT Supplemental Services

reimbursement rates and system for children and families served by Early Start. Furthermore, it is the goal of the HSC that the ICC, in its responsibility to represent the interests of children and families in need of an effective system of early intervention, strongly encourage DHS to seek reform of the current reimbursement system and rates.

Recommendation:

- 1) The HSC requests that the ICC recommend to the Department of Developmental Services (DDS) that DHS/Medi-Cal be advised in writing of concerns expressed to the ICC regarding the lack of qualified providers available to deliver medically necessary services for children and families served by both Medi-Cal and Early Start due to the low rates of provider reimbursement under Medi-Cal/EPSDT Supplemental Services and due to the complexities of the provider reimbursement system.
- 2) The HSC requests that the ICC recommend to DDS that DHS/Medi-Cal be strongly encouraged to pursue increases in the Medi-Cal/EPSDT Supplemental Services reimbursement rates and improve the provider reimbursement system in order to minimize delays in reimbursement.
- 3) The HSC requests that the ICC recommend to DDS that DHS/Medi-Cal provide a response to this communication summarizing any plans or activities, if any, relating to the reform of Medi-Cal/EPSDT Supplemental Services reimbursement rates and the provider reimbursement system.

Possible Action

- 1) Approve recommendations 1, 2 and 3.
- 2) Approve any single recommendation or any two combined.
- 3) Modify and approve any single or combined recommendations.
- 4) Reject all recommendations.

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APPROVED

Date: July 23, 1998

To: ICC Members

From: Health Systems Committee

Title: Healthy Families Program Enrollment Assistance to Children and Families Served by Early Start

Background/Discussion

Children in California who are without health care have an opportunity to obtain no-cost or low cost comprehensive health care coverage through the Healthy Families (HF) Program, implemented on July 1, 1998, and Medi-Cal for Children.

The HF Program is administered by the Managed Risk Medical Insurance Board (MRMIB) and provides health coverage to uninsured children, ages one to 19 years, from low income families that do not qualify for no-Share of Cost (SOC) Medi-Cal. HF will provide health, dental, and vision benefits to California children whose families fall at or below 200 percent of the federal poverty level (FPL). Children who will be insured by HF represent a segment of the population that differs from the Medi-Cal and commercial insurance populations.

Children enrolled in HF will receive the same type of coverage offered to children of State and local government employees through the CALPERS and Department of Personnel Administration programs. The HF benefits package includes:

- Coverage for medically necessary hospitalization
- Physician, medical and surgical services
- Inpatient and outpatient services
- Prescription drugs
- Well-child examinations and immunizations
- Family planning services
- Mental health services
- Occupational, physical and speech therapies
- Laboratory and X-ray services
- Dental benefits, including preventive and diagnostic services
- Vision benefits, including annual exams and eyeglasses

Effective March 1, 1998, Senate Bills 217 and 903 expanded Medi-Cal for children up to age 19 by providing no-SOC coverage to children whose family income is below 100 percent FPL. In addition, the legislation mandated that family resources be disregarded for children ages one-to-six years whose family income is at or below 133 percent of the FPL and children ages six to 19 years whose family is at or below 100 percent of FPL.

The legislation establishing the HF Program (AB 1126) mandated a mail-in Medi-Cal application process for pregnant women and children. It includes a common application that is usable for both the HF Program and the Medi-Cal mail-in process. The Department of Health Services and MRMIB have developed a joint application booklet containing application forms and income worksheets to allow families to determine which program to apply to for their children. The application booklet is offered in ten languages including: English, Armenian, Cambodian, Chinese, Farsi, Hmong, Lao, Russian, Spanish, and Vietnamese.

Community outreach is being conducted under contract with the State by Richard Heath and Associates (RHA), whose primary responsibility is to seek enrollment assistance in the community through community-based programs, schools, day care operators, government-funded programs, health care providers, insurance agents, and any nonprofit entity, that through its normal course of business, has significant interaction with children and parents.

An application assistance compensation fee of \$25 will be paid to organizations for each application that results in an enrollment for either of these programs. For an organization to assist a family or individual with the *Healthy Families/Medi-Cal for Children* application, and to receive the application assistance reimbursement, it must be a Certified Application Assistant (CAA). Training, at no cost, is provided through RHA to facilitate certification (training information is available through the RHA toll-free information line: 1-888-237-6248).

Information about HF and the health, dental, and vision plans available throughout California may be accessed through the MRMB web site at www.healthyfamilies.ca.gov. This web site has the application and all information about eligibility requirements available for downloading.

How to Contact Healthy Families

Application Assistance Information (RHA)	1-888-237-6248
General Program Information	1-888-747-1222
General Enrollment Information/Applications (HF's administrative vendor: Electronic Data Systems)	1-800-880-5305

Children and families served by the Early Start Program may need and be eligible for these important health care programs. The benefits and services available through the HF Program and Medi-Cal may fulfill the early intervention service needs and/or "other services" needs of children and families served by Early Start. Regional centers, Special Education Local Plan Areas, local education agencies and family resource centers/networks can play an important role in facilitating linkages to these vital programs. With this role in mind, the members of the HSC request that the ICC support the following recommendations.

Recommendation:

- 1) The HSC requests that the ICC recommend to the Department of Developmental Services (DDS) that all Early Start agencies and organizations integrate information on the HF Program and Medi-Cal for Children and take proactive steps to provide Early Start families related guidance, information and support, including facilitation of enrollment through direct assistance or referral to a source of enrollment assistance. This should include the development and implementation of appropriate protocols and procedures and in-service training as required.
- 2) The HSC requests that the ICC recommend to the Department of Developmental Services (DDS) that all Early Start agencies and organizations identify and form linkages with community organizations and resources that provide HF and Medi-Cal for Children enrollment assistance.
- 3) The HSC requests that the ICC recommend to the Department of Developmental Services (DDS) that all Early Start agencies and organizations be strongly encouraged to designate appropriate personnel, including service coordinators, to undergo the required training and become Certified Application Assistors.

Possible Action

- 1) Approve recommendations 1, 2 and 3.
- 2) Approve any single recommendation or any two combined.
- 3) Modify and approve any single or combined recommendations.
- 4) Reject all recommendations.

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APPROVED

Date: March 3, 1999

To: ICC Members

From: Marie Kanne Poulsen, Chair, Quality Assurance Committee

Title

Early Start Personnel Model (ESPM), Implementation Process and Quality Assurance and Personnel & Program Standards Committee Recommendations

Background/Discussion

Part C of IDEA states, "Early Intervention Services ...mean developmental services that (F) are provided by qualified personnel..." (Section 1432. Definitions). The Early Start Personnel Model has been designed to support the state in assuring that appropriately trained and prepared personnel are available to provide early intervention services under Part C.

The proposed Early Start Personnel Model (ESPM), Recommended Implementation Process and Quality Assurance and Personnel & Program Standards Committee Recommendations were first presented to the ICC in November 1998, as an information item. In January 1999, the Quality Assurance Committee hosted a Public Input forum at the ICC Meeting in Berkeley and received valuable feedback from field representatives. This packet has incorporated revisions from a January Quality Assurance forum, from two public input sessions held in February, one in Los Angeles and one in Sacramento, and Ad Hoc Personnel Workgroup sessions. This has been a very time-intensive task and many early intervention professionals and organizations have been a part of the development.

See the attached Early Start Personnel Model and Implementation Process and Quality Assurance and Personnel & Program Standards Committee Recommendations.

**I. Early Start Personnel
Model (ESPM)
and
II. Implementation Process**

March 3, 1999

**Quality Assurance &
Personnel and Program
Standards Committee
Recommendations**

March 3, 1999

**Quality Assurance & Personnel and
Program Standards Committee
Recommendations**

March 3, 1999

The Quality Assurance and Personnel and Program Standards Committee recommends that:

1. The Early Start Personnel Model be approved by the ICC for recommendation to the lead agency for implementation in phases.
2. Modification and expansion of early intervention competencies and recommendations be completed and incorporated into the Early Start Personnel Model.
3. Year 2000 is the target date for implementation of Phase I of the Early Start Personnel Model.
4. All phases of the model shall be implemented by 2005.
5. A timetable for implemented phases will be established by January 2001.
6. Entire model reviewed by 2005 (5 years after full implementation) through a legislatively required process for review and/or revision of the Early Start Personnel Model as needed.
7. The Part C CSPD long-term plan must support full implementation of the Early Start Personnel Model and achievement of identified competencies.
8. A standardized procedure be in place to verify that all personnel providing early intervention services meet the competencies or have an approved plan leading to completion of the competencies.
9. Program standards will be developed to support the implementation of the Early Start Personnel Model. The procedure must include a requirement that all employing agencies submit an annual list of early intervention personnel indicating the personnel category and their status on meeting the model requirements.

10. Recruitment and retention issues be addressed, including salary equity and salary differentials for personnel categories.
11. An Early Start Personnel Task Group convened by DDS be charged with the responsibility of addressing all remaining questions and issues related to full implementation of the Early Start Personnel Model through Phases I, II, III, IV and V.

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APPROVED F

Date: August 30, 1999

To: ICC Members

From: Patty Moore, Co-Chair, Family Support Services Committee (FSSC)
Chrystyne Wright, Co-Chair, FSSC

Title: Position Statement on Child Care

Background/Discussion

Families of children with disabilities report that it is difficult to access and maintain high quality child care. Juggling the demands of young children with responsibilities of work, and home are challenging for all families. For families whose children have disabilities, the added responsibility of accessing adequate supports and negotiating the serve system is overwhelming.

In November 1997, the ICC requested that the Family Support Services Committee(FSSC) address the current status of child care specifically related to infants and toddlers with developmental disabilities or who may be at risk of developmental delay. Committee members sought input from local child care resources and state agency representatives presented numerous data which reflected existing resources, challenges and barriers to quality care for both the parents and providers, training, affordability, the lack of coordination and collaboration, and up-to-date data related to child care and children with disabilities.

The FSSC began development of a Position Statement on Child Care in September 1998. On July 29, 1999, the Draft Position Statement on Child Care was presented to the ICC at the Committee of the Whole Meeting. The FSSC solicited advice and input from the ICC and members of the community. This document was finalized on August 30, 1999, for ICC approval.

Recommendation

1. The Family Support Services Committee recommends that the ICC votes to approve the Position Statement on Child Care.
2. The ICC forwards the Position State on Child Care to the lead agency.

3. The ICC requests the FSSC to develop a plan of action based upon the Position Statement on Child Care.

Possible Actions

1. Approve the recommendations in total.
2. Amend and approve recommendations.
3. Reject the recommendations.

Family Support Services Committee of the
California Interagency Coordinating Council on Early Intervention

POSITION STATEMENT ON CHILD CARE

Child care that is available, affordable and of high quality is vital to the well-being of families. The most important element in that experience and the central determinant of a child's healthy development is a stable relationship with a nurturing caregiver. Investing in young children yields substantial benefits to the public.¹

GOALS

- To identify the child care needs of families whose children have or at risk for disabilities.
- To create additional child care options to meet the needs of children with or at risk for disabilities and their families.
- To strengthen the capacity of the child care community to deliver appropriate, inclusive, high quality services.

INTENT

The Family Support Services Committee of the California Interagency Coordinating Council recommends that systems and services support families with infants and toddlers who have or are at risk for disabilities and who are eligible for early intervention services, to access and maintain high quality, inclusive child care services.

This position statement on child care frames recommendations to the Interagency Coordinating Council to be presented to the Department of Developmental Services (DDS), Part C Lead Agency, for consideration and implementation in collaboration with the California Department of Education, the California Child Care Resource and Referral Network and others as may be appropriate. If endorsed, the Family Support Services Committee will work with DDS to develop a detailed plan for implementation including schedule, responsibilities and fiscal analysis.

BACKGROUND

The availability of high quality, affordable child care for children birth to three who are typically developing is extremely limited.² Families of children with disabilities report that it is even more difficult to find and access any care for a child with a disability, let alone care that is of high quality. Juggling the demands of young children with the responsibilities of work and home are challenging for all families. For families whose children have disabilities, the added responsibility of accessing adequate supports and negotiating the service system is overwhelming.

¹ *Caring for Our Children: Our Most Precious Investment*, report of the Little Hoover Commission, September 1998.

² Cost, Quality and Outcomes Study Team (1995). *Cost, quality and child outcomes in child care centers*. Denver: University of Colorado. For additional information see NICHD Early Care Research Network (1996). Characteristics of infant child care: Factors contributing to positive caregiving. *Early Childhood Research Quarterly*, 11, 269-306.

Family Support Services Committee - POSITION ON CHILD CARE (continued)

A recent study (Thyen, Kuhlthau and Perrin, *Pediatrics*, June 1999) on employment, child care and mental health of mothers caring for children assisted by technology found:

- One third of the mothers in the study group quit employment to take care of a child.
- Single caregivers were 15 times more likely to quit employment.
- The lack of child care services was more significant than the severity of the child's disability in accessing care.
- Families had 20-fold higher uncompensated health care costs.
- Mothers reported poorer mental health and employment seemed to mediate this relationship.³

A 1998 study in the Seattle area compared the child care choices and quality of care for children both with and at risk for disabilities to the child care choices made by parents of typically developing children. The authors found that children with disabilities and those at risk entered child care at a later age and used relative caregivers more frequently. Parent choice about returning to work was greatly affected by their child's special need for about 30% of the families. The authors cite several studies that demonstrate the overrepresentation of children and families with disabilities in poverty samples.⁴ Research clearly shows the poor outcomes for children in families with cumulative risk factors including disability, poverty and single parenting.⁵

The implications of these and other studies indicate that families with children with disabilities have less choice and carry a higher financial burden than those with typically developing children when it comes to child care. This can contribute to poorer long-term outcomes for the children and the mental health and marital stability of their parents. This points to the need for specific social and economic policies, and agency responsibility for adequately assessing and addressing the child care needs of families of children with disabilities.

NEED STATEMENT

There is an urgent need for targeted efforts by multiple state and local agencies to address the unmet needs of children with disabilities or other special needs and their families to effectively access and maintain quality child care services.⁶

No agency at the state or local level has the sole responsibility or accountability for ensuring that the needs of this population are met. Data on child care need or availability of care are not

³ Thyen, Kuhlthau and Perrin (1999).

⁴ Booth and Kelly (1998). Child care characteristics of infants with and without special needs: Comparisons and concerns. *Early Childhood Research Quarterly*, 13, 4, 603-621.

⁵ Sameroff (1993). Models of development and developmental risk, in C. Zeanah (ed.) *Handbook of Infant Mental Health*. New York: Guilford Press, 3-13.

⁶ Note: Each of the systems serving children in California have different definitions of special need. For purposes of this document, the terms "disability" and "other special needs" refer to those children who meet the criteria established by the California Early Start program for children with or at risk for disability. This may include children who do not have a specific diagnosis but are in need of specialized services or for whom their development and/or behavior may affect their ability to be in a child care program.

Family Support Services Committee - POSITION ON CHILD CARE (continued)

systematically collected within and across systems. The most recent comprehensive study in California that addressed the child care needs of children with disabilities was completed over a decade ago.⁷ As a result, current information is anecdotal, scattered and/or incomplete.

Systems and policy changes have occurred in the past ten years, including the passage of the Americans with Disabilities Act (ADA), the Personal Responsibility and Work Opportunities Act (PRWORA or CalWORKs), and Amendments to the Individuals with Disabilities Education Act (IDEA), that greatly influence families' needs and ability to access child care. Part C of IDEA places a renewed emphasis on the delivery of early intervention services within natural environments. Given the number of working families, one obvious natural environment is the child care setting. There is already a tremendous need for services, supply and availability of appropriate child care. Training for providers and financial assistance for families who may need additional resources are undoubtedly impacted. This impact, however, is not well documented.

Inconsistent policy administration, systems barriers and lack of child care options for children with disabilities create a requirement that families with children with or at risk for disabilities carry a heavier load and go "above and beyond" those families with typically developing children. Economic self-sufficiency, a cornerstone of healthy families, may be impossible to achieve if the child care needs of families go unmet or are only partially met.

Immediate needs are to:

- A. Identify the child care priorities and needs for children with disabilities and their families based on current and accurate data.
- B. Coordinate the planning, design, and delivery of child care services inclusive of children with disabilities across and within state and local agencies that include training, technical assistance and targeted supports.
- C. Expand child care services for children with disabilities, including financial support to offset costs, and make the required changes to existing policies, regulations, funding mechanisms and personnel development activities.
- D. Provide increased availability of subsidies, priority status or set-asides for access, and incentives and support for providers for children with disabilities, regardless of the economic status of their families.

ASSUMPTIONS

- Infants and toddlers with disabilities and their families will be provided services in natural environments, which includes the use of natural supports and existing community resources.⁸

⁷ Berkeley Planning Associates (1987).

⁸ Individuals with Disabilities Education Act, 1997, Section 1432 (4)(G)

Family Support Services Committee - POSITION ON CHILD CARE (continued)

- Inclusive child care can be an important and positive influence yielding higher developmental outcomes and improving the child's ability to integrate meaningfully into his/her community and socialize with non-disabled peers.⁹
- Families of children with disabilities have the same rights as those with typically developing children, including options for child care services that meet the unique needs of the child and his or her family, allowing the family to stay together and contributing to community integration.¹⁰
- There are significant short and long term social and economic costs of not having inclusive, high quality child care, especially for children with or at risk for disabilities and their families.¹¹
- Among the highest need of families served, as identified by Family Resource Center staff, is the family's need for appropriate, affordable and high quality child care services.
- Children with disabilities are less likely to access quality child care services in their community despite the fact that the Americans with Disabilities Act protects them from discrimination.¹²
- Full parent participation in the individualized family service planning process includes the knowledge of and option to advocate for quality child care as a potential family support service, as part of an early intervention program and/or as the setting for the provision of early intervention services.
- It is the family's right to engage in open, constructive dialogue with the Individualized Family Service Plan (IFSP) team regarding the identification of support services, including child care as a family support service within the early intervention system.¹³
- To attain economic parity with families of typically developing children, families whose children have disabilities may require specialized equipment, supplies or additional supports to access inclusive and appropriate child care.
- Individualized early intervention services and supports for both the child and personnel working with the child and family must be provided for children with or at risk for disabilities who attend child care programs.

⁹ Lanterman Developmental Disabilities Services Act, as amended 1997, Section 4512(b).

¹⁰ Lanterman Developmental Disabilities Services Act, Sections 4648(a), 4685, and 4688.

¹¹ Thyen, Kuhlthau and Perrin, Employment, child care, and mental health of mothers caring for children assisted by technology. *Pediatrics*, Vol. 103, 1235-1242.

¹² Reported by the Child Care Law Center and the California Child Care Health program presentation, May 1999.

¹³ Lanterman Act, Section 4648(a), (b) and (c).

Family Support Services Committee - POSITION ON CHILD CARE (continued)

- Trained, supported and well-compensated child care providers can be integral partners in the early intervention services provided to children and families. This does not mean that child care providers can take the place of early intervention professionals, however, their participation in the IFSP team is critical.
- There is little policy guidance regarding the provision of child care as a family support service within the IFSP process. Policy application varies widely throughout the state, in spite of the fact that child care may be a critical need for a family.
- Appropriate child care resource and referral services are not consistently available statewide to families of children with disabilities.

Recommendations to the California Department of Developmental Services in collaboration with the Department of Education and the Department of Social Services

1. *Develop a statewide system of data collection to identify need and utilization of child care by families whose children have or are at risk for disabilities.*
 - A. Linking with current data collection efforts, conduct a needs assessment to determine the number of children, with or at risk for disability, whose families need child care services.
 - B. Identify the number of families who are working, in school or job training who are currently using child care services, including family members as providers, hours of employment/school or training, and type(s) of child care used.
 - C. Develop a statistically sound and relevant protocol for collecting these and other data statewide, across systems, and across age groups.
 - D. Work with existing data collection entities to develop a methodology that explicitly identifies the child care needs and services available to this population.
2. *Establish consistent policies regarding the use, reimbursement and support for child care.*
 - A. Collect Regional Center Purchase of Service (POS) policies as they relate to paying for child care and child care policies.
 - B. Review policies, identify inconsistencies and make recommendations that allow local flexibility but establish a level of statewide equity.
 - C. Compare actual costs paid for child care by Regional Centers, Local Education Agencies or families to the regional market rates identified by the California Child Care Resource and Referral Network and other child care reimbursement rates and/or subsidies established by the California Department of Education, Child Development Division.
3. *Support the expansion and availability of high quality child care in local communities for families of children with/or at risk for disabilities.*
 - A. Assist in identifying the child care supply and unmet need of this population.

Family Support Services Committee - POSITION ON CHILD CARE (continued)

- B. Identify the role Family Resource Centers/Networks might have in supporting the child care needs of the families they serve.
 - C. Assist child care resource and referral agencies to provide information to families on those providers who have received training related to providing care for children with disabilities and other special needs.
 - D. Ensure that representatives of the disability community participate in local child care planning efforts.
4. *Explore and identify successful and innovative models of integrated early intervention service delivery in child care and related settings.*
- A. In collaboration with the Map to Inclusive Child Care Project and others, collect and disseminate information about how services are provided, by whom, how they are paid for, who supervises and trains staff, etc.
 - B. Identify state and national models that identify barriers as well as strategies for collaborating on resources including shared or blended funding options, and family and provider support services.
5. *Assist in improving the capacity of child care personnel to meet the needs of children with disabilities in their care.*
- A. Identify the training and technical assistance needs of non-early intervention personnel working in child care settings to strengthen their ability to meet the needs of children with or at risk for disability in collaboration with early intervention personnel.
 - B. Identify the training and technical assistance needs of early intervention and related service professionals to provide services in group care settings most effectively.
 - C. Identify and make recommendations for coordinated, collaborative early intervention, early childhood special education and early childhood education personnel development, training and resources with the goal to improve and enhance services in natural environments.
 - D. Support cross-disciplinary training for all personnel working with young children.
 - E. Ensure the delivery of all available services to support children with disabilities in child care settings.
6. *Implement opportunities for full parent participation in the identification of and advocacy for child care as part of the early intervention program and/or as a setting for the provision of early intervention services.*
- A. Maximize family access to information communicating legal rights, options and selection criteria for child care settings to families of children birth to three with or at risk for disability, including written materials, Internet, CD-rom, live seminars and workshops.
7. *Establish linkages and consistency within systems across age spans, including continuity of child care services for those children who remain eligible after age three.*

Family Support Services Committee - POSITION ON CHILD CARE (continued)

- A. Ensure that child care services are addressed in transition plans and are a consideration for service delivery settings after age three for children eligible under Part B, IDEA.
 - B. Identify eligibility criteria, ongoing subsidies, supports and personnel needs for children with disabilities to maintain services in inclusive placements.
8. *Increase interagency collaboration through formal and informal agreements, memoranda of understanding and cooperative service delivery in support of quality child care services for children with or at risk for disabilities.*
- A. Appoint representative from the child care and development system to the State Interagency Coordinating Council.
 - B. Identify both existing and needed interagency responsibilities, policies, program staffing patterns and training and technical assistance activities with regard to child care for children with or at risk for disabilities from the following agencies/departments:

Department of Developmental Services

Regional Centers and Vendors

- Service Standards
- Service Coordinator training
- Transportation
- Individualized Family Service Plans

Family Resource Centers/Networks

State Interagency Coordinating Council

Department of Education

Child Development Division

- Local Child Care Planning Councils
- Child Care Resource and Referral Agencies
- Head Start Collaboration Project
- Child Development Programs Advisory Committee
- Desired Results Project

Special Education Division

- Special Education Local Plan Areas (SELPAs)
- Local Education Agencies
- County Offices of Education

Department of Health Services

EPSDT, CHDP, Healthy Families

California Children's Services

Drug and Alcohol Programs

Department of Mental Health

Department of Social Services

CalWORKs/TANF

Community Care Licensing

Head Start/Early Head Start

Local and State Children and Families Commissions (Proposition 10)

AGENDA ITEM DETAIL SHEET STATE ICC

APPROVED

Committee

- ☒ Committee of the Whole
- ☐ Quality Assurance
- ☐ Public Awareness
- ☐ Health Systems
- ☐ Family Support
- ☐ Bylaws

Item

- ☒ Action
- ☐ Consent
- ☐ Discussion
- ☐ Information

Date: September 24, 1999

To: ICC Members

From: Walter Olsen, Jr., Ed.D., Chair, Task Force on Natural Environments

Title: Natural Environments Guidelines (See Addendum)

Background/Discussion

In accordance with the 1997 reauthorization of Part C of the Individuals with Disabilities Education Act, and Title 34 of the Code of Federal Regulations, Section 303.167 (final regulations dated April 14, 1998), states are required to have policies and procedures to ensure that:

- “(1) To the maximum extent appropriate, early intervention services are provided in natural environments; and
- (2) The provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment.”

California's policy is contained in the California Code of Regulations, Title 17, Section 52106. To assist the lead agency in the implementation of this policy, the Interagency Coordinating Council (ICC) established a Task Force to develop recommendations for Natural Environment Guidelines. The Task Force included parents and representatives from the California Department of Education (CDE), Department of Developmental Services (DDS), Department of Health Services, vendored infant development programs, local education agencies, and advocacy organizations.

Recommendation

That the ICC forward the Natural Environments Guidelines to the lead agency.

Possible Actions

- 1) Approve the recommendations in total
- 2) Amend and approve recommendations
- 3) Reject the recommendations



I. Statutory and Regulatory References for Natural Environments

The following lists statutory and regulatory references for providing services in natural environments. Citations reference both federal Individuals with Disabilities Education Act law and regulations and Title 17 of the California Code of Regulations.

PART C OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) LEGAL CITATIONS

IDEA 97 Section 1432 (4) (G) Definition of Early Intervention Services

"(G) To the maximum extent appropriate, are provided in natural environments, including the home and community setting in which children without disabilities participate."

IDEA 97 Section 1435 (a) (16) Individualized family service plans.

"(16) Policies and procedures to ensure that-----

(A) To the maximum extent appropriate, early intervention services are provided in natural environments; and

(B) The provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment."

IDEA 97 Section 1436 (d) Content of the Plan

"(d) The IFSP shall be in writing and contain.....

(5) The statement of the natural environments in which early intervention services shall appropriately be provided; including a justification of the extent, if any, to which the services will not be provided in a natural environment...."

Title 34 CODE OF FEDERAL REGULATIONS SECTION 303.12 (b)

"To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate."

"...natural environments means settings that are natural or normal for the child's age peers who have no disability"

CALIFORNIA CODE OF REGULATIONS (CCR)

CCR Title 17, Section 52084: Regulations:

"(d) Evaluations pursuant to Section 52082 (Evaluation) and assessments for service planning shall be conducted in natural environments whenever possible."

CCR Title 17, Section 52106: Regulations:

"(b) The IFSP shall include the following:.....

(6) Statements of the specific early intervention services necessary to meet the unique needs of

(B) The location where the services will be delivered:

The statements of location shall specify the **natural environments** such as home, child care, school program, or private program where early intervention services shall be provided; and

The statement shall include a justification of the extent, if any, to which the services will not be provided in a **natural environment**.

II. GUIDELINES FOR IMPLEMENTING NATURAL ENVIRONMENTS

Natural Environment Defined

The natural environment means settings that are natural or typical for the child's age peers who have no disability including the home and community settings in which children without disabilities participate (CFR 303.18). Natural learning environments are the places where children experience everyday, typically occurring learning opportunities that promote and enhance behavioral and developmental competencies. When appropriate, supports and services should be provided to foster opportunities for the development of peer relationships with children without disabilities. These opportunities should also provide typically developing children with the opportunities for positive interactions with children with disabilities.

Requirements for Evaluation and Assessment in Natural Environment

According to Section 52084(e) of Title 17 of the California Code of Regulations, evaluations and assessments must be conducted in natural environments whenever possible and be conducted by qualified personnel. The interaction between a child and the environment in the context of his/her daily activities and routines allows the child's best performance to be enhanced. The assessors should focus ongoing assessment on the child's developmental skills, challenges, individual differences and responses alone and with family members. Assessors should also observe the child in social interactions and in different experiences and settings, and with different people throughout the day.

Examples of a Natural Environment in Which Services Can Appropriately Be Provided

A natural environment is:

The infant or toddler's home or another setting that offers opportunities for supporting development and parent child interaction, for example: play-time, meal times, bath time, outings in the community, or play time at a neighbor's home;

One that meets the unique needs of the child and family;

Identified in partnership with the parent;

Developmentally and chronologically suited to the child;

Individually planned;

Located where the child might participate if he or she did not have a disability;

Located where supportive and qualified personnel can deliver early intervention services;

A child care setting that offers opportunities for supporting development and relationships with a caregiver or peers;

A typical and natural childhood experience that a child does not currently have due to his/her developmental challenges;

A situation or setting that requires adaptations and supports to enable the child to benefit from the experiences that are available to typical children; and

A location that is linguistically and communicatively accessible.

IFSP must contain statements on natural environment

For each service listed on the child's IFSP, it is required to state that the service is provided in the natural environment. The statement about the natural environment in which the service will be provided must be written on the IFSP in the portion of the format that describes that service, the frequency, location, and intensity.

A written justification must be provided on the IFSP for each service that is not provided in the natural environment. Similarly, the written justification must be written in the IFSP format that describes the particular service. The justification must include a description of the efforts made to identify appropriate services that could be provided in the child's natural environments and the reasons why the services could not be obtained.

Circumstances in which early intervention services may be provided outside the natural environment

If a service can be satisfactorily achieved in the natural environment with appropriate supports and services, then it must be provided there. Some children may require intensive services and a structured environment for a short time to prepare for integration into community settings. Other children require specific instruction in communication in their primary language mode with a similar group of language peers.

The IFSP team may conclude that the provision of services outside of a natural environment can be considered. After all natural environments with appropriate supports and services have been discussed and rejected because an early intervention service cannot be achieved satisfactorily, the IFSP team may recommend providing a service outside of the child's natural environment.

A statement of the reason why early intervention cannot be achieved satisfactorily in the natural environment must be written on the IFSP. As provided for in state regulations, CCR Title 17, Section 52106, this statement is considered the "justification" for services to be provided outside the natural environment. The statement must describe:

- 1) the reason why the early intervention cannot be achieved satisfactorily in a natural environment;
- 2) how the services provided in this location will be generalized to support the child's ability to function in the natural environment; and
- 3) a timeline when the service might be expected to be provided in a natural environment. Consideration for a periodic review earlier than at the semi-annual review may be indicated.

Parent to parent support

Reducing the isolation frequently experienced by families whose infants and toddlers have or are at risk for disabilities is primary to promoting positive parent-child relationships and enhancing parents' capacity to meet the needs of the children.

Family support services, including parent-to-parent support, are not required to be provided in a natural environment. Through the IFSP development, team members will identify, with the parents' participation, their needs for family support services and how the services will be provided.

Providing services in a natural environment does not preclude bringing families together to receive training or counseling or to network and to support one another.

In addition to the parent-to-parent support services offered by family resource centers and networks, family support services provided in group settings are allowed and supported in federal and state law.

Determination of the natural environment

Part C requires that the setting in which the service is to be provided must be individually determined as to whether the location is a natural environment for providing a particular service for that child. In all instances, the individual determination must be made by participants on the IFSP team, which includes the parent, regarding the services to be provided to an infant or toddler, including the location in which appropriate services will be provided. The IFSP team must make decisions as required under federal and state statute and regulations. If the determination is made by the IFSP team that, based on a review of all relevant information regarding the unique needs of a particular child, the child cannot satisfactorily achieve identified early intervention outcomes in natural environments even with appropriate supports and services, that child could receive

specific services outside of a natural environment. In that case, the IFSP must include a justification of the extent to which services will be not be provided in a natural environment.

When concerns, priorities and resources are discussed in preparation for writing the IFSP, several options may be considered. To the maximum extent appropriate to the needs of the child, services are provided in locations which include typically developing age peers. The exception to the natural environment requirement is when the early intervention cannot be achieved satisfactorily even with appropriate supports and services.

Parent input is considered within the context of the federal law. Under Part C, the IFSP team, which includes the parents, has the decision-making responsibility to identify early intervention services that meet the unique developmental needs of the child and the child's family related to enhancing the child's development. These decisions are based on information from completed evaluations and assessments, including information provided by the family.

Part C recognizes the importance of parent involvement through the IFSP process and requires their participation in the process. The State, however, is responsible to ensure that other regulatory and statutory requirements, including the natural environments provisions, are met. Parents provide input regarding the provision of services, ultimate responsibility for determining what services are appropriate for a particular child, including the location of such services, rests with the IFSP team as a whole. IFSP team decisions cannot be made unilaterally based solely on preferences of any single team member. If agreement cannot be reached, due process procedural safeguards may be pursued. Service coordinators have a responsibility to inform parents that they can refuse consent for one or more early intervention services and still receive the other services specified on the IFSP.

Opportunity to identify natural environment options

During the 45 day initial evaluation and assessment period, parents should be asked about options already available to the family for appropriate settings. The team conducting the assessments should find out how and where the child spends the day, for example: home, grandmother's house, child care, or child development center. These are the environments that should be considered first by the IFSP team for delivery of services.

Professionals who conduct assessments will dialogue with parents about where the child spends his or her waking hours. They will ask questions of parents in the initial assessment period and assure parents that the appropriate supports and services will be

provided by qualified personnel in the child's natural environments. The assessor will enlist the parents' help in identifying settings where early intervention services can be provided. If the child will receive services in a natural environment outside of the family home, the IFSP team must consider the need for appropriate supports and services in that environment to ensure the provision of identified early intervention services.

Examples of natural environment options

Options in the natural environment must include settings that are natural or typical for the child's age peers without disabilities. Natural settings include typically occurring day-to-day experiences where the child routinely spends time. Coordinated early intervention services must be available to enhance development and relationships in natural environments where the child and family need support. Natural environments foster participation and learning opportunities, and strengthen existing capabilities while promoting new skills. Identifying a location in which a service will take place must be determined on an individual basis, not based on the type of disability of the child.

The natural environments in which early intervention services can be provided include:

Home/residence of family	Babysitter's location
Family child care home	Early Head Start
Adult education program	Child development programs
Public and private child care centers	Parent cooperatives
Daddy/Mommy and Me community groups	Teen parenting programs
Parks and recreation settings	Story time at the library
Gymnastic type classes	Restaurant
Play Groups	

Natural environment must be considered for all early intervention services on the IFSP

For every early intervention service, the frequency, initiation, duration, intensity, method, type and location must be specified as provided in the natural environment unless there is a written justification of the extent, if any, to which the service cannot be achieved in a natural environment. (CFR 303.167) The natural environment requirement does not pertain to "other services" or "a referral to a non-required service".(GC 95020 (e) (2) and (3)

III. Frequently Asked Questions

Is the requirement for natural environments new?

The requirement to provide services in a natural environment is not new.

Public Law 102-119, October 7, 1991, introduced the requirement that early intervention services, to the maximum extent appropriate, are provided in natural environments. However, Public Law 105-17, June 4, 1997, amended IDEA to add the requirement that early intervention services can be outside of a natural environment only when early intervention cannot be achieved satisfactorily in a natural environment. If early intervention cannot be achieved in the natural environment, then a justification for providing services in another environment must be written on the IFSP.

What are some considerations for implementation?

Staff providing services in homes or other natural environments may need additional training in:

- adult learning styles;
- personal safety techniques;
- home visiting;
- mental health techniques and understanding social-emotional development;
- cultural competency;
- modifying environments to support developmental needs;
- supporting relationships with other adults and children;
- providing interventions to facilitate natural and typical developmental and family experiences; and
- focused intervention and support to assist the child with development in collaboration with primary caregivers and other providers.

In addition, there may be a need to shift allocation in resources related to increased travel time; coordination with other members of the IFSP team; portable materials; storage space; language and cultural support; flexible hours, and; caseload control.

Who will provide early intervention services in the natural environment?

Early intervention services will be provided by qualified personnel. Personnel standards for personnel who deliver early intervention services will not be compromised when early intervention services are provided in the natural environment.

Is child care an early intervention service under Part C?

Child care itself is not considered an early intervention service. However, if the IFSP team determines that a certain amount of participation in a group setting with children without disabilities is necessary to address an assessed need for socialization, referral to a child care group setting may be considered an early intervention service. Early intervention services under Part C regulations mean services that are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development. Appropriate supports and other early intervention services needed by the child as identified on the child's IFSP may also be provided while the child is in the child care setting.

Can regional centers and local education agencies pay for the time a child spends in a child care setting?

Yes. Regional centers may pay for child care group setting services if the child's IFSP contains a specific outcome which requires socialization or interaction with non-disabled age group peers. Regional centers agencies may purchase child care in order to facilitate attainment of that outcome. Local education agencies may only purchase child care for children with solely low incidence disabilities under their existing service mandates to achieve the identified outcome for that child.

If the child's IFSP specifies an amount of time in a child care setting as an early intervention service, the regional center or LEA assumes the financial responsibility for that portion of the group setting associated with the specific early intervention outcome. The purchase of the group setting would be only for the time the child is receiving the early intervention services identified on the IFSP to achieve the stated outcome. However, if the parent decides to place the child in a child care setting or preschool for any time beyond that identified in the IFSP, the parent would be responsible for payment of the additional child care or preschool service costs. Regional centers may purchase child care support for families to accomplish other outcomes unrelated to early intervention services under their Welfare and Institution Code responsibilities.

Who pays for early intervention services?

Regional centers and local education agencies are financially responsible for early intervention services identified on the child's IFSP regardless of where those services are provided. This includes the time the child spends in a typical group setting if that service has been identified as a requirement to address a specific assessed need for improved socialization or similar outcome.

What does it mean for early intervention to be satisfactorily achieved?

An early intervention that is satisfactorily achieved means that the intervention enables the child or family to achieve a positive change in a developmental or behavioral outcome as identified on the IFSP. The intent is to maximize the family's ability to incorporate supports into daily activities, routines and significant relationships identified in the IFSP, thereby assisting them to enhance the development of the child.

How can regional centers, LEAs and infant programs with separate or segregated group settings/centers make changes in their existing service delivery model?

Part C statutory and regulatory requirements necessitate a fundamental shift in early intervention service delivery models in the California. The shift is not intended to disadvantage existing programs, which provide high quality early intervention services in a center-based program environment. The intent is to bring the appropriate early intervention services into the child's natural environment. This shift requires a re-design of some current service delivery models.

DDS and CDE will work with regional centers, local education agencies, service providers, and other interested community groups to develop strategies that minimize disruptions to children and families, and economic hardship for early intervention service providers.

Can infant programs maintain services in disability specific settings?

The natural environment must always be the first location considered for the provision of early intervention services. Additional supports and services may be required by individual children to meet IFSP outcomes in the child's natural environment.

How is a natural environment different from the least restrictive environment (LRE) that is used for preschoolers under Part B of IDEA?

Least restrictive environment under IDEA Part B, requires that: "Children with disabilities, to the maximum extent appropriate, including children in public or private institutions or other care facilities are educated with children who are not disabled. Special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily." (34 CFR 300.550) LRE also requires that there be a continuum of placement options for all children in the 3-21 year old population. The continuum includes: regular class placement, resource specialist program, designated instruction and services, special classes and centers, nonpublic nonsectarian school services, state special schools, settings other than the

classroom where specially designed instruction may occur, and home or hospital instruction.

Natural environment promotes community acceptance for children with disabilities, expands options for supports, provides opportunities to blend early intervention services, informal supports and opportunities for generalization of learning. Home visits and individualized services can be conducted in different locations, for example: a child care setting, the park, a grocery store, or a restaurant. In assessing the family, the IFSP team, which includes the parent, determines what the natural environment for the family may be.

Natural environments are intended to allow parents to obtain the maximum benefit for their child by assisting parents to identify opportunities in their everyday lives to teach their children.