AGENDA ITEM DETAIL SHEET
STATE ICC

Committee
___Committee of the Whole
___Quality Assurance
___Public Awareness
_x_Health Systems
___Family Support
___Bylaws

Item
_x_Action
___Consent
___Discussion
___Information

APPROVED

Date: October 18, 1999
To: ICC Members
From: Health Systems Committee

Title: Role of Occupational Therapy, Physical Therapy, And Speech-Language Therapy in Early Intervention Services in California

Background/Discussion

In response to continuing reports of barriers to the delivery of therapy services, the Health Systems Committee (HSC) has surveyed the provision of occupational therapy (OT), physical therapy (PT), and speech-language therapy (ST) services for infants and toddlers with disabilities. Evidence has been gathered from families, service providers, researchers, and funding agencies regarding the access and reimbursement of OT, PT, and ST services in California. The committee report generated provides a narrative synthesis of the challenges and recommendations as they relate to the provision of therapy services. The report focuses on four major categories that influence the provision of therapy services as part of early intervention, including: 1) therapy services in early intervention; 2) California's current therapy programs and services; 3) funding sources and payment for therapy services; and 4) barriers to services and unmet needs.

Recommendation

The HSC recommends that the Interagency Coordinating Council (ICC) request that the Department of Developmental Services (DDS), as lead agency:

1. Request and assist the California professional associations for occupational therapy, physical therapy, and speech therapy, to develop a written guidance document pertaining to their area of expertise regarding the therapy services effective for infants, toddlers and their families, and request that these associations also address the issue of potential best practice guidelines for early intervention. These guidance documents should be shared with Early Start agencies for training and therapy referral purposes. HSC requests that DDS provide the ICC with a written statement of the progress in this matter by January 2001.

2. Support the inclusion of therapy professionals as part of the multidisciplinary team to provide therapy assessments and recommendations for infants and toddlers as part of the Individualized Family Service Plan process, described in the Early Start regulations, section 52104.

3. Develop, implement and monitor a plan to ensure adequate access to therapy services, via: funding for additional therapy time; increasing reimbursement for therapy services; and training and recruiting therapists with early intervention expertise, particularly for under-served areas.

4. Collaborate with the federal ICC to obtain a waiver from HCFA to permit therapists to bill for services provided in a full range of environments, including home and community.

5. Facilitate strongly stated interagency agreements among DDS, CDE, and DHS pertaining to therapy services that clearly delineate obligations of each agency. The state model should be used as a guide for local agencies in order to foster consistency and efficiency in the referral, delivery, and payment for therapy services. As much as possible, within their mandates of populations served, consistency in eligibility should also be addressed. A reimbursement policy between departments should be in place if the responsible agency is not able to provide services. HSC requests that DDS provide a summary of the interagency agreements regarding therapy issues to the ICC by January 2001.

6. Support interdepartmental efforts to implement a coordinated and integrated service delivery model for infants and toddlers with disabilities. This discussion should examine, but not be limited to the option of delivering therapy services through a single agency with blended funding and would include support from State level agencies. The HSC requests that the interdepartmental workgroup provide the ICC with a copy of their review and recommendations by January 2001.

Possible Action

1. Approve recommendations 1-6.
2. Approve any single recommendation or any combined.
3. Modify and approve any single or combined recommendations.
4. Reject all recommendations.

California Interagency Coordinating Council
Health Systems Committee

Role of Occupational Therapy, Physical Therapy, and Speech-Language Therapy in Early Intervention Services in California

October 26, 1999

I. PURPOSE OF THIS REPORT

In December 1997, the Interagency Coordinating Council (ICC) requested that the Health Systems Committee (HSC) address key issues affecting occupational, physical and speech/language therapy services for children in early intervention. These included:

- therapy services and their role in early intervention
- current programs and services
- funding sources and payment for therapy services
- barriers to services and unmet needs

In carrying out this charge, the HSC utilized the expertise of: its own members, experts in each of the therapy areas, professional therapy associations, families, service providers, and funding agencies. Policy articles, research data, California program policies, regulations and payment schedules were also reviewed. Only occupational, physical and speech/ language therapies were evaluated and these are the therapy services referred to in this document.

II. THERAPY SERVICES IN EARLY INTERVENTION

A. The Role of Therapy Services in Early Start

1. Goals of Services

Therapy services are mandated in federal regulations for the Early Intervention Program for Infants and Toddlers with Disabilities, which implemented the "Individuals with Disabilities Education Act" Amendments of 1991 - Part H, (revised as Part C and called Early Start in California). The goals for therapy services are to: 1) provide opportunities to improve skills in areas of deficit or delay; 2) optimize parent-child interactions, which are essential for child development; and 3) adapt the child's environment to maximize the child's function.

The developmental role of the therapy is a critical feature in these services. It reflects an integrated, interdisciplinary approach that considers the child's skills within the context of the family. Therapy services can stand alone or therapy providers can function as a part of the early intervention team, depending on the child's and family's needs.

2. Research Support for Benefit of Services

There have been few research studies designed to document the benefit of therapy services for young children with "at risk" or disabling conditions. Some of these studies have demonstrated improvement in children with developmental delays. Variations in populations, therapy professionals' research methods and lack of long term follow up make interpretation of results difficult. Most efficacy studies have used small sample sizes and qualitative or limited experimental designs. The measurement of outcomes in this therapy field is basically just beginning.

However, research does suggest that therapy is effective for specific interventions. Occupational therapy and physical therapy have been provided to children of all ages with neuromuscular conditions, through the California Children Services (CCS) program, for many years. Speech and language therapy services have also been provided through CCS paneled members. These efforts are accepted interventions. In addition, other therapies, such as occupational and speech therapy for children with oromuscular and/or feeding problems, have been widely accepted.

Recent studies have suggested that children with developmental disabilities may also benefit from therapy. Positioning, feeding, developmental interaction with caregivers and functional guidance, and use of toys and equipment, can help parents assist their children to develop and utilize their maximal abilities. These therapies have become an accepted part of the service delivery system in Part C, when employed as part of the Individualized Family Service Plan (IFSP) needs assessment and early intervention services. Recent research suggests that efforts during the first three years of life, to help brain development, are crucial for long term social, emotional, cognitive, language and motor development.

B. Types of Therapies Available

Therapy services are defined in 34 Code of Federal Regulations (CFR) Part 303, Section 303.12 as follows:

1. Occupational Therapy (OT)

Services to address the functional needs of a child related to: adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

a)Identification, assessment, and intervention

b) Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

c) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

2. Physical Therapy (PT)

Services to address the promotion of sensori-motor function, through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

a) Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;

b) Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and

c) Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

3. Speech- Language Pathology (ST) or (SLP)

Services include:

a) Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in these skills;

b) Referrals for medical or other professional services necessary for the habilitation or rehabilitation of children with oropharyngeal disorders and delays in development of communication skills; and

c) Provision of services or treatment to prevent, alleviate, or compensate for swallowing or communicative oropharyngeal disorders and delays in development of communication skills.

C. Education, Training and Qualifications of Providers

Practice in each profession requires academic training and monitoring by a professional organization.

1. An Occupational Therapist (OTR)- must meet the requirements of the Occupational Therapy Trademark Bill (Business and Professions Code Section 2570). An OTR shall be certified by and meet the educational standards of the National Board for Certification of Occupational Therapy. Eligibility for certification is made on the basis of the following qualifications:

a) Completion of attendance at an academic institution certified by the American Occupational Therapy Association (AOTA). Degrees can be either: Bachelor of Science or Arts (BS or BA), Masters of Science or Arts (MS or MA), Doctor of Occupational Therapy- clinical (DOT), or Doctor of Occupational Therapy- educational (Ph.D.);

b) Completion of six months of approved clinical internship; and

c) Passing the national, written certification exam.

2. A Physical Therapist (PT)- must meet the requirements of the Physical Therapy Practice Act. A PT shall be licensed by the Department of Consumer Affairs Physical Therapy Board of California and meet the educational standards of the Physical Therapy Examining Committee. Eligibility for licensure is made on the basis of the following qualifications:

a) Completion of attendance at an academic institution that has been certified by the American Physical Therapy Association (APTA). Degrees can be either Bachelor of Science or Arts (BS or BA), Masters of Science or Arts (MS or MA), Doctor of Physical Therapy, clinical (DPT), or Doctor of Physical Therapy, educational (Ph.D.);

b) Completion of a minimum of 18 weeks of approved clinical internship at a state approved academic institution; and

c) Passing the written, national licensure examination from California (or oral examination if applying to practice in California after being licensed in another state).

3. A Speech-Language Pathologist (ST or SLP)- shall be licensed by the Department of Consumer Affairs, Speech Pathology and Audiology Examination Committee and shall meet the educational standards of that committee. Eligibility for licensure is made on the basis of the following qualifications:

a) Masters degree in speech pathology from a Committee approved educational institution. Degrees can be either Masters of Sciences or Arts (MS or MA), or Doctor of Speech and Language Pathology (Ph.D.);

b) Completion of approved clinical experience;

c) Passing the National Examination; and

d) C.C.C. (Certificate of Clinical Competency) issued by the American Speech and Hearing Association (ASHA).

4. Pediatric and Early Intervention Expertise

a) OT- For early intervention pre-service training, OT students are required to meet competencies in pediatrics that include services to infants and young children, and which address evaluation, intervention, and working with families. Students may also select an early intervention setting as one of their internships.

b) PT- Curriculum in PT schools includes a growth and development class. There are also voluntary pediatric therapeutic exercise classes and pediatric internships. With respect to early intervention, some schools specialize in pediatrics and include courses and training on the 0 to 3 year old, and specific clinical internships may include this population.

D. Relationships Among Therapy Services

1. Separate Professions- Each of the three therapy services is a separate,

distinct profession. Each has a unique set of course work. No one therapy can substitute for another.

2. Commonalities- There is some overlap in the types of courses and clientele served. There is a general core body of knowledge about children and families that is shared. This is particularly true in early intervention practice, which relies upon a developmental model, is family centered, and incorporates infant mental health principles. The scopes of practice are also overlapping. The American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) have developed more global practice guidelines but these are not specific to young children and frequently duplicate each other. The California Department of Education (CDE) has sought to define early intervention practice for OT and PT ("Guidelines for Occupational Therapy and Physical Therapy in California Public Schools", 1996). The American Speech and Hearing Association (ASHA) has developed a position paper for early intervention services and the California Speech, Language and Hearing Association is in the process of updating a position paper for speech/ language pathologists in the field of early intervention.

3. Individual Expertise- Local therapy services can be influenced by the training and experience of therapists in the region. For example, either a PT, OTR, or ST may perform feeding therapy in any given geographical area. Also, not all therapists within a profession have been trained to serve infants and toddlers. There are differences in emphasis across academic institutions and differences in the types of clinical internships selected by the individual student and/or mandated by the profession.

4. Confusion- The separate but overlapping roles of the early intervention professionals has contributed to confusion among families, health care providers, public officials and legislators, as to the purpose and expected outcomes of the therapies.

E. Methods for Delivery of Therapy Services

The method of delivery depends on the needs of the child and family, the training and experience of the treating therapist and the agency providing therapy. Different services models and locations may be utilized.

1. Models for Delivery of Services

a) Direct treatment- The therapist directly uses intervention techniques with the child and family to elicit developmental and/or therapeutic changes.

b) Collaboration- A joint effort between the therapist and another adult (parent/ teacher/child care attendant) provides intervention that elicits developmental or therapeutic changes in the child.

c) Consultation- The therapist provides specific expertise regarding the child's intervention to another adult (parent/teacher/child care attendant). The other adult carries out the therapist's recommendations. The therapist may or may not monitor the service delivery.

d) Monitoring and training other team members- The therapist designs the service plan to meet the needs of the child and then trains another person in the child's environment to implement that service plan. The therapist remains in contact with the child and the individual implementing the plan, in order to ensure that the plan activities are achieving their stated objectives.

2. Sites for Therapy Services

a) Center based- Children and families come to a center location for services. These centers can be structured like a nursery school environment, local recreational program, or other community parent-child program. Treatment may also be given in a school based clinic or hospital setting.

b) Home based- Intervention is provided in the family's home. The therapist can provide services through direct treatment, collaboration with the family, or consultation with another care giver.

c) Community based- Therapy is provided in any setting that involves the child and family. The setting can be a structured setting, such as child care or the therapists office, or unstructured, such as parks, or homes of relatives.

III. CALIFORNIA'S CURRENT THERAPY PROGRAMS AND SERVICES

A. Agencies Providing Therapy Services to Young Children

The three major agencies in the State of California, providing these services, include:

1. Department of Developmental Services (DDS): Regional Centers

As specified in the Lanterman Developmental Disabilities Services Act (Division 4.5 of the Welfare and Institutions Code), DDS is responsible, via contract, for administering a statewide community-based system of diagnosis, service coordination, and consumer and family support, for persons with developmental disabilities. Contracts are maintained with 21 independent nonprofit corporations known as Regional Centers.

DDS has lead agency responsibility, through the California Early Intervention Services Act Title 14. (Government Code Section 95000 et seq.), to implement the State's interagency early intervention service program (Early Start). DDS, in collaboration with the California Department of Education, serves children from birth to 36 months of age, with developmental delays, disabilities and at risk for disabilities.

Regional Centers and Local Education Agencies are the local agencies that receive referrals, evaluate eligibility, conduct assessments for service needs, prepare an IFSP, and assure coordination of service delivery. To the extent possible, services are to be provided in "natural environments", such as the home or community. Regional centers must assure provision of all therapies determined to be necessary by the multidisciplinary team, including the parents.

DDS is the payor of last resort. There are no financial eligibility criteria and services are provided at no cost to the family.

2. California State Department of Education (CDE): Local Education Agencies (LEAs)

The California Department of Education, through LEAs provides occupational, physical and speech therapy to children from birth through 21 years of age, who do not require medically necessary therapy. California Children's Services (CCS), described below, provides the medically necessary therapy in medical therapy units located in public schools. The therapies provided by the schools are free to all children with exceptional needs. In addition, the LEAs are required by IDEA, Part B, to furnish therapy that CCS is unable to provide, if it is written on an Individualized Education Plan.

For children under the age of three, LEAs provide all models of therapy service delivery to children who have solely low incidence disabilities. OT and PT services are only provided in a consultative model for children who are developmentally delayed or who have an established risk for a developmental delay. LEAs provide speech therapy for all eligible children within their funded capacity. Many LEA infant programs have OT, PT and ST permanent staff members on the multidisciplinary team. Therapy is provided in home or community settings, whenever possible.

3. Department of Health Services: California Children's Services (CCS)

The CCS program originated with the legislative enactment of California's "Crippled Children's Services Act" of 1927. It is the oldest publicly funded health care program in California and is a joint county and State program. CCS provides diagnostic, treatment and case management services, to children under 21 years of age, with CCS eligible medical conditions and who meet financial eligibility criteria. Medical eligibility criteria include most chronic and/ or severe conditions. CCS is California's Title V program for children with special health care needs. CCS also provides case management services for Medi-Cal Managed Care and Healthy Families (the California Title XXI Children's Health Insurance Program).

CCS provides medically necessary therapy in the medical therapy units (MTUs) located in public schools. OT and PT are provided in these units to children up to age 21, with eligible neuromuscular conditions, without consideration of family income. OT and/ or ST may also be provided to children for purposes of feeding or language development, if related to an underlying CCS medical condition.

Therapy is usually provided in an MTU or therapist's office but may be provided in the home, if required by the child's medical condition. The therapy model used is to be child appropriate and the CCS mandate is to provide family-centered, community-based, coordinated care for children with special needs and to facilitate the development of community-based services for such children and their families.

B. Discrepancies in Services Provided

1. Independent Functioning

The three major agencies (DDS, CDE and DHS) desire to serve infants and young children with special needs and their families. However, each agency has different approaches, philosophies and procedures that guide the services provided. The types of children accepted, the use of therapy services and payment for services are determined independently. As a consequence:

a) There is no consistent policy across agencies regarding the assessment

of need for therapy services. Some agencies incorporate therapists in initial evaluations, while others determine the need for therapy and then refer the child to a service provider for therapy assessment;

b) Therapy evaluations may not be accepted between the agencies, necessitating repeat evaluations before services begin;

c) Physicians and service providers from different environments are not consistently included in communications regarding comprehensive evaluations, assessments and IFSPs. For example, CCS therapists have often not been included in IFSPs and have not regularly attended these meetings, so that they are not aware of input from other team members; and

d) Some children receive therapy from multiple providers who do not have opportunity for collaboration and coordination of care often resulting in fragmentation of the child's treatment.

2. Queuing of Services

As noted, CCS has set eligibility criteria. Due to lack of diagnostic medical information about the child or insufficient staff, CCS may not be able to determine eligibility or provide services in the MTU in a timely manner, therefore Regional Centers or LEAs may have to provide therapy initially. Testimony submitted to the committee stated that Regional Centers and LEAs have required determination of eligibility for CCS and MTU treatment before they will assume payment for services. Families, therefore, sometimes have to apply and wait for a CCS denial, before they can receive therapy through other sources.

3. Discontinuity and Interruption of Services

CDE is the primary agency for children with certain disabilities. While awaiting determination of CCS eligibility, LEAs may provide services. If CCS eligibility is then established, families may have to switch providers, either because CCS requests another provider or the therapist is unwilling to switch funding sources.

CCS services may also be discontinued, if therapy is duplicated by another service. This makes frequent communication among agencies imperative.

IV. FUNDING SOURCES AND PAYMENT FOR THERAPY SERVICES

A. Funding Sources for Therapy Services

The major funding sources for therapy services in children under three years of age are currently:

1. CCS and CCS MTUs;
2. Medi-Cal, Fee For Service and Managed Care;
3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)- either as CCS MTU children or separately under Fee For Service Medi-Cal;
4. Early Start/ Part C- through DDS or CDE (when not provided

by private or public insurance);
5. Private insurance, including Healthy Families;
6. Other private, non-profit programs and agencies

B. Rates of Payment

1. Medi-Cal Rates

DDS paid services are tied to the Medi-Cal rate, unless waived. In practice, it is difficult to renegotiate a therapy rate and requires a public hearing. Regional Centers, therefore, cannot pay above Medi-Cal rates to individual vendors. None-the-less, some Centers do negotiate contracts with therapists that allow an increased rate of pay. This increases their ability to recruit and maintain therapy services, to the detriment of locales that pay only the Medi-Cal rate. Other Centers creatively fund therapy by giving more hours for some services and offer families supplemental therapy. This variation in funding practices means that some children have more access to therapies than children living in other areas.

2. Payment Codes

Available payment codes do not correspond to, nor meet the needs for, the therapy services provided. For example:

a) There are Medi-Cal codes for group services provided by ST but not OT or PT;

b) There are no Medi-Cal codes for writing reports by ST;

c) There is no Medi-Cal/ EPSDT code for attending the IFSP team meeting, making it difficult for therapists to participate in the multi-disciplinary meeting, even though this meeting is required by law; and

d) California does not have special billing codes for early intervention, as exist in some other states.

3. Low Payment Rates and Delay in Payment

Numerous anecdotal reports suggest that the Medi-Cal/ EPSDT reimbursement rate is so low, that therapists will not work for this rate. Few Regional Centers are able to find therapists to provide in-home evaluations at a Medi-Cal rate.

There is also a reportedly slow response time with Medi-Cal authorization. Current concentration of MediCal therapy review authorization in the San Francisco MediCal regional office has been helpful. In the Early Start program structure, Regional Centers are the payor of last resort and there may not be incentive for CDE, CCS and Medi-Cal to pay in a timely manner.

4. Third Party Payers:

The number of hours a month that are authorized by Medi-Cal, private insurance, or private health plans for therapy services is often very limited. In particular, there is a

growing issue of restrictive authorization of therapy services by both Medi-Cal and private health care plans. Therapy services may not be authorized because there isn't agreement that therapies recommended by the Multidisciplinary Team in the IFSP are beneficial to accomplish the identified developmental outcomes. Further, a therapy department or vendor may not be able to supply services to a family because it does not contract with a specific Medi-Cal or private managed care plan.

Some health care plans have benefits which include therapy services only when there is a clear indication of medical need. Some plans do not include therapy services as benefits or may not authorize therapies related to developmental delays. Some health plans include benefits for therapy services, if there is a specific impairment secondary to injury or a post-surgical condition.

Families may not consider issues relevant to therapy services when they select health care plans. However, each company offers different benefit packages and families must check their plan's coverage prior to delivery of services.

5. Co-payments

Under Part C regulations a family may not be required to use insurance or pay insurance co-payments. Use of insurance is voluntary.

V. BARRIERS TO SERVICES AND UNMET NEEds

A. Availability of Therapists

1. Numbers of Therapists

The number of skilled therapists, who are trained to work with young children in Early Start is insufficient. Multiple agencies may be needed to provide the time and specialized staff for the indicated services, in part due to the lack of qualified therapists. Functionally, the agencies are in competition for limited personnel.

2. Access to Therapists

a) Distribution of Therapists- The distribution of therapists in the State varies widely. Urban areas that have therapy schools have greater access to therapy services, as graduates tend to stay in the area. However, programs located in urban areas that are less safe and have a high degree of poverty, appear to have more difficulty recruiting therapists. Rural areas can also have difficulty recruiting therapists and lack access to pools of possible candidates. Programs that have a lower pay scale have greater difficulty recruiting therapists. Settings with limited therapist access often do not offer full-time employment to therapists, thereby re-enforcing the barrier to obtaining needed staff.

b) Access to Services- Access to services, such as transportation to sites of therapy, which are benefits of Part C, may not always be available. Some transportation policies require the child to be accompanied by the parent. Working parents may not be able to take the child to a therapy site or accompany the child requiring

transportation. Therapy sites may be too distant for some families.

3. Effect on Therapy Delivery Systems

Regions that have less therapist availability rely more on consultative style scenarios, where a therapist is available fewer hours per client or as a resource for other professionals.

T

B. Concerns and Confusion about Therapy Type and Validity

1. Agencies and Payors

There is uncertainty among those outside the therapy professions regarding the purpose and possible outcomes of therapy for infants and toddlers. Lack of efficacy research has led payers, such as Medi-Cal to deny services.

Funding agencies are also concerned about the lack of guidelines to determine when therapy should be discontinued and what levels of services are needed for different levels of functioning. The overlapping domains of services are also confusing to payers and referral agencies. The skills within a discipline are not consistent, requiring consideration of referral to specific individuals and not necessarily disciplines. This has generated interest in developing models to determine the discipline to which a referral is made and the frequency and duration of services.

2. Families

The overlap in services and skills among therapies can be confusing to families as well. In addition, families can be unsure of the type and range of services that might benefit their child. Families may request a specific therapy discipline or treatment technique, rather than participating in what they perceive to be is a "generic" early intervention program. Yet the latter may actually provide more appropriate services to a given child.

C. Programmatic Issues

1. Discrepancies in Services

Most of the issues discussed in III. B, above, Discrepancies in Services Provided, inadvertently result in practical barriers to accessing therapy services.

2. Exclusion of Families

Parents need to be actively involved in formation of the IFSPs and therapy processes in DDS, CDE and CCS. It has been reported that some CCS programs at MTU's may not include families in the therapy activities.

3. Therapy Settings

Required use of hospital and school based therapy settings may limit treatment options and accessibility.

D. Financial Issues

The issues discussed in IV. B, above, Rates of Payment, result in barriers to accessing and providing therapy services.

VI. RECOMMENDATIONS

The findings of the Health Systems Committee (HSC), functioning in response to the ICC charge, have been discussed in this document. Based on these findings, the HSC recommends that the ICC request the Department of Developmental Services, as lead agency, to:

1. Request and assist the California professional associations for OT, PT and ST to develop a written guidance document pertaining to their area of expertise, regarding the therapy services effective for infants, toddlers and their families, and request that these associations also address the issue of potential best practice guidelines for early intervention. These guidance documents should be shared with Early Start agencies for training and therapy referral purposes. HSC requests that DDS provide the ICC with a written statement of the progress in this matter by, January 2001.
2. Support the inclusion of therapy professionals as part of the multidisciplinary team to provide therapy assessments and recommendations for infants and toddlers as part of the Individual Family Service Plan process, described in the Early Start regulations, section 52104. (This support includes continued training of Early Start personnel in multidisciplinary team process and may also include adjustment in funding including Medi-Cal allowable billing and rates so that therapists may attend Multidisciplinary Team Meetings.)
3. Develop, implement and monitor a plan to ensure adequate access to therapy services, via: funding for additional therapy time; increasing reimbursement for therapy services; and training and recruiting therapists with early intervention expertise, particularly for under-served areas.
4. Collaborate with the federal ICC to obtain a waiver from HCFA to permit therapists to bill for services provided in a full range of environments, including home and community.
5. Facilitate interagency agreements among DDS, CDE, and DHS pertaining to therapy services that clearly delineate obligations of each agency. The state model should be used as a guide for local agencies in order to foster consistency and efficiency in the referral, delivery, and payment for therapy services. As much as is possible, within their mandates of populations served, consistency in eligibility

should also be addressed. A reimbursement policy between departments should be in place if the responsible agency is not able to provide services. HSC requests that DDS provide a summary of the interagency agreements regarding therapy issues to the ICC by January 2001.

6. Support Interdepartmental efforts to implement a coordinated and integrated service delivery model for infants and toddlers with disabilities. This discussion should examine, but not be limited to, the option of delivering therapy services through a single agency with blended funding and would include support from State level agencies. The HSC requests that the interdepartmental workgroup provide the ICC with a copy of their review and recommendations by January 2001.

Additional issues were raised by the HSC findings that will require further study and discussion, before any other recommendations can be made.

AGENDA ITEM DETAIL SHEET
STATE ICC

APPROVED

APPROVED

Committee
___Committee of the Whole
___Quality Assurance
_X_Public Awareness
___Health Systems
___Family Support
___Bylaws

Item
_X_Action
___Consent
___Discussion
___Information

APPROVED

Date: November 17, 2000
To: ICC Members
From: Elaine Fogel Schneider and Martha Sanchez, Co-Chairs, Public Awareness Committee

Title
Recommendations for California Early Start Strategic Plan for Comprehensive Child Find and Public Awareness for (2000-2003)

Background/Discussion
The Public Awareness Committee has developed recommendations for a strategic plan that identifies potential activities, products and strategies that will assist the lead agency in providing a statewide public awareness program that focuses on early identification of infants and toddlers at risk of or with disabilities. Strategies to disseminate Early Start information to primary referral sources and hard to reach populations is a priority.

The attached plan identifies and prioritizes potential products and activities that address families specifically, personnel development, dissemination strategies and electronic dissemination. Federally required products are also included. A plan to evaluate the effectiveness of child find and public awareness efforts is also recommended.

Recommendation
That the ICC approve the recommendations for the California Early Start Strategic Plan for Comprehensive Child Find and Public Awareness (2000-2003) for submission to the Department of Developmental Services (DDS).

Possible Actions
1. Approve the ICC's recommendations for the California Early Start Strategic Plan for Comprehensive Child Find and Public Awareness (2000-2003) for implementation by DDS.

Interagency Coordinating Council's Recommendations for
CALIFORNIA EARLY START
Strategic Plan for Comprehensive Child Find and Public Awareness (2000 - 2003)

	GENERAL AWARENESS			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	Newsletter • English • *Spanish articles*	tri-annual		
2.	Governor's Proclamation	annually in March		
3.	Information Packets	revise/ reprint		
4.	TV PSA • English • *Spanish*	update English version to reflect a continuum of services	Spanish translation	
5.	*Media Kit*	develop	publish	training
6.	*ICC Calendar with developmental milestones*		develop	publish

	SPECIFICALLY FOR FAMILIES			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	*IFSP brochure*	develop/publish	Spanish	Vietnamese and Chinese

	COMPREHENSIVE SYSTEM OF PERSONNEL DEVELOPMENT (CSPD)			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	*Personnel Recruitment* • *ad* • *brochure* • *poster*	develop and publish brochure	develop and publish ad and poster	
2.	Governor's Conference			
3.	Personnel Development Fund Brochure	disseminate		
4.	*Exemplary sites and practices directory*	develop	publish	disseminate

CALIFORNIA EARLY START

Strategic Plan for Comprehensive Child Find and Public Awareness (2000 - 2003)

	TARGETED DISSEMINATION STRATEGIES			
		FY 00/01	FY 01/02	FY 02/03
1.	Hard-to-reach populations: • Native American • *Chinese (Cantonese/Mandarin)* • *Russian* • *Hmong/Korean/Laotian* • *Cambodian*	Native American Chinese	Russian	Hmong Korean Laotian Cambodian
2.	Health Care Professionals: • *Diagnostic signs wall or desk reference*		complete development of wall/desk reference	
3.	*Other Referring Professionals* • *Referral brochure (generic)*	develop and publish referral brochure		
4.	*Substance Abuse and Perinatal Programs*	develop strategies	implement	
5.	*Child Care Providers:* • *Developmental milestones wall reference*		develop	publish and implement
6.	*Interagency Partners:* • *Healthy Start* • *Early Head Start* • *DSS* • *CDE* • *Probation* • *DHS* • DMH	Early Head Start MOU	develop strategies	implement

CALIFORNIA EARLY START

Strategic Plan for Comprehensive Child Find and Public Awareness (2000 - 2003)

	WEB SITE AND ELECTRONIC DISSEMINATION			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	*Central Directory on DDS web site*			
2.	Early Start Home Page on DDS web site			
3.	*Library data base on-line*			
4.	*ICC information on DDS site*			
5.	*Link to Spanish language web sites*			
6.	*Products on-line*			
7.	WestEd web site			

	EVALUATION			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	Evaluate effectiveness of outreach efforts		develop plan	implement

	FEDERALLY REQUIRED PRODUCTS			
	Product	FY 00/01	FY 01/02	FY 02/03
1.	Annual Performance Report			
2.	Central Directory			

AGENDA ITEM DETAIL SHEET
STATE ICC

APPROVED

Committee
___Committee of the Whole
___Quality Assurance
___Public Awareness
___Health Systems
___Family Support
X Other

Item
X Action
___Consent
___Discussion
___Information

Date: July 10, 2001
To: ICC Members
From: ICC Ad Hoc Committee on Foster Care

Title: **ICC Recommendations on Early Start Collaboration with Foster Care**

Background/Discussion
An ad hoc committee of the ICC was named to review the outcomes of discussions by the ICC Committee of the Whole (COTW) on issues of access and quality of services to infants and toddlers with a developmental delay, or at risk for or with a developmental disability and their families involved in the foster care system. This ad hoc committee was given a charge to complete two tasks and to report back to the ICC COTW. These two tasks are to:

1) Review the short and long term goals to increase awareness of the access for infants and toddlers in the foster care system and their families who may be eligible for early intervention services under Early Start; and

2) Draft recommendations from these goals for presentation and discussion by the full ICC for approval and submission to the Department of Developmental Services (DDS) as lead agency for Part C in California.

Recommendation
The ICC Ad Hoc Committee on Foster Care requests the ICC vote to approve the Recommendations on Early Start Collaboration with Foster Care and submit the Recommendations to DDS, with a copy to the DSS.

Possible Actions

1) Approve the Recommendations in total. APPROVED

2) Amend and approve Recommendations.

3) Reject the Recommendations.

DRAFT 07-10-01

INTERAGENCY COORDINATING COUNCIL RECOMMENDATIONS ON EARLY START COLLABORATION WITH FOSTER CARE

The Interagency Coordinating Council submits the following recommendations to the Department of Developmental Services, lead agency for Part C of IDEA. These recommendations provide advice and assistance on essential interagency strategies to promote and support increasing collaboration among health, human service and education agencies. The focus is on shared responsibilities for serving or administering programs for infants and toddlers with, or at-risk of, disabilities, and their families involved in the foster care system.

1. **State Departments of Social Services (DSS) and Developmental Services (DDS) will review their State Interagency Agreement and revise as necessary.** The IA will address:
    - The need for consistent outreach and information procedures to assure timely referrals from County Welfare Services (CWS) agencies to the regional centers of infants and toddlers, 0-3, who may require early intervention services;
    - Support for encouragement of local interagency activities to include on-going cross-agency and joint training and technical assistance strategies and opportunities,
    - Collaboration in coordination and delivery of services,
    - Mechanism for tracking infants and toddlers that are in both systems including 1) CWS clients referred to Regional Centers and 2) Regional Center consumers referred to CWS needing family preservation or child protective services,
    - Procedures regarding identification and training of Surrogate Parents for children in foster care.

2. **Develop a consistent county level outreach and information procedure.** Such a procedure must assure cross-agency understanding of pertinent issues such as family preservation, supports and services and include:
    - Eligibility criteria
    - Referral and other timelines
    - Local linkages
    - Identification of a tool to assist CWS staff, foster parents and kinship care providers in identifying children who may benefit from early intervention services
    - An all-county information notice (ACIN)
    - Appropriate use and dissemination of the Early Start information packets and Central Directory
    - A mechanism to increase awareness of developmental considerations by the courts and Judicial Council
    - Survival Guide for legal and court personnel
    - Identification of other appropriate strategies and materials.

3. Develop an effective interagency/system cross-training training program. Such a training program will need to focus on:
    - Identification of current state and local cross-agency efforts
    - Agency referral processes, eligibility and timeline requirements
    - Identification and/or development and use of a referral tool (brochure) to assist CWS staff and foster parents in identifying children who may benefit from early intervention services (this tool would also be proposed for inclusion in the CCFC Prop. 10 Parent Kit),
    - Designated agency based liaison staff at the local levels (possibly DSS Public Health Nurses and designated Early Start staff in regional centers)
    - Designation of Surrogate Parents
    - Relationship-based service delivery with a focus on infant-family mental health, social-emotional development and emotional care plans for children in foster care, and the special needs of:
        1) Infants and toddlers at-risk or with developmental disabilities in out-of-home placement through CWS
        2) Foster parents/kinship care providers who are caring for infants with delays and/or disabilities,
        3) Biological parents with children in out-of-home placement through CWS, and
        4) Family members in various "maintenance" programs aiming toward reunification.
    - Consider incorporation of relevant DSS/CWS and Foster Care issues in Early Start Core Institute trainings or target as a Special Topic training event.
    - Development and implementation of local Interagency Agreements or Memoranda of Understanding (MOU).
    - Identification of promising/successful collaborative practices and evaluation for applicability across the state.

4. **Establish a linkage to the DSS Stakeholders group to share information, concerns and recommendations from the ICC and regularly communicate to the ICC on behalf of the Stakeholders.** The committee recommends that DDS/ES Lead Agency representative be so designated. This individual will be asked to coordinate with other ICC lead agency staff from DMH, DHS, DSS and ADP (also represented in the Stakeholders group) as a conduit to ensure two-way communication between CWS Stakeholders and ICC.

California Early Start
IDEA – Part C
California Interagency Coordinating Council (ICC)
Health Systems Committee (HSC)

Recommendations for Vision Evaluation for Children in the Early Start Program

Rationale

It is the responsibility of the Health Systems Committee (HSC) of the Interagency Coordinating Council (ICC) to advise the Council on issues of health and appropriate access to health care. Committee goals include facilitation of service implementation to ensure that all children receive appropriate and timely care. Professionals and families should be provided needed information in regard to health care for the children.

With this in mind, the HSC has reviewed the federal and state legal requirements for vision assessment/screening in order to ensure that all Early Start children receive appropriate evaluation and referrals as necessary.

Importance of Vision Screening/Assessment (VS/A)

Vision is a key sensory ability that plays an important part in child development and function. The development of vision skills is crucial during the first few years of life when the visual portion of the brain is most rapidly growing and forming critical synapses. This is the time of greatest susceptibility to external visual stimulation and also lack of appropriate visual experiences. Therefore, visual problems should be screened for, identified and treated as soon as possible to achieve the best possible outcome.

Adequate vision is especially important in children with health and developmental problems, such as children in Early Start. These children particularly rely on visual skills to help them cope with other medical and developmental challenges. Thus, children in Early Start who have visual problems need special attention to assure their visual abilities are maximized.

Early identification of visual impairment in infants and toddlers is essential to facilitate appropriate treatment referrals and design of early intervention services. Visual problems may be primary (i.e., specific conditions of the eye), secondary (i.e., part of a medical condition, e.g., rubella syndrome) or associated (i.e., may occur related to conditions such as cerebral palsy). In general, eye and vision problems are more common in children with special needs, such as those children in Early Start.

Problem

Early Start monitoring via local site visits conducted by the Department of Developmental Services (DSS) and the California Department of Education (CDE) suggests that children referred to Early Start may not be getting the vision screening, evaluation and referrals necessary to ensure their visual abilities are fully attained.

Issues Identified

- There is confusion regarding interpretation of federal and state requirements for the extent of vision testing. Medical recommendations use the word "screening" for initial evaluation of the eye or vision, and federal law and state regulations use the word "assessment" for the purpose of documentation in the initial IFSP. This document will use the terminology "vision screening/assessment" (VS/A).

- Review of records overseen by the DDS and CDE as part of agency visitation reveals that VS/A guidelines need to be developed and implemented that are consistent and standardized for all Early Start children.

- There is wide variation across the state in what is included in VS/A, who does it and how the resultant data and information are collected, reviewed, and reported.

- Although vision status is reported on the majority of Individual Family Service Plans (IFSPs), the information given via observation is often reported by untrained persons. Although the information may prove to have been correct, there is frequently inadequate documentation to substantiate that trained persons have appropriately screened the children's eyes and vision

- There is confusion about the extent of the VS/A that must be completed prior to the initial IFSP (e.g., screening with referral for further evaluation, or complete assessment prior to completion of the initial IFSP).

Principles of VS/A used to guide the HSC in this review

- Early and appropriate vision screening and referral for necessary evaluation and treatment are guidelines within Early Start for both DDS, CDE and the Department of Health Services (DHS) (also see First Look[ii], p65)

- Primary health care providers (PHCP) should maintain primary responsibility for vision screening, referral and overall medical case management of significant ophthalmologic problems. Early Start case managers should work with the health care providers and families to facilitate necessary care. Private and public health insurance should be available for payment for health related services for most Early Start children with such needs (see First Look, p16-17)

- The required time frame of 45 calendar days from date of referral to Early Start specifies screening within that period. Service coordinators in local Early Start programs at Regional Centers, Special Education Local Planning Areas (SELPA), Local Education Agencies (LEAs) should work with families and primary health care providers to ensure such requirements are met. Further evaluation may occur after this period as specified within the IFSP.

- Vision Screening/Assessment must be conducted by persons who are qualified and trained to utilize appropriate methods and procedures, to base reports on informed clinical opinion, and to include review of pertinent medical and developmental records related to the child's current health status, developmental and medical histories.

- Local Early Start programs must have qualified staff and/or consultants to gather and review information regarding VS/A, and to facilitate and complete such screenings and referrals as necessary and appropriate.

- Personnel "qualified" to provide review of records and vision screening of children should be determined under guidelines established by the state DDS and CDE.

- Approval may be given to local Regional Centers, SELPAs, and LEAs for utilization of "qualified" staff and/or consultants based on local availability and substantiation of skills and ability to perform vision screening and assessment requirements.

- It is essential that a health care professional participates in person or by report as a member of the Regional Center/SELPA/LEA multidisciplinary team for the IFSP meeting.

Screening Guidelines

Federal legislation requires assessment in all developmental areas, including vision (Part C, Section 34 Code of Federal Regulations 303.322). California law provides similar requirements (CA Code of Regulations Title 5, Section 3027). CDE "qualified personnel" are defined in CCR, Title 5, Section 591 and Education Code Section 49452. Specific guidelines for vision screening and assessment are provided in First Look (p19-21).

Other vision screening standards reviewed as part of these recommendations include:

- The American Academy of Pediatrics statements on vision screening (1996[iii] and 2001 revision in Draft[v])
- Policies and Procedures from other states for IDEA Part C
- Procedures used by Regional Centers, SELPAs, and LEAs

Since there are no criteria regarding what information must be documented for vision screening/assessment for the initial IFSP, examples and best practice samples should be developed that demonstrate the minimum information necessary for the VS/A. DDS, in conjunction with CDE, DHS, and professional groups such as AAP, AAFP, AAO and AOA should review standards and advise DDS/CDE regarding minimum guidelines for the initial Vision assessment/screening.

New recommendations, technologies and equipment should be considered for their applicability to VS/A via periodic review by DDS, CDE and DHS representatives.

Local Regional Centers, SELPAs, and LEAs will need to apply the guidelines for VS/A to their particular local needs and situations.

Examiners and Timing

Since eye and vision problems are more common in children with special needs, all Early Start children should have a complete physical examination including examination of the eyes regarding vision by the Primary Health Care Provider (PHCP). As vision status may change, especially in very young children, the PHCP examination should be

completed within a 6 months period prior to the initial IFSP. The primary health care provider should refer the child for a specialty eye evaluation if indicated.

The Early Start system must involve the Primary Health Care Provider. This PHCP may be a pediatrician, family practice physician or pediatric nurse practitioner. If the child does not have a primary health care provider from whom to seek information regarding VS/A, it is the Service Coordinator's responsibility to assist the family in connecting the child to a PHCP where the child will have a Medical Home.

State agencies and local Early Start programs have varying qualifications for VS/A examiners. Minimum standardized requirements are needed to enable Early Start personnel to have the eye/vision information necessary to establish developmentally appropriate IFSPs.

Since it is not always possible to arrange for a vision examination by a PHCP within six months of the planned IFSP, or to obtain information within 45 days prior to the initial IFSP, other qualified persons within the Early Start system may complete the Vision Screening/Assessment, in coordination with the PHCP. Such persons may include:

- Certified Vision Specialists in California Department of Education system

- Licensed Registered Nurses trained in Vision Screening/Assessment working in Schools or Clinics or in Early Start programs

- Other Early Start Health Care Providers such as Speech Language Pathologists, Occupational Therapists, Physical Therapists trained in Vision Screening/Assessment

- Other Early Start Program Staff and Early Interventionists trained in Vision Screening/Assessment

These providers may complete VS/A that can be documented and used for the initial IFSP. It is the expectation that before the next periodic review of the IFSP, the primary health care provider will have evaluated the child.

Other local resources may be used by the Regional Centers, SELPAs, and LEAs to complete VS/A examinations. These resources include:

1) Appropriately trained Regional Center staff
2) Appropriately trained Regional Center health care professionals
3) Health care professionals who are members of the multidisciplinary team as part of a developmental assessment
4) Clinics or other health organization (e.g., contracts)
5) Health care professionals in infant development programs (e.g., contracts with Speech and Language Pathologists, OT's, PT's who are health care providers for MediCal)
6) Parents who receive training to assist in the VS/A process
7) Bright Start and other screening programs as appropriate.

Reporting and Review

DDS and CDE should determine the minimum VS/A findings that must be recorded and reported.

To facilitate both the examination by the PHCP or other qualified examiner in completing the VS/A, a simple standardized reporting form should be developed and implemented by DDS/CDE and provided to the examiners for reporting to the Early Start team.

It is the responsibility of the service coordinators within Regional Centers, SELPAs, and LEAs to:

- arrange for appropriate completion of release of information forms,
- obtain reports regarding VS/A, and
- ensure appropriate review of all VS/A reports by trained and qualified staff prior to the development of the initial IFSP.

Funding

Most VS/A exams should be completed by the PHCP as part of a periodic child health exam. A PHCP may need more time to complete the eye examination for the vision screening/assessment and complete forms for the Early Start child, so additional funding systems and opportunities for examinations should be made available.

The service coordinator may need to assist the family with referrals and connections to the appropriate support agency (e.g., Medi-Cal, Child Health and Disability Prevention (CHDP), California Children Services (CCS), Healthy Families, etc.).

Training

Early Start staffs and PHCPs may benefit from training appropriate for their level of skill and experiences in order to improve the quality of eye and vision information used to develop the IFSPs. This is especially applicable since different disciplines may be asked to complete the VS/A examinations.

Appropriate training curriculums need to be developed for PHCPs, other health care professionals and Early Start staff to ensure children receive necessary VS/A. Information and consultation should be obtained from professional organizations (e.g., AAP, AAO, AOA, AAFP), community organizations (e.g., Blind Babies Foundation), University faculty, agency representatives (e.g., First Look) and others. Parent groups (e.g. Family Resource Agencies) should be consulted regarding ways to improve parental observation of vision and function and sharing of information with examiners. Information regarding new technologies should be included as appropriate. Training should include how Early Start staff can coordinate referrals of children with vision needs to specialists in cooperation with the PHCP, and resources for such expertise (e.g., CCS, Blind Babies Foundation, etc.).

References are provided below to indicate some current VS/A guidelines from professional groups and Early Start agencies.

Recommendations:

1. Vision screening and assessment
   - DDS and CDE, with consultation from appropriate specialty organizations, should determine the appropriate level of VS/A that must be completed for the initial IFSP
   - PHCP should perform the VS/A for the initial IFSP or by the next periodic review of the IFSP
   - Further evaluation and assessment may be specified in the initial IFSP and occur thereafter.

2. Reporting
   - An explanation and simple, standardized reporting form requesting specific eye and vision screening/assessment information from the PHCP or other qualified examiner should be developed in consultation with specialty professional organizations (AAP, AAO, AOA, AAFP) and implemented. This will serve to facilitate obtaining needed information for the IFSP, and to inform the health care provider what information is needed within a specified time frame.

3. Funding
   - DDS, CDE and DHS should consider support systems to allow families without adequate income and insurance to obtain necessary VS/A. This may include authorization of extra CHDP visits to PHCPs to enable timely VS/A examinations.
   - DDS, CDE and DHS should cooperate to facilitate development of primary and specialty resources and appropriate financial compensation to ensure children have access to necessary VS/A and follow up specialty consultation.

4. Training
   - Training curriculums should be developed and implemented in consultation with specialty organizations to ensure appropriate skills for VS/A by PHCPs, other HCPs and other examiners.
   - Training should be provided in collaboration with DDS, CDE, DHS, AAP

5. Monitoring
   - DDS and CDE should include evaluation of the VS/A process during site monitoring visits
   - DDS and CDE should develop an appropriate data collection, monitoring and program evaluation system to ensure that all aspects of the VS/A process (i.e., establishment and implementation of S/A guidelines, examiner qualifications, inclusion of the PHCP, recording of data in client records, reporting of data to local Regional Centers, SELPAs and LEAs and to DDS/CDE, and site visit reviews of vision data) are appropriately implemented and that child functional outcomes are consistent with the child's vision status.

References:

AAP[iii]

Newborn

Gross Exam (cataracts, malformations)

Review of prenatal, perinatal and early childhood histories for infections, retinopathy of prematurity and genetic, medical and developmental information that would arouse concern for vision difficulties

Family History of congenital cataracts, retinoblastoma, metabolic or genetic diseases

Children at risk[iii]

All Health Supervision Visits[iv]

Vision Screening – beginning at age 3 yrs

See First Look Appendix J – Eye and Vision Screening Recommendations for Primary Care Providers p63

AAP Birth – 3 years old[v]

1. Ocular History
   - Family history of eye disorders
   - Family history of early use of eyeglasses (parents and siblings)
   - Questions of parents
     - "Does your child seem to see well?"
     - "Does your child hold objects close to his or her face when trying to focus?"
     - "Do the eyes appear straight or do they seem to cross, drift or seem lazy?"
     - "Do you notice any unusual reflexes or colors from they eyes?"
     - "Do the eyelids droop or does one eyelid tend to close?"
     - See First Look (p12, 23, 31 and 43) for other parent question options

2. External inspection of eyes and lids (lids, conjunctiva, sclera, cornea and iris) See First Look (p13,26) High Risk Signs, Observation of Behaviors and Observation of the Eyes, Level of Vision Development Checklist (p14-15)

3. Vision screening – ability to fix and follow (awake and alert child)
   Fixation:
   - each eye – fix on object
   - maintain fixation
   - follow object into various gaze positions

4. Ocular motility assessment – need to differentiate from pseudostrabismus
   a) corneal light reflex testing
   b) cross cover test
   c) random dot E stereo test

5. Pupils
   a) equal, round and reactive
   b) slow, poorly reactive, asymmetry

6. Red reflex (Bruckner Test) – with direct ophthalmoscope
   a) Both eyes: asymmetric refractive errors, strabismus (3 ft)
      Each eye: color, asymmetry, size, brightness
      Unilateral high myopia, hyperopia and astigmatism: reflexes that are lighter, brighter or bigger

7. Photoscreening: produces red reflex in both pupils – to recognize characteristic changes in the photographed papillary reflex
   Procedure can be fast, efficient, reproducible and highly reliable – for strabismus, refractive errors, cataracts and retinal abnormalities are still in process of development and evaluation.

8. Vision Screening – 2 years (see tips for screening[ii])
   Allen Picture Cards

1. See First Look for other recommendations for vision screening and assessment, including Vision Responses to Stimuli and Visual Reflexes, and Visual Skills (p27-28). Also see Appendix E - Functional Vision Screening Checklist – Level 2 p39-41 and Functional Vision Assessment Checklist (level 2 – p47-50)

[ii] First Look – Vision Evaluation and Assessment for Infants, Toddlers and Preschoolers, Birth Through Five Years of Age

[iii] Eye Examination and Vision Screening in Infants, Children and Young Adults; AAP Committee on Practice and Ambulatory Medicine. Section on Ophthalmology. Pediatrics 1996; 98:153-157.

iv. Recommendations for Preventive Pediatric Health Care, Committee on Practice and Ambulatory Medicine, American Academy of Pediatrics 2001

v Eye Examination and Vision Screening in Infants, Children and Young Adults; AAP Committee on Practice and Ambulatory Medicine. Section on Ophthalmology. DRAFT 2001

vi Decision Tree – HSC January 2001: Flow Chart and Description

Submitted 3/21/02 Health Systems Committee - ICC

1. See Decision Tree[vi]
   Questions:
   - For children not vision screened within the past 6 months upon application to Early Start, should the initial vision screen be done by Early Start staff or the PHCP? Can the PHCP do this within 45 days?
   - Referral to an ophthalmologist should be the responsibility of the PHCP, including coordination and report sharing with the Early Start SC;
   - Are there different screening standards for PHCP v. RC RNs and LEA vision specialists?
   - Are CHDP standards directed to physicians and nurse practitioners?
   - Is there current data to document the reliability and efficacy of LEA vision screening policies as described in First Look?
   - The best format and details for written communication between Early Start staffs and PHCP should be discussed and determined with the interested parties – including provision of vision screening and assessment guidelines to PHCP and the combining of vision with hearing screening information requests.
2. The ICC HSC should formalize the Vision Screening subcommittee with representation from parents, vision professionals, health professionals and early intervention providers
3. The ICC HSC should consult with the AAP California District regarding a desired format and communication process with primary care pediatricians
4. The ICC HSC should consult with the national AAP Section on Ophthalmology and Committee on Children with Disabilities
5. The ICC HSC should consult with other states regarding similar policies for vision screening for Part C children
6. The ICC HSC should consult with California Regional Centers and LEAs
7. The ICC HSC should consult with the pediatric ophthalmologist from DHS Children's Medical Services (CMS) regarding policies, procedures and related vision screening issues

The ICC HSC should consult with DDS and CDE liaisons to coordinate policies and procedures between the two departments to ensure comparable and comparative vision screening of all Early Start children from both programs.