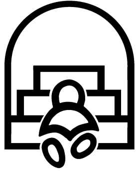
First Steps

UTS TRAINING TIMES

Volume 2 Issue 4 **December 2006**

Inside this issue....

In October 2006, Indiana adopted the Assessment, Evaluation and Programming System (AEPS®) for Infants and Children, Second Edition, 2002, as its sole assessment test for eligibility determination. Prior to October, Eligibility Determination (ED) teams received training in the administration of the AEPS® from AEPS® co-authors, Kristie Pretti-Frontczak, Ph.D., and JoAnn (JJ) Johnson, Ph.D. Additional training is planned for 2007. In the meantime, this issue of the *Training Times* provides an overview of the AEPS® and answers many of the questions submitted by First Steps providers. We are grateful to Brookes Publishing for allowing us to reproduce text and tables from the AEPS® Administration Guide, 2002 and the *Supporting Documentation for Use of the AEPS® to Determine Eligibility for Indiana Part C Teams, 2006.*

Also included in this edition of the *Training Times* is the first issue of the ***Provider Update Newsletter***. The newsletter, published by the Bureau of Child Development Services, provides information on many topics of interest to all First Steps providers.

Finally, this is the last issue of the *UTS Training Times* for 2006. The *Training Times* has published original and reprinted articles on many topics, including; Autism, Transition, Home Visiting, Relationship Based Interventions, Change and Sensory Integration, just to name a few. (Back issues are archived on the UTS-ProKids website, click on Newsletter at http://www.utsprokids.org.) We welcome your comments and suggestions for article reprints or future training topics. You can email us at training@utsprokids.org.

SEASON'S GREETINGS AND HAPPY NEW YEAR FROM EVERYONE AT UTS-PROKIDS

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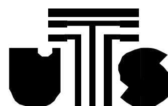

INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

Annual Training Fee Is Now Due

Annually, all First Steps providers are required to register and pay an annual training fee. The training fee offsets the cost of the quarterly Training Times and assessments (February, April, June & Sept, 2007), mandatory provider trainings and maintenance of your online training profile. The training fee remains at $60 and this year's fee is due by December 31, 2006. The 2007 mandatory provider trainings will be offered from March through September. Providers will be notified by email when dates and locations are available. The state has directed that this year's mandatory provider training include an overview of the AEPS, ISTAR and best practices in assessment.

To register and pay your annual training fee go to http://www.utsprokids.org/

- ⇒ Click on Account login in the upper right hand corner
- ⇒ Log in with your user name and password (If you have forgotten your username password click on the 'forgot password' link. AOL users must email registration@utsprokids.org for their username/password as AOL often blocks our automated password system.)
- ⇒ Select 2007 Annual Training Fee Registration
- ⇒ Please review your information and edit your address, email and other information, if needed
- ⇒ Select to pay by credit card (credit card payments are secure and can take up to 10 days to process and appear on your account) or purchase order/check.

A reminder to new providers – the Training Times assessment is taken online at http://www.utsprokids.org/. Please make sure that you have completed the entire assessment before submitting your answers. Failure to answer all questions may result in a failed score. Once a failed score is entered, you cannot receive credential points for completion of the assessment. If you need assistance getting started, please email registration@utsprokids.org.

Finally, it is important to make sure that we have your current mailing and email address. Please check your profile information. We receive many email bounce backs, sometimes because your firewall or security system will not accept our emails. Please set your security to accept *utsprokids.org* to your safe recipient list. If your hospital or agency has an information officer, please ask that our email be added to their safe list.

Attention New Providers and Service Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (http://www.utsprokids.org). Obtaining an account is easy.

1. Click on Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click on Update Info.
5. Register for your mandatory training fee.
6. Once you payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Meg in the UTS Connect office at: registration@utsprokids.org

Indiana First Steps

UTS Training Times

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Web Address: www.utsprokids.org

Email: Training questions training@utsprokids.org

Registration questions: registration@utsprokids.org

Betsy Ray Joins UTS-ProKids Staff

Indiana's First Steps Program for infants, toddlers and families has a unique training system that is committed to a community-based, family-centered, multi-agency system of services. Unified Training System (UTS) was created to be a coordinated effort that provides a variety of learning opportunities for early intervention providers and families. Since the inception of First Steps in Indiana, UTS has been providing quality training. To continue to provide this same level of training and to meet the ever changing training needs of First Steps providers and families, UTS saw the need to add a new member to its staff whose primary responsibility will be to focus on curriculum review and revision. Betsy Ray joined UTS in October of 2006 as its Training Coordinator.

In this role, she will initially focus on reviewing and revising training curriculum for Indiana's First Steps program. Betsy has over 25 years of experience as an educator. She began her teaching career as a high school business education teacher. She then moved into adult education and taught business subjects for AIC School of Business in Iowa and Indiana Business College for 20 years. She was named Teacher of the Year in 1997 at Indiana Business College. In addition to her classroom duties at Indiana Business College, she served as the Business Chairperson responsible for curriculum development, program development, textbook selection, and employer needs assessments. In May of 2003, she completed Indiana University's master's degree in adult education and now serves on the Adult Education Advisory Board at IUPUI. In addition to her full time duties, she also facilitates distance learning courses for IUPUI and is an adjunct faculty member at Indiana Tech.

Upon receiving her master's degree, Betsy accepted a position as a training coordinator for a behavioral health network. In this capacity, she coordinated staff development and training programs, surveyed member facilities to identify training needs, developed an annual training schedule, recruited speakers, provided research assistance to develop curriculum for new training programs, converted current face-to-face curriculum to electronic format for member distribution, and assisted with web page development.

Betsy has been attending both service coordinator and direct service provider trainings as well as attending ICC and SPOE/LPCC meetings to learn about the First Steps program and assess provider and family training needs. Her first two projects will center around the service coordination baseline training and direct service provider orientation. UTS has recognized the need to provide just in time training to newly hired service coordinators, so Betsy will be converting the existing seven service coordination baseline training modules to a form of interactive distance education. Service coordinators can then have immediate access to the basics of the First Steps program which will include the following areas of focus: First Steps history, mission and vision; procedural safeguards; service coordination responsibilities; evaluation and assessment; the Individual Family Service Plan (IFSP); and transition into, within, and out of First Steps. Once service coordinators complete these modules, they will then participate in on-site Service Coordination Level 1 and Level 2 training to both review what they have learned in the distance education setting and to further apply the principles to learning activities provided by face-to-face trainers.

Betsy will also be revising the direct service provider orientation curriculum to include topics directly related to service providers and their responsibilities including but not limited to background information about First Steps in Indiana, working with families and service coordinators, navigating the billing system, completing a Matrix, preparing quarterly notes, participating in IFSP meetings, etc. You can contact Betsy by email at bray@utsprokids.org.

AEPS Chosen for First Steps Eligibility Determination

In October 2006, Indiana chose the AEPS® as the sole assessment test for determining eligibility for the Indiana First Steps program. Prior to this adoption, all ED Team members were required to attend one of three, 2-day training sessions on the AEPS® which were presented by AEPS® co-authors. Additionally, an Indiana AEPS® eligibility determination manual was developed by AEPS®. This manual provides standard deviation (SD) scores of –1 SD, -1.5 SD and –2 SD for each age interval and developmental domain. All potentially eligible children referred to First Steps must receive a complete AEPS® assessment. This assures that all infants and toddlers referred to First Steps receive a global developmental evaluation, even if the concern is only for a specific domain (ex. communication delay) and that entrance data is collected for future OSEP child outcome reporting.

While all providers will have the opportunity to learn more about the AEPS® in 2007, a brief overview is included here to address many of the questions providers have about this assessment test. The AEPS® is a criterion-referenced, curriculum-based assessment (CBA) that was designed to produce a comprehensive and detailed picture of children's behavioral profiles. The preferred means of gathering accurate assessment information from young children is through parent or provider observation of children as they participate in play and daily activities. The AEPS® is particularly useful because items were included only if they address important developmental skills. Consequentially, items can serve as educational goals, and items can be modified (e.g., using sign language or communication boards) to accommodate children's disabilities and interests.

The AEPS® was chosen as the assessment test for eligibility determination by an ICC stakeholder group made up of parents, providers, state staff and other interested persons. A primary feature in the choice of the AEPS® was its design as an authentic assessment. An authentic assessment focuses on the collection of developmental data on children while they engage in typical routine and play activities in familiar settings. Authentic assessments have been specifically designed to overcome many of the challenges of using traditional standardized norm-referenced tests.

"Curriculum-based assessment (CBAs) are defined as "a form of criterion-referenced measurement wherein curricular objectives act as the criteria for the identification of instructional targets and for the assessment of status and progress" (Bagnato & Neisworth, 1991, p. 97). CBAs are considered authentic forms of assessment because assessment data are collected through observation of children in familiar setting as they engage in routine and play activities. Further, most CBAs typically are composed of functional items that produce results that can be used to develop educationally and therapeutically relevant goals and intervention content.

The use of the AEPS® Test to determine eligibility produces at least three important benefits.

1. First, the AEPS® Test is a comprehensive curriculum-based assessment and therefore the information derived from the AEPS® Test during eligibility determination can be used for multiple purposes: 1) to help establish eligibility for services, 2) to develop meaningful, functional, and developmentally appropriate outcomes/goals, and 3) to create effective intervention content and procedures. The information from a completed AEPS® Test provides intervention personnel with an array of useful developmental information that can be used directly to create developmentally appropriate goals and intervention content.

2. A second benefit accrues because agency and program personnel can save time and valuable resources. Administration of the AEPS® Test can be done by a wide variety of personnel and adults who are familiar with the child, giving SPOEs and ED teams flexibility in who is involved and coordination of assessment efforts. Further, information gained from the AEPS® Test can be used more productively to develop quality goals and implement effective intervention strategies.

3. Third, using the AEPS® Test to determine eligibility meets all Division of Early Childhood recommended assessment practices (Sandall et al., 2005) as well as the recommendations of the President's Commission on Excellence in Special Education, 2002. The assessment recommendations issued by these bodies represent the most current and effective information available to the field of EI/ECSE and, consequently, it is essential to follow such recommended practice to ensure offering children and their families the highest quality services." (Supporting Document for Use of the AEPS®, 2006, pages 5, 6, & 7)

Assessment, Evaluation and Programming System — AEPS®

Reprinted with permission from Brookes Publishing, Assessment, Evaluation and Programming System for Infants and Children, Second Edition; 2002 . The AEPS® Administration Guide, AEPS® Level I Test and Curriculum for Birth to Three can be ordered from Brookes Publishing at (800) 638-3775 or at http://www.brookespublishing.com/store/books/bricker-aeps/index.htm. Brookes Publishing also offers an online interactive AEPS® at http://www.aepsinteractive.com/. For a limited time, you can sign up for a free 30 day trial.

(*Excerpted from Assessment, Evaluation and Programming System for Infants and Children, Second Edition; Chapter 3. The following serves only as an overview of the AEPS®. Providers wishing to use the AEPS® in their practice need to study the Administration Guide, and/or attend formal training and practice.)*

The AEPS® collects comprehensive information on the developmental status in six domains: Fine Motor, Gross Motor, Adaptive, Cognitive, Social Communication, and Social. Each domain area encompasses a particular set of skills, behaviors or information.

Each developmental area is divided into strands. Table 1 provides an overview of the six areas and the stands for each. Strands consist of related groups of behaviors organized under a common category; for example, behaviors relating to large muscles movements used in play are grouped in the Play Skills strand of the Gross Motor Area. Each strand contains a series of test items called goals and objectives.

Table 1—Overview of the Areas and Strands for AEPS®

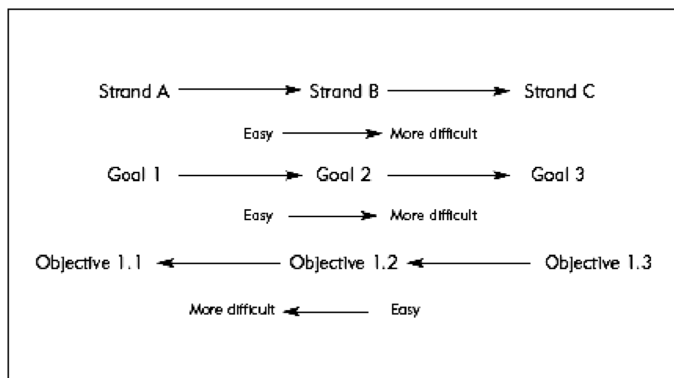
Areas	Birth to Three Strands
Fine Motor	A. Reach, Grasp, and Release B. Functional Use of Fine Motor Skills
Gross Motor	A. Movement and Locomotion in Supine and Prone Position B. Balance in Sitting C. Balance and Mobility D. Play Skills
Adaptive	A. Feeding B. Personal Hygiene C. Undressing
Cognitive	A. Sensory Stimuli B. Object Permanence C. Causality D. Imitation E. Problem Solving F. Interaction with Objects G. Early Concepts
Social-Communication	A. Prelinguistic Communicative Interactions B. Transition to Words C. Comprehension of Words and Sentences D. Production of Social-Communicative Signals, Words, and Sentences
Social	A. Interaction with Familiar Adults B. Interaction with Environment C. Interaction with Peers

The Objectives represent components of the goals or more discrete skills. AEPS® Test items within a given strand are sequenced to facilitate the assessment of a child's ability to perform a particular behavior within a developmental sequence of skills.

Whenever possible, strands and goals have been arranged from easier to more difficult or developmentally advanced skills. The objectives associated with each goal are arranged in reverse sequence—that is, generally the most difficult items occur first and the less difficult items follow sequentially. The strands, goals and objectives were arranged to facilitate test administration, for example, if a child performs a more advanced objective within a sequence of objectives, then the assessment of earlier objectives within the sequence is generally unnecessary.

The hierarchical nature of the strands, goals and objectives is shown in Figure 1. The identification system associated with strands, goals and objectives reflects the sequential arrangement. The user can choose to assess one area at a time or assess across areas as items are observed. The latter procedure is more efficient, but requires greater familiarity with the AEPS® Test.

Figure 1—Hierarchical arrangement of strands, goals and objectives



The AEPS® Test includes three methods of collecting assessment and evaluation information: observation, direct test and report. **For eligibility, ED Teams are to apply the direct test criteria, to their observations and caregiver report.**

Items on the AEPS Test are scored with a 2, 1 or 0. When a child consistently meets the criterion as specified on the Child Observation Data Recording Forms with Criterion, then the item is scored a 2. See Table 2 for examples of how the AEPS Test item would be scored when comparing the child's performance with stated AEPS® Test criteria. The Child Observation Data Recording Forms must be used for eligibility determination because the child must be assessed on the specific criterion for each item.

Table 2.

AEPS Test item and criterion	Score	Child's performance
Goal: **Alternates feet walking up and down stairs**	2	Child independently and consistently walks up and down a variety of stairs alternating feet
Criterion: **Child walks up and down stairs, alternating feet without holding handrail or wall.**	1	Child walks up stairs at home but does not walk up stairs at school or Grandma's house **OR**
	1	Child walks up stairs independently but needs to have help when coming down stairs **OR**
	1	Child does not alternate feet going up or down stairs
	0	Child does not walk up or down stairs with or without assistance

As previously noted, for eligibility purposes, children are assessed using the Direct Test scoring guidelines, as shown in Table 3. Using the direct test scoring guidelines holds the child to the highest standard, helping to assure that children who truly meet Indiana eligibility guidelines are found eligible.

Table 3. Scoring Guidelines for AEPS® using Direct Test

Direct test	
2 = Consistently meets criterion	Child performs the item as specified in the criterion on at least two out of three trials. Child performs the item independently on two out of three trials. Child uses the skill on two out of three trials across time, materials, settings, and people.
1 = Inconsistently meets criterion	Child performs the item as specified in the criterion on one out of three trials. Child performs the item with assistance on one out of three trials. Child performs only portions of the item or certain aspects of the specified criterion on one out of three trials. Child performs the item under one situation or one set of conditions.
0 = Does not meet criterion	Child does not yet perform the item as specified in the criterion on zero out of three trials when assistance is provided or when modifications and adaptations are made. Child was not observed performing the item because it is not expected based on knowledge of development (e.g., the child's chronological age is 6 months and he or she would not be expected to perform such items as categorizing similar objects, copying simple shapes, or walking up and down stairs); thus, no trials are given.

AEPS® has four guidelines for scoring.

1. All goals should be assessed and scored.
2. If a goal is scored as 0 or 1, then all associated objectives should be assessed and scored.
3. The 3 point scoring options (2, 1, 0) should be used with all items scored.
4. When items are directly tested or information is obtained through report, corresponding scoring notes should be so indicated on the Child Observation Form.

A step-by-step summary of how users can compare children's area goal scores with the AEPS® cutoff eligibility scores for the purpose of determining eligibility is contained in Table 4 on page 7. The AEPS® test for eligibility determination can yield one of three outcomes.

1. The child's scores are above the cutoff scores for his/her age level in each domain. The child's development is typical and he/she does not meet eligibility for First Steps.
2. The child's score is at or below the cutoff scores for his/her age level in any domain, but the score is not at the level of –1.5 SD in two domains or –2 SD in one domain. The child's development is atypical in one or more areas, but the degree of developmental delay does not meet Indiana's eligibility criteria. The child is not eligible for First Steps. (Refer to Step 4, page 7)
3. The child's score is at –1.5 SD in two or more domains (excluding –1.5 in ONLY gross and fine motor) or –2 SD in any one domain (including gross and/or fine motor). The child meets Indiana eligibility for First Steps.

Preliminary studies on the effect of the change in Indiana's eligibility rules predicted that approximately 10% fewer children would be eligible for First Steps services; specifically those children who previously were eligible at 15% or –1 SD delay in two areas or a 20% or –1.5 SD delay in one area.

In October, with the introduction of the AEPS, the Bureau of Child Development Services (BCDS) reviewed every ED Team evaluation. The previous predictions have held and the state is experiencing a decrease in the number of children found to be eligible for First Steps. The BCDS has working with SPOEs and Service Coordinators to help identify other resources for families and children who have atypical development, but who are not eligible for First Steps.

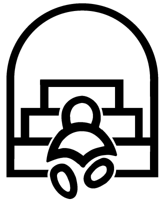
Table 4. Step By Step Instructions for using the AEPS® to determine eligibility for Indiana First Steps (Supporting Document for Use of the AEPS®, 2006, pages 8, 9, & 10)

Step	Procedures
Step One: Select Appropriate Level of the AEPS® Test to Administer and Score	Calculate the child's chronological age (CA) Select Level I of the AEPS® Test if a child's CA is between birth (0) and 36 months Select Level II of the AEPS® Test if a child's CA is between 37 and 66 months (eligibility cutoff scores are not provided for the 67-72 month interval)
Step Two: Administer and Score the Chosen Level of the AEPS® Test	Review procedures for administering the AEPS® outlined in the 2nd edition AEPS® Administration Guide Use observation, report, and/or direct test to assess a child's performance across the 6 developmental areas Observe a child's performance in vivo where scores and notes are made directly onto a paper copy of the Child Observation Data Recording Form (CODRF), or by taking notes during the live observations and then assigning scores and notes through retrospective conversations and debriefings. Obtain information regarding a child's performance on all AEPS® Test **goal** items Compare a child's performance to each goal's stated AEPS® Test criteria and assign a score using the three-point scoring option (2, 1, or 0) Assign scoring notes (e.g., Q, B, A) and other important comments regarding the child's performance onto the CODRF
Step Three: Calculate Area Goal Scores	Calculate an Area Goal Score for each of the 6 developmental areas of the AEPS® Test Calculate an Area Goal Score by adding together the raw scores assigned to each **goal** within a given developmental area (i.e., sum the 2s and 1s together)
Step Four: Determine Eligibility Status	Compare the child's Area Goal Score for each of the 6 developmental areas with the corresponding area cutoff score for the appropriate age interval Locate a child's chronological age within the intervals provided on the tables contained in Appendix A of this manual Child's development is not delayed if the child's Area Goal Score is **above** the cutoff for a given area Child's development is delayed if the child's Area Goal Score falls **at or below** the cutoff for a given Area Follow state/territory eligibility guidelines in determining the child's status Compare the child's Area Goal Score to the standard deviations (SD) found in Appendix A of this manual Determine if Area Goals Scores are **at or below** 1.5 SD in **two or more areas** or **at or below** 2.0 SD in one area to assist in making an eligibility determination

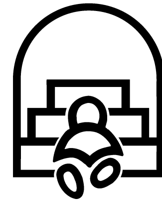
UTS-ProKids is planning its second annual Service Coordination Conference for May 2007. This conference is developed especially for Intake and Service Coordinators, although parents and direct service providers are welcome to attend.

We are looking for interested intake/service coordinators who would like to participate on the planning committee. Contact Mindy Dunn at mdunn@utsprokids.org if you would like to help. Mindy is also interested in ideas for speakers and break out sessions.

Check out the UTS web site for updated training information
http://www.utsprokids.org



Indiana First Steps
Early Intervention System Provider Update Newsletter
November 2006 Volume 1, Issue 1



Welcome to the first issue of the Provider Update Newsletter. This is a way for the state to communicate important information to all First Steps providers. We would encourage you to send your questions, comments and feedback to the First Steps website at: firststepsweb@fssa.state.in.us. Please use the volume and issue number as a reference if you need clarification about something in one of the issues. We will respond as quickly as possible.

Services within the IFSP Written for 7 Months

IFSPs will continue to be written for a one year period, however, as a general rule, services will only be authorized for a maximum of seven (7) months at a time. This will allow the team to hold the 6-month IFSP meeting and review the outcomes to determine what modifications are needed. Once the team determines which services are necessary to assist the child and family in meeting the IFSP outcomes, the Service Coordinator will obtain the appropriate signatures from the parent and primary care physician. With good planning, services should never lapse.

To assist with the planning and preparation of the IFSP meeting, the ongoing therapists must get updated progress reports to the Service Coordinator 14 days prior to the meeting. This will allow time for the Lead ED Team member to review the reports and actively participate as a team member. If the ongoing therapist fails to get the report to the team prior to the review meeting, services will not be authorized until the team has an opportunity to review the report and the service recommendations.

Progress Reports: Ongoing providers are responsible to get a progress report to the Service Coordinator at the **beginning** of the **3rd, 5th, 9th, and 11th month of the IFSP**. We always go by the date the IFSP was written to determine these dates. These reports must reflect the outcomes you are working on as listed in the IFSP and update the progress that has been made towards the written outcomes. You are also responsible to review these reports with the family before any IFSP meetings.

Change in Eligibility: Indiana's Eligibility Definition

New eligibility guidelines for First Steps Early Intervention Services went into effect on May 1, 2006. Each state is responsible for defining its eligible population within the parameters set by IDEA. While Indiana did tighten its definition of developmental delay, eligibility remains broad in comparison to other states.

In Indiana, eligible children must have a developmental delay or medical condition that has a high probability of resulting in a developmental delay, be birth through two years of age and be in need of early intervention services. Eligibility is determined by a multidisciplinary team using multiple sources of information and must be re-determined annually. Indiana has defined eligibility in two categories.

Developmental Delay

Children shall be considered eligible to receive early intervention services if they are experiencing developmental delays, as measured by standardized assessments or criterion-referenced measures. A developmental delay is defined as: (1) delay in one or more areas of development as determined by: (A) two (2) standard deviations below the mean; or (B) twenty-five percent (25%) or more in function below the chronological age (adjusted for prematurity, if applicable) on an assessment instrument that yields scores in months; or (2) a delay in two (2) or more areas of development as determined by: (A) one and one half (1 ½) standard deviations below the mean; or (B) twenty percent (20%) or more in function below the chronological age (adjusted for prematurity, if applicable) on an assessment instrument that yields scores in months (Rule 7. Eligibility 470IAC3.1-7-1). The five developmental domains include: cognitive development, physical development, including vision and hearing, communication development, social/emotional development and adaptive development.

High Probability of Development Delay - Diagnosed Physical or Mental Condition

In order to be eligible in this category the child must have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Specific diagnoses and conditions of eligibility are defined in Indiana law. These diagnoses and conditions must be supported by a physician or psychologist indicating what the physical or mental condition is and a multidisciplinary evaluation report that Early Intervention services are needed. The categories include:

- Chromosomal abnormalities or genetic disorder;
- Neurological disorder;
- Congenital disorder;
- Sensory impairment, including vision and hearing;
- Severe toxic exposure, including prenatal exposure;
- Neurological abnormality in the newborn period;
- Low birth weight of less than or equal to one thousand five hundred (1500) grams

Informed Clinical Opinion

Informed clinical opinion is the opinion of the eligibility team (including the SC and parent) that, based on clinical evidence, the child has a delay or delays that meet the State's eligibility guidelines. Your team would use informed clinical opinion when there are no criterion referenced or standardized tests that are appropriate for the child or the child's disability. In the event that a test is used that does NOT accurately capture the child's development, the team may document why the test observations/results are not accurate as well as where the child is developmentally.

Because the AEPS utilizes a variety of assessment activities, including: parent report, structured observation, health information, other caregiver report, it may not be necessary to complete another assessment (test).

We do know that, like most (if not all) assessments for birth to 3 months, the AEPS is not able to provide a true report of a child's abilities in the form of a "score". Therefore, for children birth up to age 3 months, the team will complete the AEPS and will use informed clinical opinion (based on the evidence collected during the AEPS and document review) to substantiate a developmental delay meeting the State definition.

Because informed clinical opinion is the collective agreement/opinion of the eligibility team, which includes the parent and SC working with the family, eligibility must be established during the eligibility meeting. If providers cannot attend the meeting, they must submit their written statements supported by evidence for discussion.

Informed clinical opinion is not the right of the team to simply override the scores provided by a standardized or criterion referenced test. Therefore, if the AEPS is appropriately administered, and the scores show that the child does not meet a standard deviation meeting eligibility, it is not within the right of the team to override the scores, making the child eligible. IF the team feels that the child should be eligible, there must be evidence to show that the test was not appropriate for the child in determining scores and/or that critical information was "missed" and therefore, the assessment was not complete or accurate. In that case, the team could update the test (NOT simply change scores) based on the new evidence.

Based on the new eligibility criteria, Indiana will see an increase in the numbers of children that do not meet eligibility guidelines. It is anticipated that the increase will be approximately 10% over last year. Because there will be children that would benefit from services, but are not eligible for the program, the State will be working with the LPCCs and SPOEs in identifying local resources that are available.

AEPS (Assessment, Evaluation, Programming System for Infants and Children)

(***Please refer to Training Times 12/06)***

October 1, 2006 was the date the AEPS went into effect for determining eligibility for children in First Steps. We are using it at initial and annual evaluations. This is a comprehensive system that ties together assessment, goal development, intervention, ongoing monitoring and evaluation. The AEPS yields educationally relevant, meaningful and functional information that can be used to formulate developmentally appropriate goals, outcomes and objectives/benchmarks for children. It is linked directly to intervention content and procedures offered in the curricular components of the AEPS. This allows the AEPS to form a comprehensive and linked system that permits using assessment results to develop intervention content and to monitor child progress.

The state will be offering an AEPS Overview training to all providers beginning Spring 2007. This will be included in the annual mandatory training for First Steps providers. Stay tuned for dates and locations in future issues of the newsletter.

Face-to-Face Forms

(*Reminders, Please refer to Training Times 12/06)*

Every provider must have documentation of their direct therapy time with each family. Attached is a form to use. You may personalize the form to meet your needs as long as the content is the same as the sample form. (See Attached Form) You may also find a copy of the form at: http://www.state.in.us/fssa/first_step/pdf/facetoface.pdf A copy of the billing documentation requirements may be located at: http://www.state.in.us/fssa/first_step/pdf/issue037A.pdf Please remember, if you do not have complete and appropriate documentation to support the delivery of service, you may not seek reimbursement from the First Steps system. Documentation must include all of the elements included on the face-to-face form. Specific detail should be given to including the actual start and end time of the session and the parent's signature, as these are common errors that result in repayment of

funds. In addition to the items on the form, please remember that when billing, you may only claim payment for whole billing units (15 minutes). You may **NOT** round-up time to the next unit.

Developmental Therapy White Paper

Attached you will find a white paper defining developmental therapy. The paper will also provide a description of who would benefit from this service. While a Developmental Therapist is not typically licensed, they do provide experience and knowledge in early childhood development. Like any provider or therapist, a Developmental Therapist should not practice outside of their credential or training. For example, a Developmental Therapist may not do any feeding activities with children, who have oral motor dysfunction, feeding tubes or other medical conditions that may predispose them to aspiration or other medical complications, unless they are specially licensed, trained or certified to perform oral feeding therapies.

Request for Change or Addition in Service with ED Team Response

Changes to the IFSP must be reviewed and supported by the IFSP team, including the ED team, parent and Service Coordinator. To facilitate this process, the ***change in service*** form has been updated and is attached. Ongoing providers must use this form to initiate a change in service to a current IFSP. It is the ongoing provider's responsibility to start this paperwork and submit it the ongoing Service Coordinator. This is true even if the family is suggesting a change. The Service Coordinator will then coordinate communication with the team and parents regarding the suggestion. If the change is supported by **all** team members, the Service Coordinator will add the change to the IFSP change page and will obtain the signature of the parent and primary care physician. Once both signatures are obtained, the provider is authorized to provide services. If the team is not in complete agreement, it may be necessary to gather more information to support the listed change. Service providers should receive a copy of the change and see their authorization on Web interChange within 10 days from the signatures.

How to contact us

If you have questions that cannot be answered by your local SPOE, please feel welcome to email the First Steps web at firststepsweb@fssa.in.gov. If you require immediate assistance, you may contact a First Steps consultant. Below you will find the contact information for the consultants along with their specialty assignments:

Provider enrollment Provider relations Training ED teams	Janet Ballard	317-234-4494
LPCC liaison UTS liaison Contract development Web liaison	Mary Chalmers	317-234-4380
Complaints Quality Assurance Prior Authorizations	Kelli Plummer	317-234-3476
SPOE/CRO liaison Data	Cathy Robinson	317-233-6094

This paper was developed with input from the 1/27/97 meeting of the Central Directory, Comprehensive System of Personnel Development and Personnel Standards Committee. On May 14, 1997, the ICC adopted this white paper as a recommendation to the lead agency for consideration when developing policy around Developmental Therapy. On August 13, 1997, the state lead agency adopted this position statement as the basis for all policy related to developmental therapy in the First Steps Early Intervention System.

What is Developmental Therapy and who is Likely to Benefit?

Developmental therapy is a specific, individualized and focused intervention designed to promote an eligible child's motor, cognitive, language, and socio-emotional development as well as self-help skills. Not all infants and toddlers with disabilities will require developmental therapy. Those children who are most likely to benefit from this early intervention service have delays in more than one area of development and require enhancement of their specialized services (physical therapy, occupational therapy, speech/language therapy) through the integration of those services into functional activities across developmental domains. Children with mild delays in one or more areas of development may benefit from developmental therapy as a more appropriate intervention service rather than intensive specialized therapeutic intervention services.

Developmental therapy is an appropriate strategic intervention when it is a planned, individualized interaction that is documented and deemed necessary to address the infant/toddler delays and when incorporated into an IFSP outcome(s).

What Do Developmental Therapy Specialists Do?

Developmental therapy specialists design specific, individualized and focused direct intervention strategies that promote the acquisition, integration and generalization of knowledge and skills included on the IFSP across all developmental domains (motor, cognitive, language, socio-emotional, and self-help). These strategies involve planning and arranging the learning environment, including activities, materials, time and space as well as planned interactions with peers and adults that promote the successful achievement of IFSP outcomes.

Developmental therapy specialists may also provide follow through services that enhance the outcomes resulting from specific therapeutic interventions within the IFSP. Developmental therapy specialists may provide specific, focused and direct intervention with infants and toddlers, and they may intervene indirectly by providing families or early childhood educators with information, skills, and support for implementing specialized intervention plans in the home or in a community early childhood setting through planned consultative services.

What is Appropriate Training for a Developmental Therapy Specialist?

A developmental therapy specialist should have formal training in the six competency areas for service providers listed in the First Steps Personnel Guide (p.13)

These include:

I. Foundations of Early Intervention

II. Infant and Toddler Typical and Atypical Development

III. Infant/Toddler and Family Assessment

IV. Early Intervention Service Delivery Strategies

V. Family Partnerships and Support Strategies

VI. Team Relationship Skills

Developmental therapy specialists have been formally trained in curriculum and intervention strategies, including but not limited to:

- development and assessment of individual learning programs that address IFSP outcomes, including determining the effectiveness of intervention;
- implementing recommended practices for enhancing the development of infants and toddlers;
- working with families and other adults involved with the child or family, including team membership, collaboration, and supervision of adults;
- supervised field experiences that supplement formal classroom education.

AEPS® Train-the-Trainer Course

UTS will offer an AEPS® Train-the-Trainer course for a limited number of providers meeting AEPS® trainer requirements. This course will be directed by AEPS® co-authors, Kristie Pretti-Frontczak, Ph.D. and JoAnn JJ Johnson, Ph.D. Participants must have attended one of the 2-day AEPS® trainings and have experience in administering the AEPS®, Second Edition. UTS is seeking ED Team members, of all disciplines, who are interested in training providers to use the AEPS.

The AEPS® Train-the-Trainer course is tentatively scheduled for Friday, Febraury 16th, 2007 in Indianapolis. There will be no charge for participants to attend, but each participant will be required to assist in at least one, 2-day, AEPS training for First Steps providers in 2007. AEPS trainers will be compensated for facilitating these trainings. If you are interested in becoming a UTS AEPS trainer, please email UTS at training@utsprokids.org for additional information.

First Steps

Request for Change or Addition in Service with ED Team Response

To be completed by requesting provider and forwarded to Service Coordinator:

Child's Name: ____________________________ ID# ________________________ DOB: ___________

SERVICE	CURRENT		CHANGE REQUEST		PROVIDER NAME	PHONE#	Justification
	Duration	Frequency	Duration	Frequency			Y/N

Request is for: ____Change in Current Service; ____Change in location: ____Addition of new service

Requesting Provider Signature ______________________ Date ______________ Provider Phone Number ______________

Service Coordinator ______________________ Date ______________ Phone Number ______________

- -

Justification:

____

____

____

____

Ideas/Strategies already utilized:

____

____

Documented Communication with team:

____

____

** **ED Team Use Only** **

___ **Support Request** ___ **Need additional information to support request**

ED Team Comments:

____

____

____

____

Signature of ED Team Member ______________________ Date ______________ Billable Time ______________

Frequently Asked Questions About the AEPS®

Why did Indiana choose to use the AEPS for First Steps eligibility determination?

1. Indiana wanted a consistent tool that could provide a percent delay or standard deviation score, as required by Indiana rules, to determine eligibility. Prior to October 1, 2006, many different tools were used to determine eligibility. The vast majority of these tools did not provide any type of score. The move to one approved test improves consistency across the state. A child in Evansville is held to the same standard as a child in Ft. Wayne or Indianapolis.
2. Indiana needed an assessment tool to measure child outcomes now required by the Office of Special Education (OSEP). Beginning in 2006, Indiana is required to measure child performance at entry and exit from Part C and report child progress in its annual report to OSEP. Improvement in development is used to measure these child outcomes.
3. ED Teams were not always assessing children in all domains as required by Indiana and federal laws. Many children referred to First Steps were only receiving assessments in the areas of concern. This was especially true of children with "speech only" delays. AEPS provides a global assessment of the child's development.
4. ED Teams were using only parts of some assessment tools, calculating age ranges and percent delays based on tools that were not designed to provide them (EX. HELP). Many of the assessment tools used were not developed to yield an age equivalent score. Providers have been reviewing the child's developmental skills and assigning their own interpretation of the child's developmental age.

Why don't AEPS® test items have age equivalents?

Most traditional standardized norm-referenced tests and some criterion-referenced assessments provide users with age equivalent scores; however, there are a number of problems with this practice. First, for many tests the age associated with a given item is not determined empirically; rather the item's age assignment is based on the age assignments of similar items in other tests. For example, the Gesell is frequently used to determine the age equivalent of items for newly developed tests. This is problematic because the Gesell data are not current, the items may differ in wording and criteria, and the larger context of the test may differ (observation versus direct test). Such differences likely affect the age equivalency of individual items. Second, age equivalencies do not inform teams as to a child's strengths, emerging skills, or needs. Third, having chronologically-based ages assigned to items may lead interventionists and caregivers to select intervention targets based on the age level of an item rather than selecting items that address children's current developmental needs. These significant drawbacks resulted in the adoption of empirically derived cutoff scores rather than using age equivalencies for AEPS test items.

Should I adjust for prematurity?

Yes, adjusting for prematurity may be important if the infant was one or more months preterm. Use of the actual date of birth, during the first two years of life for preterm infants may lead to inappropriate developmental expectations. Adjustment for prematurity is done to make more accurate determinations of the child's developmental skills (or maturity) based on his or her expected date of birth rather than the actual date of birth. Age adjustment or correction is done by subtracting the months a child is preterm from their chronological age (CA) when represented in months. For example, a child who was 2 months premature, and whose CA is 18 months would have an adjusted age of 16 months. If adjusting for prematurity then the adjusted age would be used when locating the appropriate month interval within the tables.

Can an Area Goal Score other than a whole number be calculated for a child?

No, based on AEPS test scoring rules, a child's Area Goal Score can only result in a whole number even though there are eligibility cutoff scores that include decimals.

(Continued on pages 16 & 17)

Frequently Asked Questions About the AEPS

How does AEPS support best practice for assessment in early childhood?

AEPS is a curriculum-based assessment developed as a strong alternative to norm-referenced tests to support the delivery of quality instruction and intervention to children with delays or disabilities and their families. AEPS meets NAEYC and DEC guidelines for early childhood assessment and supports best practice in the following critical ways:

- AEPS is an *authentic* assessment that relies on observations of a child in natural learning environments (e.g., home, classroom) during everyday activities (e.g., play, mealtime) rather than a in contrived arrangement in an unfamiliar testing room.
- AEPS permits modifications and accommodations for individual differences and needs and is sensitive to small increments of change in children's behaviors.
- AEPS links test items directly to effective interventions to inform programming and ensure that children make progress over time.
- Assessment with AEPS is collaborative, relying on the observations of multiple practitioners, and ensures that parents contribute by observing and making judgments as team members. AEPS tools such as the Family Report and Child Progress Record keep families involved across all phases of assessment, intervention, and evaluation.

AEPS consists of functional, measurable, and teachable skills that are meaningful to the child and family in everyday life. For example, rather than focusing on whether a child can fit 8 pegs into a test pegboard, AEPS assesses how the child is able to fit his own real-life items into his defined spaces.

How does AEPS request and use input from parents? What functions does AEPS have for reporting to parents?

An integral part of the AEPS assessment, the AEPS Family Report provides parents and caregivers with the opportunity to describe their child's interest, participation, enjoyment, and/or difficulties in daily activities, family activities, and community activities. As part of the Family Report, parents complete an assessment of their child's skills that has a one-to-one correspondence with the goals assessed by the AEPS Test. The AEPS developers strongly encourage family participation in assessment to help identify the child's strengths and needs. AEPS users are also strongly encouraged to include the family's priorities for intervention, also included on the Family Report, in all intervention programming.

Families love the AEPS Child Progress Record, which provides a graphical view of a child's progress across all of the developmental domains and is a critical tool providers can use to support their collaboration with parents. In Spring 2007, parents and families will be able to join the online collaborative space of AEPSi, where the Child Progress Record will be available with the click of a button. Parents will also be able to complete the Family Report online and read the Child Journal for their child, as well as contribute entries on the progress they see their child making at home.

How do I determine if a child has a delay in physical development when the AEPS® Test is composed of both Fine Motor and Gross Motor items?

In Indiana, a child's physical development would be considered delayed if they had an Area Goal Score that was at or below -2.0 SD in **either** Fine Motor **or** Gross Motor. If however, the child's Area Goal Score falls at or below -1.5 SD delay in the Fine Motor and/or Gross Motor area, teams would consider this just one area of development that is delayed and the child would need to demonstrate another -1.5 SD delay in at least a second area of development (i.e., Adaptive, Cognitive, Social-Communication, or Social) to be determined eligible for Part C.

Will all providers be required to use the AEPS?

The AEPS is only required to be completed for eligibility determination. Providers may continue to use their preferred assessment tool for curriculum planning and measuring progress. Providers do need a basic understanding of the AEPS and its scoring to understand eligibility decisions. In addition to the information provided in the *Training Times,* providers will have the opportunity to attend AEPS training in 2007.

Is the AEPS a reliable test?

Since 1984 numerous grant-funded studies, many supported by the U.S. Department of Education Office of Special Education Programs (OSEP), have demonstrated the system's reliability and validity in assessing and developing appropriate goals for young children. Some specific findings:

- AEPS is **valid and reliable** and has been shown to have concurrent validity with the *Bayley Scales of Infant Development* (AEPS Birth to Three) and the *McCarthy Scales of Children's Abilities* (AEPS Three to Six).

- **Treatment validity** studies prove that the AEPS Test improves the quality of services delivered to children and produces *measurable child performance outcomes that surpass expectations*. Interventionists have been found to create significantly higher quality IFSP/IEP goals with AEPS—goals that are measurable, more functional, easier to sequence, and easier to integrate into daily activities. One study also showed that using the AEPS Test shaves an average of 57 minutes off the time it takes to create an IFSP/IEP for each child.

- **Item analysis** studies confirm that AEPS items are arranged from simple to more complex in each developmental area, demonstrating appropriate developmental skill sequencing.

- A study of the **effectiveness of AEPS family measures** found that interventionists using AEPS include significantly more family-related outcomes on children's IFSPs, which improves families' satisfaction with their child's progress and the child's program.

- A substantial **majority of AEPS users** find that instructions for administration are clear, test results are highly useful for developing intervention plans, and test items cover their pressing concerns for the children they teach.

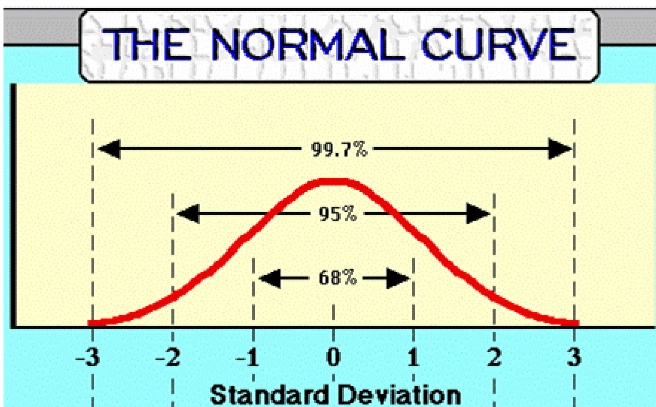
Why does the AEPS use standard deviations from the norm in place of percent delay.

As noted previously, the AEPS® does not assign age equivalents to its items. Assessments that do not assign an age equivalent cannot provide a percent delay; which would be based on chronological age and the corresponding age equivalent of the child's performance on the test.

In research, the authors of the AEPS have identified standard deviations for each age interval in each domain area. Indiana rules have always provided for the use of standard deviations to determine eligibility.

What exactly is a standard deviation?

The standard deviation measures the spread of a distribution around the mean. A normal distribution is mainly defined by the mean and standard deviation and is illustrated as a bell curve. These parameters give an easy way to summarize data as the sample becomes large: 68% of the values are within one standard deviation of the mean. 95% of the values are within two standard deviations of the mean. More than 99% of the values are within three standard deviations of the mean.



For any developmental skill in typically developing children, there is variation in the age at which the skill is mastered. If those ages were plotted for a sample of children, the results would be expected to fall within the bell curve. The greatest number of children, the arithmetic mean, would be at 0 standard deviation, because there is little variance in their distribution. Children whose development is delayed will fall further from the mean. The amount of this variance is measured in standard deviations. To be eligible for First Steps using the AEPS®, the child score must be at least –1.5 SD (in 2 or more developmental domains) or –2 SD (in one developmental domain) from the mean.

Provider Billing Reviews and Audits

Provider billing reviews are performed annually as part of the state's quality review initiative. Reviews are required to be performed on 15% of First Steps providers annually. Providers are chosen randomly from the EDS Enrollment database. The state also has set billing parameters that can trigger a review; these ***may*** include billing more hours than most other providers, annual billings in the top 5% or other situations that are outside of the norm for provider billing. ***Please note that being outside of provider billing norms in and of itself does not imply that the provider has done anything wrong.*** The state is required to provide assurances that state and federal funds are being used appropriately. Quality Review (QR) billing reviews are not the same as an FSSA audit. An FSSA audit is a more comprehensive review of provider billing performed by state auditors.

Providers who have been selected for a QR billing review will receive a letter outlining the period of the billing review, the documentation required and the timeframe in which the documentation is due. The provider is asked to copy the face-to-face sheets, IFSP or other meeting minutes, (that confirm attendance and time billed) and ED team cover sheets and review logs (if applicable). The billing documentation is requested to be sent immediately (within 3 business days). The QR contractor reviews the provider billing findings with the BCDS consultant. The QR contractor may send letters to providers who have minor or no billing issues. Those providers with billing issues are referred to the Bureau for follow up. This may include a request for additional information, repayment of an undocumented visit, or a referral to FSSA for a formal billing audit. Any falsification of records may be grounds for disenrollment.

The state does not require use of the state Face-To-Face form (copy printed on page 19), but providers using their own form must include all of the required elements. Below is the Issue Clarification regarding billing documentation.

Issue Clarification

NUMBER:	12-0601-037A
DATE:	October 15, 2002
TOPIC:	**Family Signature on Billing Documentation**
RELEVANT SECTIONS OF THE MANUAL:	**Financial Administration**
AUDIENCE:	Service Providers Service Coordinators Families

ISSUE FOR CLARIFICATION: Required documentation needed to support billing activities for First Steps services and revisions to the providers' Face to Face Summary Sheet.

CLARIFICATION: The Bureau of Child Development has made revisions to the Face to Face Summary Sheet. (see attached form) Revisions include the addition of the:

- Location, including the address where services are provided,
- Date, time and location of the next scheduled visit,
- Information pertaining to any missed appointments, and
- Statement, signed by the parent, certifying the amount of direct service provided.

The information listed above, as well as the original documentation requirements, is required in order to substantiate billing for First Steps services.

Providers are to utilize the revised documentation sheet immediately. Personalized or modified versions of this form are allowable, as long as all of the information contained in the attached form is present. Once completed, the family is to be provided with a copy of the form. It is advisable to have the form made into a two-page carbonless form or to use carbon paper to allow the parents to be left with a copy at the time of the session. However if carbonless forms or carbon paper are not available, the provider is to have a photocopy made and sent to the family within 5 business days. To hand-write a duplicate is not acceptable documentation.

If the provider is involved in an audit or review of billing, and the required information is not available or present to support the provider's payment, the provider will be required to return the payment as requested by the lead agency. In addition, any falsification to this document or any other First Steps documentation may be grounds for disenrollment

You can download this form at: http://www.state.in.us/fssa/first_step/pdf/facetoface.pdf

You should personalize this form with your company name and contact information

First Steps Service Provider
Face to Face Summary Sheet

Revision 10-15-02

Sample of Information Gathering Tool

Child's Name: ______________________ Child name should match billing name **Date:** ______________________ Must be actual date of service and match date on claim

Time of Arrival: ______________ Should be exact time started; **Time of Departure:** ______________ Should be exact time session ended; with AM or PM or military time

Location of service: ______________________________ Should be place of service address, with city and zip

Street address City

IFSP Outcome to be addressed: ____

Result of Visit:

Follow-up Needed:

Family Education/Involvement:

Next Scheduled Session: ____

Day Date, Time, Location

Please note if there have been any cancelled sessions (and not rescheduled) in between this visit and your last visit.

Yes, the provider needed to cancel the session scheduled for ________________.

Date

Yes, I (the parent) needed to cancel the last session scheduled for ______________.

Date

My signature certifies that the activities identified above occurred at the time and location indicated and that _______ minutes/hour of direct service were provided to my child/family.** **State total time to be billed

Parent Signature Date Telephone

Parent or caregiver signature is mandatory with date

Provider Signature Date Telephone

Note: The parent is to be provided with a copy of the completed form.

UTS Programmatic Training
ProKids, Inc.
2511 East 46th Street Suite E-1
Indianapolis, IN 46205

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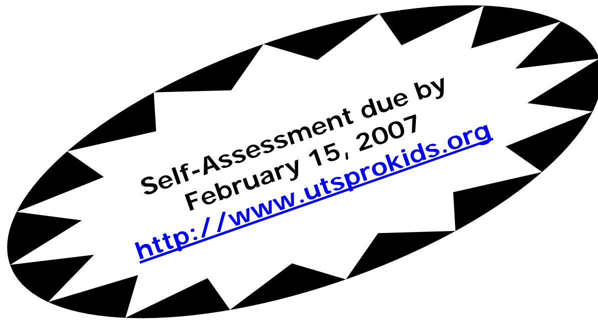

Save The Dates

THE Institute for Strengthening Families - Indianapolis, IN

APRIL 9, 10, & 11, 2007

SEPTEMBER 17, 18, & 19, 2007

Indiana Association for the Education of Young Children

Indiana Early Childhood Conference - Indiana Convention Center Indianapolis, Indiana

April 12 - 14, 2007

The Infant Toddler Mental Health Association

Annual Conference
August 24, 2007

Infant Toddler Specialist of Indiana

Annual Conference

August 2007

Conference dates and information can be found at the Early Childhood Meeting Place Calendar

http://earlychildhoodmeetingplace.indiana.edu/