Telepractice for Part C Early Intervention Services: Considerations for Effective Implementation and Medicaid Reimbursement

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Overview

State early intervention (EI) Part C systems should consider *telepractice* as a method for improving equitable access for all young children with disabilities and their families to high-quality EI services. In response to inquiries concerning implementation of the Individuals with Disabilities Education Act (IDEA) Part C use of funds in the current COVID-19 environment, the Office of Special Education Programs (OSEP) in its Question and Answer (Q&A) document mentions telepractice: "Use of telecommunications technology as a mechanism to provide service coordination and early intervention services, including home visits for infants and toddlers with disabilities and their families are sometimes referred to as: telehealth, tele-intervention, tele-therapy, and tele-practice." (Q&A Guidance https://sites.ed.gov/idea/files/qa-part-c-use-of-funds-06-25-2020.pdf) To plan for the continued successful use of telepractice, states will need to: (1) make decisions based on all available data, (2) explore state and federal policies and requirements, (3) consider and respond to issues related to Medicaid reimbursement, and (4) provide information and supports for families, providers, and state staff.

The purpose of this report is to provide information about the use of telepractice as a delivery method for EI services and the process for Medicaid reimbursement. States can use the state examples, resources, and information in the four Appendices to develop their own state-specific policies, procedures, and written guidance for using Medicaid dollars to reimburse for telepractice.

Introduction

During 2020, the COVID-19 pandemic disrupted in-person services for infants and toddlers with developmental delays and disabilities and their families. As a result, states turned to remote service delivery, often referred to as telehealth or telepractice. In response to the public health crisis, the Centers for Medicare & Medicaid Services (CMS) issued a Medicaid waiver to support the provision of EI services through telepractice (Centers for Medicare & Medicaid Services CMS waiver). Forty-seven (47) states already used Medicaid to reimburse Part C EI services, according to the Infant and Toddler Coordinators Association's (ITCA) 2016 finance survey (2016 ITCA Finance Survey) Therefore, for most states, working with the state Medicaid office is a starting place to continue reimbursement for telepractice.

States have indicated a desire to continue remote EI services which have been documented within Individualized Family Service Plans (IFSP), once the COVID-19 public health emergency ends. This service delivery option can increase a state's capacity to meet the diverse needs of infants and toddlers with disabilities and their families. This report will provide Part C state systems with information and guidance about how to secure Medicaid reimbursement for services delivered via telepractice. Specifically, we identify considerations, recommend activities, and provide summaries of relevant information and resources. States can use the information and resources to develop their own policies, procedures, and associated documents/materials to support Medicaid reimbursement.

Terminology

First, consider what is meant by telepractice and determine which terminology to use. The language states use to describe telepractice must clearly convey that it is a *method* for delivering EI services that utilizes telecommunication technology as a method to provide services when the family/caregiver and the provider are not in the same location at the same time, i.e., the family home or other community setting. Medicaid uses the term *telehealth*, but states and EI in their guidance and policy have used a number of terms including:

- telepractice
- teleintervention
- telehealth
- synchronous audio and visual communication
- video visits, live video visits, visits via video conferencing
- remote (or virtual) service delivery

The following passages define and clarify the modalities of telehealth and can inform decisions states make about the terminology to use.

- The Medicaid website defines telehealth as follows:
  - "For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment." (https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html)
- As defined by the American Telemedicine Association, telepractice may be:
  - ***Synchronous:*** *"Interactive video connections that transmit information in both directions during the same time period," or*

  - ***Asynchronous:*** *"Store-and-forward transmission of medical images and/or data, referred to as asynchronous because the data transfer takes place over a period of time and typically in separate time frames. The transmission typically does not take place simultaneously." Asynchronous telehealth allows providers to securely share information about a client/patient, typically for consultation purposes.*

- The Center for Connected Health Policy (CCHP) provides a comprehensive discussion of telehealth definitions and terminology. In general, the Center tends to use the term *telehealth* to describe the remote delivery of health services, including therapy services. The following definitions from the CCHP website emphasize telehealth as a method of service delivery and not a service per se:

  - *"Telehealth is a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies. …Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery."*
  - *State and federal agencies often differ on how they define telehealth. For example, California law defines telehealth as:*

    > *"The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers."*

  - *"Medicare reimburses for a set of services that are not labeled as 'telehealth' in the program but use telehealth technologies to deliver those services. This grouping of services is called 'technology-enabled' or 'communications-based' services."*
  - *"Telehealth is the use of virtual and digital technology to provide health care, education, and other health related services from a distance. Telehealth encompasses such service delivery modalities as live video teleconferencing, asynchronous secure transmission (store and forward) and remote patient monitoring."*
  - *"Telehealth—the use of technology to provide and coordinate health care services at a distance."*

- The federal Health Resources and Services Administration defines telehealth as:

  "The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."

Key Takeaway: Make a decision about the *telehealth* term to use and use it consistently in guidance, policies, and procedures. The definition should emphasize that it is a method of service delivery.

Communication with the state Medicaid office can help states determine which term(s) and definitions are most appropriate to adopt for statewide use. This will ensure that terminology will not create barriers regarding funding.

In this report, the terms telepractice, telehealth, and remote and virtual service delivery are used interchangeably.

Medicaid and Telepractice: Considerations

State Part C EI staff will need to communicate with their state Medicaid office to determine if and how they can use Medicaid funds to pay for telepractice beyond the COVID-19 public health emergency. Regardless of the payment source, Part C staff should also review state and federal policies, as well as legislative and statutory requirements, to determine whether they allow telepractice as an EI service delivery method.

First, states should determine whether their state Medicaid office plans to continue the use of Medicaid to reimburse for telehealth in general and how this will affect telepractice for EI services.

- If yes, then the Part C system and Medicaid office will need to collaboratively work out the details that best meet the needs of children and families in the state and document this decision in their Medicaid administrative agreement.
- If no, then the Part C system may want to explore options for pursuing Medicaid reimbursement. Strategies might include engaging stakeholders, making necessary changes to policies, providing data on the cost-benefit of telepractice, or continuing to work with staff in the Medicaid office to address barriers.

The following section will provide Part C staff with federal and state-level considerations for pursuing Medicaid reimbursement of telepractice.

Learning about Medicaid Requirements and Policies

State Part C EI staff need to learn about the federal Medicaid program as well as their state's Medicaid policies and procedures. At the federal level, the CMS continues to provide support for states' adoption of telepractice. Each state also has its own laws, policies, and reimbursement rates for telehealth; these can be found on the Center for Connected Health Policy website. Each state Medicaid agency develops a state plan that determines which populations can be served using Medicaid reimbursement, the range of services covered by Medicaid, qualified technologies for delivering telehealth services, the geographic regions permitted, and payment rates and policies. Working with their state's Medicaid office will help Part C staff understand their state's Medicaid plan, requirements for reimbursement, and the specific policies and procedures or state plan amendments that need to be in place. Similarly, State Part C staff also have a role in educating the state Medicaid office to increase awareness of EI evidence-based practices, such as coaching, to inform allowability for reimbursement of those practices. State Part C EI staff should then work with the state Medicaid agency staff to determine any changes that might be needed to allow the continued use of telepractice with options for reimbursement. State overviews can be accessed on the State Overviews page of the Medicaid website.

In 2020, the CMS released a helpful guide for the use of telehealth in response to the COVID-19 pandemic (State Medicaid and CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth-COVID-19 Version). The guide was "intended to help states identify which aspects of their statutory and regulatory infrastructure may impede the rapid deployment of telehealth capabilities in their Medicaid program. As such, this guide describes each of the policy areas and the challenges they present below. The toolkit concludes with a list of questions state policymakers can use to ensure they have explored and/or addressed potential obstacles." This report provides additional information in appendices, including:

- A set of quick facts from that guide, in Appendix A.
- Other Medicaid-released guidance for states about policy options for paying Medicaid providers that use telehealth to deliver services, in Appendix B.
- A listing of organizations with resources and information about teleservices, in Appendix C.

Relationships with Key Partners

Partners play a critical role in helping State Part C EI systems make a convincing argument for the use of Medicaid to reimburse EI services delivered via telepractice. Relevant stakeholders, selected strategically and with intention, can provide key support for this objective. Stakeholders to involve may include Medicaid staff, other state staff (e.g., those responsible for finance, personnel certification, or licensing), EI providers, families, the Interagency Coordinating Council (ICC), professional organizations (e.g., American Speech-Language-Hearing Association [ASHA], American Physical Therapy

Association [APTA], American Occupational Therapy Association [AOTA]), legislators and other state leaders, and representatives from community organizations. It would also be strategic to involve stakeholders who might be resistant to the notion of Medicaid-reimbursed telehealth and work to address their concerns.

A tool for planning the expansion of Medicaid reimbursement for EI services is available on the Early Childhood Technical Assistance Center (ECTA) website (Exhibit 1).

Exhibit 1. Planning Tool: Building the Case to Expand Medicaid and Private Insurance for EI

This planning tool is designed for state teams exploring the expansion of funding—either Medicaid and/or private insurance—to cover EI supports and services. It includes detail on the considerations, information, and data needed to craft a document that makes a compelling argument for the expansion. The tool serves as a guide and provides a means to capture the objective, as well as the process and information used in the expansion effort.

This document can be found at the ECTA website: Medicaid planning tool

Using Telepractice to Deliver EI Services: Considerations

States have several issues to consider related to the use of telepractice for delivering EI services. We have organized these considerations into four categories: reimbursement, service delivery, professional development, and technology. All three considerations are crucial to effective planning.

Reimbursement

States must determine which EI services Medicaid funds will reimburse. Multiple service provider types provide EI services. States must carefully review state and federal regulations, policies, and guidelines to make sure Medicaid can reimburse all provider types for specific services. State Part C EI staff may need to consult with staff from other regulatory state agencies to identify current regulations for Medicaid reimbursement and the process for including new services and providers. States may also need to identify the specific coding, service definitions, and documentation requirements to ensure reimbursement for telepractice can continue to occur.

Additional resources about reimbursement are available on the ECTA website: https://ectacenter.org/topics/disaster/ti-funding.asp

States must investigate whether licensing requirements prohibit providers from delivering services that are not in person. CMS has identified provider issues as follows: "*In addition to provider licensure and credentialing in Medicaid, states must also consider whether a provider's professional scope of services enables him or her to bill*

for a telehealth service, and whether any changes to that scope of services are warranted" (https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf, page 6).

States must consider how to include telepractice in their EI pre-authorization requirements. Telepractice must be included in any state's required preauthorization process. States should review state and federal policies and guidelines related to Medicaid reimbursement and EI services to determine when preauthorization is required and which services are included in the requirement. If telepractice is not explicitly listed, states should craft language that will allow telepractice as a method for delivering EI services. This language can then be added to the state's preauthorization policies and guidelines. Partnerships with state agencies that oversee pre-authorization policies and guidelines will help state Part C EI systems add telepractice for EI services in a smooth and timely manner.

Service Delivery

States must identify privacy and confidentiality issues related to using telepractice. Part C staff can begin by reviewing current state policy and privacy/confidentiality requirements for telepractice to address privacy and confidentiality issues that may require new guidance for programs, providers, and families. New guidance should include specific language that describes the use of telepractice and its relationship with federal laws that protect the privacy and security of individuals, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act of 1974 (FERPA).

Privacy and confidentiality considerations relate to both the setting of, and technology used for, EI services. All EI sessions must be provided in a private and confidential setting in which conversations cannot be overheard, nor video viewed by others. Part C agencies will need to adhere to privacy guidelines and ensure that parents understand their privacy and confidentiality rights. For instance, states may wish to require service providers to use only state-issued equipment with HIPAA-compliant software and a secure Wi-Fi network.

- Additional resources about this topic are available on the ECTA website, Technology and Privacy https://ectacenter.org/topics/disaster/ti-hipaa.asp
- The Connecticut Office of Early Childhood developed a guidance document, titled Remote Early Intervention, located on their Connecticut Birth to Three Procedures webpage https://www.birth23.org/providers/provider-resources/procedures/

Professional Development

States should plan to meet the need for additional professional development (PD) to support providers' effective delivery of services via telepractice. States and providers should work collaboratively to develop and review telepractice guidance and determine

the need for PD. Potential topics may include clarifying that the method of service delivery is determined by the IFSP team which includes the family, identifying best practices for using technology, preparing and coaching families and caregivers via telepractice, and documenting the services delivered. After developing new PD for service providers specifically related to the implementation of telepractice, states should include those trainings in their ongoing PD and training requirements.

As one state example, Illinois' Part C program partnered with the Early Intervention Training Program at the University of Illinois to create training materials and resources for providers to address the use of telepractice during the COVID-19 pandemic. https://blogs.illinois.edu/view/6150/807741.

Additional resources to support effective delivery of EI services via telepractice include:

- Online training for service providers http://www.cvent.com/d/0nqr11
- Guidance documents outlining state policies and procedures http://www.wiu.edu/coehs/provider_connections/pdf/20200406livevideovisits.pdf
- Tip Sheets https://blogs.illinois.edu/files/6150/807741/171255.pdf
- Resource lists directly related to service provision https://eiclearinghouse.org/keyword/telehealth/
- Videos related to parent perspectives https://youtube.com/playlist?list=PLflwZ3IuvaQaoVUjKqdYWQUfz_7XLbAxf

Resources about service delivery using telepractice on the ECTA website include:

- Provider and Educator Resources https://ectacenter.org/topics/disaster/ti-service.asp
- Family Resources https://ectacenter.org/topics/disaster/familiesathome.asp

The use of telepractice can provide unique opportunities for professional development. With parent permission, providers can observe sessions and learn from their peers. Telepractice can facilitate learning, communication, and partnerships among service providers, families, and other caregivers (e.g., child-care providers). By allowing service providers to observe each other working with families and communicating with each other and families during virtual sessions, a coaching model can be used to strengthen the skills of providers as well as families.

Technology

States must consider the technological infrastructure that is required for delivering services via telepractice. Technology includes access to internet and equipment for families and providers. In an article about telepractice in EI, Cason (2011) identified the following technology infrastructure issues and questions for consideration when implementing and expanding the use of telepractice.

Technology issues:

- Equipment and connection/broadband access issues
- Sound and image quality
- Policies for HIPAA and FERPA compliance and security
- Family and provider experience and comfort level using technology
- Privacy and confidentiality
- Policies for accessible use of state-owned equipment.

Technology questions:

- What are the training needs of both providers and families?
- How will training be provided?
- Does training cover use of equipment and technology problem solving?
- Does training include security protocols?
- Does training contain instruction to meet the policies related to state-owned equipment?
- Is there sufficient broadband statewide to support EI telehealth services?
- Is access to broadband/internet service available at low cost or free in all areas?
- How can the state mitigate any issues related to access and the use of technology for both families and service providers?

Additional resources about use of technology are available on the ECTA website:

- Technology and Privacy Resources https://ectacenter.org/topics/disaster/ti-hipaa.asp

Telepractice in EI: Anticipated Benefits

States can anticipate the benefits of telepractice as a method for delivering EI services. In 2021, rigorous high-quality research on telepractice was limited because widespread use of telepractice in EI was relatively new. However, a small set of qualitative and quantitative studies has examined remote service delivery in EI, including telepractice for pediatric practices. Appendix D provides brief abstracts of this research that states can reference when developing their own policies and procedures.

Access

States may be able to reach families who otherwise might not be reached. For example, the IFSP team may decide that for an infant or toddler living in a rural area, until a local provider is available, telepractice would provide them access to providers not currently available in their community. In addition, the IFSP team of an infant or

toddler with medical issues requiring minimal contact with people may determine the best method of service delivery to be through telepractice.

Telepractice may also support the provision of equitable services and should be made available to all eligible children and families. As an example, access to translators who can join sessions via technology may help providers and families participate together in the implementation of service delivery. Telepractice can also increase access for families with travel or scheduling challenges that create barriers to full participation in in-person or specialized services. The IFSP team, which includes parents, may determine that a combination of in-person and virtual services can meet the needs of their infant and toddler and help them receive more of their planned services. However, telepractice should not be used to avoid certain homes or neighborhoods based on the personal preference of providers.

Continuity of Care

States may find that the use of telepractice improves continuity of services. With telepractice, families may also have better access to service providers which will, in turn, support achievement of positive child and family outcomes. The IFSP team has the option to combine in-person visits with telepractice to best meet the needs of infants and toddlers with disabilities and their families and promote better continuity of care. When in-person services are interrupted due to natural disasters or other unforeseen circumstances, telepractice allows services to continue for children and families.

Provider Shortages

Telepractice can help address provider shortages. Some of the earliest descriptions of telepractice in EI tout this benefit. For example, Kentucky used telepractice in 2007 to specifically address provider shortages, particularly in rural areas (Cason, 2009). They found that personnel using telepractice could serve a greater number of children and families in the same amount of time, and at a similar cost, as in-person visits. A study of Part C state systems, conducted between October 2019 to June 2020, found that telepractice helped address regional disparities in access to infant and early childhood mental health services (Smith et al., 2020).

Telepractice services may be particularly helpful for improving access to providers who are not universally available across a state and can lead to the provision of services in a more timely manner. For example, telepractice can improve access to translators, specialists who conduct assessments and evaluations, and specific types of therapists or providers (e.g., infant mental health specialists). If outlined in the IFSP, providers in one area of a state can use telepractice for service delivery to children and families who live in other parts of a state where personnel shortages exist. This kind of increased access to service providers can also improve timely transition conferences when time used for travel is eliminated. There can also be better participation of family members and multiple providers in a virtual meeting. As a reminder, the IFSP team determines

the method of service delivery. If a provider shortage is the sole reason for perusing the use of telepractice this should only be used until a local provider is identified or hired.

Quality of Services

Telepractice supports the use of evidence-based services. Telepractice as the method of service delivery can encourage implementation of evidence-based practices, such as embedded instruction or routines-based practices within natural settings and coaching and consultation with parents and caregivers. Telepractice allows providers to work with parents and caregivers to embed learning opportunities into naturally occurring routines that promote skill development and functional outcomes and doing so builds parent skills and confidence. Telepractice also provides the ability to combine home visits and virtual visits to enable the EI provider to follow-up with coaching regarding an embedded learning activity that was addressed at the in-person visit. Several states have collected provider comments that highlight their positive experiences with telepractice, shown in Exhibit 2.

Exhibit 2. What Providers Say about Quality of EI Services Delivered by Telepractice During the 2020 COVID-19 Pandemic

"It has been a great way to utilize the coaching approach that EI should be centered around. It has also helped me develop new skills as a practitioner that I will always hold as very valuable in my career as I believe telehealth will be around for a long time."

"For many families, coaching can be more easily achieved during telehealth services since they are more naturally a participant and less of an observer."

"I have developed strong rapport with families through telehealth and have been able to coach them on how to implement effective strategies. I have also been able to get a good sense of the child's skills and developmental levels via telehealth."

"My clients are getting higher levels of carry-over than they ever got before, parents are feeling empowered and confident in carry over strategies. I've had so many clients graduate since starting telehealth. It is hard for school-based services though."

"I feel that teletherapy has been very beneficial. It has actually increased the level of parental involvement in sessions, and I feel that overall carryover of therapy techniques has increased."

"Services provided via teletherapy have facilitated more parental involvement, and I have found the same, or in some cases, more improvement than expected, which I attribute to parents having to become better participants because of the virtual visits."

Source: These quotes are from qualitative data collected by Part C programs in Connecticut, the District of Columbia, Louisiana, and New Jersey in 2020 during the COVID-19 pandemic.

Family Engagement and Satisfaction

Telepractice can increase family and caregiver engagement and satisfaction with services. Although only a few small studies comprise the research base on family and

caregiver satisfaction with telepractice in EI, those studies show high levels of family satisfaction with telepractice for EI service delivery (Kelso et al., 2009; Wallisch et al., 2019). This includes families living in rural areas (Kelso et al., 2009). Providers may also be more apt to engage families through coaching strategies when services are remote. Better family engagement can lead to better satisfaction with EI services.

Studies of remote pediatric practices can inform Part C EI. For example, Tanner et. al. (2020) reviewed the feasibility and acceptability of pediatric telehealth services for speech-language therapy, developmental occupational and physical therapy, and sports and orthopedic therapies. These studies found that therapies delivered via telehealth were feasible to implement and highly acceptable to the patients. Given patient satisfaction surveys, almost 100% gave telehealth positive ratings.

Several Part C systems collected data qualitative about family and caregiver satisfaction with Part C telepractice during the 2020 COVID-19 pandemic and found high levels of reported satisfaction with this method (see Exhibit 3).

Exhibit 3. What Families and Caregivers Have Said about Satisfaction with EI Services Delivered by Telepractice during the 2020 COVID-19 Pandemic

"The sessions are focused and concise, and I enjoy being able to have my son be comfortable in our home."

"We are actively involved in each therapy session and can express any concern or ask questions as they appear."

"Our telehealth sessions have been wonderful! While we love our in-person sessions, I feel that our telehealth sessions have been better than our live sessions! My son is more engaged and attentive to the provider, and I feel like I am able to participate in our sessions more effectively."

Source: These quotes are from family survey qualitative data collected by Part C programs from Connecticut, the District of Columbia, Louisiana, and New Jersey in 2020 during the COVID-19 pandemic.

Child Outcomes

There is not enough research to show that telepractice for EI services leads to child outcomes that are better than, or at least the same as, those found with in-person service delivery. However, the few EI studies that do exist suggest that positive child outcomes *may* be a benefit because of other positive features of telepractice. The positive features of telepractice presented thus far in this report include improved access to services, better continuity and fewer missed services, positive solutions to provider shortages, better use of family coaching ideally resulting in higher quality of services, and high levels of family and caregiver satisfaction and engagement with visits (Behl et al., 2017; Cason, 2011; Cole, Pickard, and Stredler-Brown, 2019; Wallisch et al., 2019. If these benefits occur, child outcomes are likely to be positive. States can provide useful information and may consider collecting data to demonstrate the impact of telepractice on service provision and child and family outcomes.

Data for Supporting and Tracking Telepractice

State collected data will be important to understand and track the effect of telepractice on service provision and childhood outcomes. States should consider the quantitative and qualitative data they could collect on the use of telepractice for delivering EI services. The following questions can guide this discussion:

- What data do you need to **support justification for the use of Medicaid funds** to reimburse for telepractice?
- What data do you need to **describe the use of telepractice?**
- What data do you need to **demonstrate the benefits**?
- What data do you need to **demonstrate the cost effectiveness?**
- What data do you need to **describe the outcomes for children and families receiving in-person services versus through telepractice?**

The planning tool described in Exhibit 1 suggests types of data that states might summarize to make the case for Medicaid reimbursement.

These include data that describe:

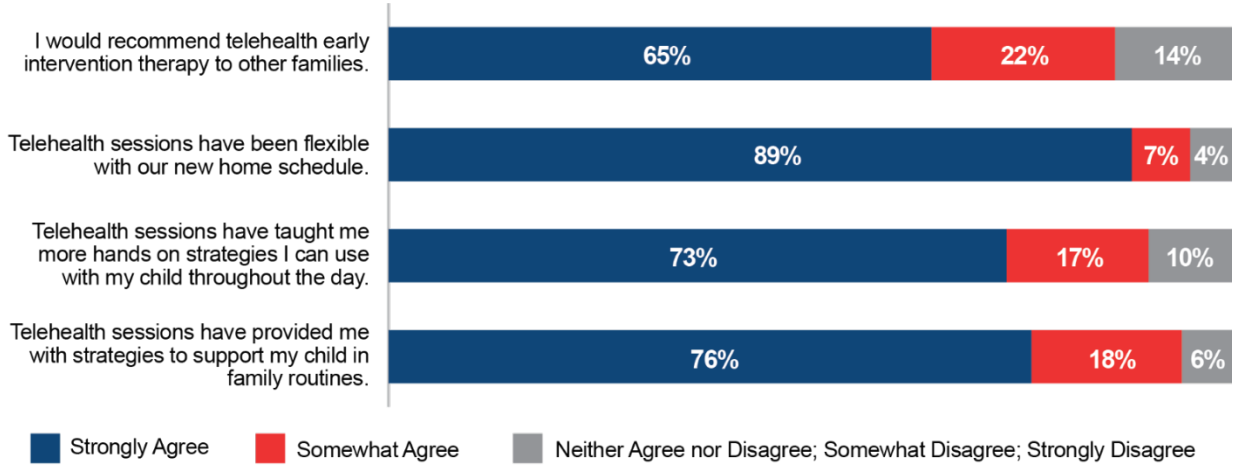
- The estimated number of children to be served
- Types and units of services provided
- Geographic areas served
- The associated costs of the services.

Research on the use of telehealth in pediatrics (Tanner et al., 2020) suggests that the data states collect about services delivered by telepractice include:

- Counts of visits – number of virtual visits
- General information, such as geographic location
- Service descriptions – types of services, types of providers, length of visits
- Descriptions of children and families served – demographic and disability characteristics
- Family satisfaction and perceptions of remote services – ratings and qualitative data collected via surveys
- Costs of remote services – including comparison of costs of remote versus in-person service delivery.

Several state Part C systems surveyed families and providers about telepractice services during the 2020 COVID-19 pandemic. States may want to consider collecting and using similar survey data, as shown in the example from New Jersey in Exhibit 4.

Exhibit 4. New Jersey's Data about Family Perspectives on Part C Telepractice Services during the 2020 COVID-19 Pandemic



Source: Family surveys collected by New Jersey's Part C program in 2020.

Development of Guidance about Telepractice and EI Services

States should develop guidance summarizing policies and procedures for programs and providers on the use of telepractice for delivering EI services. The use of telepractice as a method of service delivery is ultimately a decision made by the IFSP team, which includes the family, and is based on the individualized needs of the child and their family. State-specific requirements regarding use of telepractice may vary. States can draw from a variety of national resources and examples from other states. It is recommended that the guidelines address at least four sets of factors: populations, services, providers, and technology (https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf , pages 4–6). State Part C EI programs must make sure that guidelines for programs and providers align with their State Medicaid Plans.

State guidelines, policies, and regulations for using telepractice for delivering EI services should specify:

- Which specialty services allow telepractice as a delivery method.
- Which types of services or Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes can be reimbursed.
- Which providers can be reimbursed (e.g., speech and language pathologist, nurse, developmental specialist/special educator).

Guidance for service providers, families, and other stakeholders will need to clearly state which types of services can be delivered through telepractice and reimbursed

using Medicaid funds. Some states have developed telepractice guidance that can serve as models. Exhibit 5 shows examples of guidance from three states.

Exhibit 5. Examples of State Part C Telepractice Guidance

Colorado

Four modules developed by a Colorado Task Force focused on:

"(a) *establishing that telehealth is just a different way of providing services that has many advantages for both families and providers;*

(b) the fundamentals of telehealth and early intervention-related legislation, billing, required forms, etc.;

(c) details on how to plan for and conduct a telehealth session; and

(d) reviewing actual telehealth sessions (featuring Task Force members) to better understand how to conduct a successful session."

Source: Cole, B., Stredler-Brown, A., Cohill, B., Blaiser, K., Behl, D., & Ringwalt, S. (2016). The development of statewide policies and procedures to implement telehealth for Part C service delivery. *International Journal of Telerehabilitation, 8*(2),77–82. http://telerehab.pitt.edu/ojs/index.php/Telerehab/article/ view/6206/6668

Connecticut

The state of Connecticut developed a written guidance document, titled Remote Early Intervention, about telepractice (using the term remote service delivery) that included information on the following topics:

- general uses of remote service delivery
- major provider eligibility criteria
- privacy and confidentiality requirements (including software with a HIPAA-compliant option)
- IFSP requirements
- room requirements
- distance requirements
- prior authorization
- billing and payment
- documentation of the visits

Source: Connecticut Office of Early Childhood's Connecticut Birth to Three Procedures webpage

Idaho

The state of Idaho created an EI telepractice guidance document (using the term virtual EI) for state staff and contractors. The document is a state example that defines what is covered when using a virtual EI method to deliver all aspects of Individuals with Disabilities Education Act (IDEA) Part C requirements during the COVID-19 Idaho Declaration of Emergency. Guidance is provided for these questions:

1. How do the Infant and Toddler Program (ITP) state staff and contractors qualify to deliver virtual EI?
2. Who can receive virtual EI?
3. Where do ITP state staff and contractors need to be located to deliver virtual EI?
4. What are the device and security requirements for state staff and contractors to deliver virtual EI?
5. What are some of the technical requirements for virtual EI?
6. Where does the family/caregiver need to be located to receive virtual EI?
7. What services are included and excluded for use of virtual EI as a delivery method?
8. How do I get started with the family/caregiver once it is determined that virtual EI is a good fit?
9. What required documents do I need to complete/provide specific to virtual EI?
10. How do I document virtual EI visits in the IFSP?

Source: Virtual Early Intervention Implementation Guidelines for State Staff and Contractors, March 18, 2020

The ECTA website provides a compilation of information about telepractice for state EI Part C and early childhood special education IDEA Part B Section 619 programs including technology and privacy, reimbursement, provider and educator use of technology, family resources, state guidance and resources, and research. https://ectacenter.org/topics/disaster/tele-intervention.asp.

Communicating about Telepractice and EI

Materials to communicate about the use of telepractice in EI for families, providers, and programs should explain what telepractice is, its uses, and its benefits. Such materials can also dispel families' and providers' myths or misconceptions about telepractice. Myths about telehealth found in Colorado (Cole et. al., 2016) include beliefs that (a) telehealth may be 'lesser than' in-person services, (b) providers cannot build rapport with families with virtual services, and (c) technology is too expensive and hard to use. Informational materials can also describe potential benefits of telehealth services, as detailed throughout this report.

Exhibit 6 shows an example language from a flyer developed by Idaho to explain telepractice to families in Idaho. The flyer defines telehealth and its benefits and provides links to references and tools. Flyers such as this can also inform providers, program administrators, and other stakeholder groups.

Exhibit 6. Excerpt from Idaho's Virtual Early Intervention Family Flyer

"What is a Virtual Early Intervention (EI) visit?

- *Also known as telehealth, Virtual EI visits are a method of providing services via the internet. Virtual EI visits can be provided through a personal computer, laptop, tablet, or smartphone using a secure network. The EI professional and family or caregiver are both present in real time.*

How can Virtual EI visits support families?

- *Allow families to gain access to early childhood professionals who may be far away or very specialized*
- *Focuses on parent-child relationship and interactions, increasing parent confidence in supporting their child*
- *Allow families with internet access the flexibility to work with EI professionals from a secure location*
- *Families can schedule times that are convenient and may include additional family members*
- *Empower families to confidently implement strategies between sessions*

Benefits of Virtual Early Intervention (EI)

- *Multiple research studies demonstrate that the outcomes of children and families receiving Virtual EI are equal to families receiving in-home services. (Connected Health Policy, August 2018).*
- *Virtual EI visits encourage parents to utilize developmental strategies through coaching from their provider. (Fiechtl et al., 2014).*
- *Caregivers report that therapy conducted via Virtual EI helped them learn how to support their child better than the traditional model. (Blaiser, Behl, Callow-Heusser, & White, 2013).*
- *Virtual EI leads to more consistent services due to decreased cancellations related to illnesses or inclement weather. (Cason, Behl, & Ringwalt, 2012).*
- *The focus of the session shifts from the therapist and the child to the family and the child. (Blaiser, Behl, Callow-Heusser, & White, 2013.)"*

Excerpted from: Virtual Early Intervention Family Flyer from the state of Idaho
https://ectacenter.org/~pdfs/topics/disaster/id_Virtual_EI_Family_Flyer_March_2020.pdf

Conclusion

Telepractice can be a delivery method that state EI Part C systems and local programs should consider for improving equitable access for all infants and toddlers with disabilities and their families to access high-quality EI services. States will need to plan for the continued successful use of telepractice, and: (1) make decisions based on all available data, (2) explore state and federal policies and requirements, (3) consider and respond to issues related to Medicaid reimbursement, and (4) provide information and supports for families, providers, and state staff.

The information in this report can help states think through and plan for a variety of issues related to using telepractice as a delivery method for EI services and the process for Medicaid reimbursement. States can use the state examples, resources, and information in the four Appendices to develop their own state-specific policies, procedures, and written guidance for using Medicaid dollars to reimburse for telepractice.

Appendix A. Quick Facts from the State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version

"CMS encourages states to consider telehealth options as a flexibility in combatting the COVID-19 pandemic and increasing access to care. States are encouraged to facilitate clinically appropriate care within the Medicaid program using telehealth technology to deliver services covered by the state.

- *States have a great deal of flexibility with respect to covering Medicaid and CHIP services provided via telehealth. States have the option to determine whether (or not) to utilize telehealth; what types of services to cover; where in the state it can be utilized; how it is implemented; what types of practitioners or providers may deliver services via telehealth, as long as such practitioners or providers are "recognized" and qualified according to Medicaid federal and state statute and regulation; and reimbursement rates. States have full discretion to select from a variety of HCPCS codes and modifiers in order to identify, track and reimburse for these services.*
- *States are not required to submit a state plan amendment (SPA) to pay for services delivered via telehealth if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting. States may submit a coverage SPA to describe services delivered via telehealth. A state would need an approved state plan payment methodology (and thus, might need to submit a SPA) to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting.*
- *States have broad flexibility to adopt telehealth options in CHIP. The flexibilities discussed in this toolkit generally apply to separate CHIP programs. States should contact their CHIP Project Officer for assistance.*
- *Services delivered via telehealth seek to improve a patient's health through two-way, real time interactive communication between the patient, and the provider. Services delivered in this manner can, for example, be used for assessment, diagnosis, intervention, consultation, and supervision across distances.*
- *States may pay a qualified physician or other licensed practitioner at the distant site (the billing provider) and the state's payment methodology may include costs associated with the time and resources spent facilitating care where the beneficiary is located, such as a medical facility or the beneficiary's home. States are strongly encouraged to include costs associated with providing services via telehealth within Medicaid payment methodologies and ensure rates are adequate to facilitate telehealth services. The billing provider may distribute the payment as appropriate.*
- *Medicaid guidelines require all providers to practice within the scope of their State Practice Act. States should follow their state plan regarding payment to qualified Medicaid providers for telehealth services.*

- *States may also pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services. A state would need an approved state plan payment methodology that specifies the ancillary costs and circumstances when those costs are payable.*
- *Ancillary costs associated with the site where the beneficiary is located may be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program.*
- *States may wish to consider issues with consistency between fee-for-service and managed care telehealth coverage that may cause confusion for providers.*
- *States may wish to re-evaluate scope of practice laws, including restrictions imposed by state boards of medicine, to ensure maximum utilization of telehealth flexibilities. Consideration may need to be given to revising scope of practice for some professional types, such as optometrists, in order to explicitly allow delivery of care via telehealth. In other cases, it may be necessary to revisit practice policy to ensure it is not unnecessarily restricting the delivery of care via telehealth.*
- *States are encouraged to reach out to their CMS state lead as soon as possible if they are interested in submitting a state plan amendment."*

Source: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf (pages 3–4)

CMS = Center for Medicare and Medicaid Services (https://www.cms.gov/)

Appendix B. Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth

"This document is intended to assist states in understanding policy options for paying Medicaid providers that use telehealth technology to deliver services. The overview and sample state plan language apply to Medicaid fee-for-service payments and additional considerations may be warranted for states interested in offering telehealth within other delivery systems. CMS encourages states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care. Overview of Fee-for-Service Telehealth:

- ✓ *States are encouraged to facilitate clinically appropriate care within the Medicaid program using telehealth technology to deliver services covered under the State plan.*
- ✓ *States have a great deal of flexibility with respect to covering Medicaid services provided via telehealth.*
- ✓ *States are not required to submit a state plan amendment (SPA) to pay for telehealth services if payments for services furnished via telehealth are made in the same manner as when the service is furnished in a face-to-face setting.*
- ✓ *A state would need an approved State plan payment methodology (and thus, might need to submit a SPA) to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting.*
- ✓ *States may pay a qualified physician or other licensed practitioner at the distant site (the billing provider) and the state's payment methodology may include costs associated with the time and resources spent facilitating care at the originating site. The billing provider may distribute the payment to the distant and originating sites.*
- ✓ *Medicaid guidelines require all providers to practice within the scope of their State Practice Act. States should follow their state plan regarding payment to qualified Medicaid providers for telehealth services.*
- ✓ *States may also pay for appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for the delivery of telehealth services. A state would need an approved State plan payment methodology that specifies the ancillary costs and circumstances when those costs are payable.*
- ✓ *Ancillary costs associated with the originating site for telehealth may be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program.*

States are encouraged to reach out to their state lead as soon as possible if they are interested in submitting a state plan amendment. Sample State Plan Fee-for-Service Payment Methodologies for Telehealth. Below are examples of language states have used, and CMS has approved, to describe telehealth payment policies within the Medicaid state plan.

Example 1:

For services provided via telehealth, the billing provider will code the service using modifier (x). The provider will receive an add-on fee of $x, which is effective for services on or after xx/xx/xxxx; all rates are published at [state's website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The distant site provider will also be reimbursed in accordance with the standard Medicaid reimbursement methodology for the allowable Medicaid services performed.

Example 2:

Qualifying patient sites are reimbursed a facility fee. The fee is set at x% of Medicare and is effective for services on or after xx/xx/xxxx; all rates are published at [state's website]. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

Distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

Further guidance on telehealth/telemedicine may be found on Medicaid.gov: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html*.*

On 3/12/20, CMS posted COVID-19 frequently asked questions on Medicaid.gov. Additional questions may be directly to the mailbox: MedicaidCOVID19@cms.hhs.gov*."*

Source: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf

Appendix C. Organizations and Resources with Information about Telepractice

The Center for Connected Health Policy - https://www.cchpca.org/

- The Center for Connected Health Policy is a nonprofit, nonpartisan organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. Their expertise in telehealth policy was recognized in 2012, when it became the federally designated National Telehealth Policy Resource Center using a grant from the Health Resources and Services Administration to become the federally designated National Telehealth Policy Resource Center. This is an independent center of excellence in telehealth policy; it provides technical assistance to twelve regional Telehealth Resource Centers (TRCs), state and federal policymakers, national organizations, health systems, providers, and the public. Its website contains information regarding telepractice, including information about using Medicaid for providing services via telepractice.

Centers for Medicare & Medicaid Services (2020). *State Medicaid & CHIP Telehealth Toolkit- Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version.* https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf

- This resource is a toolkit that contains information to assist state policymakers in efforts to expand the use of telehealth services in Medicaid programs. States can use this resource to identify the aspects of their statutory and regulatory infrastructure that may impede the use of telehealth services in their Medicaid programs. CMS identified the purpose of this toolkit as: "*To support state policymakers in their efforts to expand the use of telehealth services in Medicaid programs, this Medicaid Telehealth Toolkit aggregates information and highlights questions that states may ask themselves when establishing new telehealth policy, including telehealth policies for pediatrics.*"

Centers for Medicare and Medicaid Services (CMS) - https://www.cms.gov/

- CMS is a federal agency that is part of the Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. The website contains many resources about telehealth services and policies.

COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies (Last Updated January 6, 2021) - https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

- The CMS released six sets of general Frequently Asked Questions (FAQs) to aid state Medicaid and Children's Health Insurance Program (CHIP) agencies in their response to the coronavirus disease 2019 (COVID-19) pandemic. CMS also released two sets of FAQs providing guidance to states on the implementation of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act. On January 6, 2021, CMS released an updated FAQ document that incorporates all eight sets of COVID-19 FAQs into one comprehensive FAQ document.

Early Childhood Technical Assistant (ECTA) - https://ectacenter.org/topics/disaster/ti-efficacy.asp

- ECTA has been compiling information about remote services delivery and distance learning for state EI Part C and early childhood special education Part B Section 619 programs– including sections on technology and privacy, reimbursement, professional associations, provider and educator use of technology, family resources, state guidance and resources, and research.

International Journal of Telerehabilitation
http://telerehab.pitt.edu/ojs/index.php/Telerehab/index

- This is a biannual journal that publishes articles about telerehabilitation research and practices.

National Consortium of Telehealth Resource Centers (TRCs) - https://telehealthresourcecenter.org/

- The National Consortium of Telehealth Resource Centers is a collaborative of 12 regional and 2 national Telehealth Resource Centers. TRCs have been established to provide aid, education, and information to organizations and individuals who are actively providing or interested in providing health care at a distance. Their charter from the Office for Advancement of Telehealth is to help expand the availability of health care to rural and underserved populations. They are funded by the U.S. Department of Health and Human Services and Health Resources and Services Administration to provide timely and accurate information on telehealth across the nation.

Question and Answer (Q & A) document from Office of Special Education(OSEP) issued June 25, 2020 - https://sites.ed.gov/idea/files/qa-part-c-use-of-funds-06-25-2020.pdf

- The Office of Special Education Programs (OSEP), within the U.S. Department of Education's (Department) Office of Special Education and Rehabilitative Services (OSERS), issued this Question and Answer (Q & A) document in response to inquiries concerning implementation of the Individuals with Disabilities Education Act (IDEA) Part C use of funds in the current COVID-19 environment.

Appendix D. Summary of the Research about Telepractice and Part C EI

The information below summarizes information from studies about the use of telepractice in Part C EI.

Behl, D.D., Blaiser, K., Cook, G., Barrett, T., Callow-Heusser, C., Brooks, B.M., Dawson, P., Quigley, S., & White, K.R. (2017). A multisite study evaluating the benefits of early intervention via telepractice. *Infants and Young Children*, *30*(2),147–161. https://journals.lww.com/iycjournal/Fulltext/2017/04000/A_Multisite_Study_Evaluating_the_Benefits_of_Early.5.aspx

This resource describes a multisite study to determine the effectiveness of telehealth as a method of delivering EI services to families of infants and toddlers who are deaf or hard of hearing. The study included 15 providers, 48 families from across five states. States can use this study as part of the research base about use of telehealth services for EI. The authors found that child and family outcomes were similar for in-person and televisits as a method of delivering EI services to families of infants and toddlers who are deaf or hard of hearing This research team also found some evidence for better use of the coaching model with telehealth.

Blaiser, K.M., Behl, D., Callow-Heusser, C., & White, K.R. (2013). Measuring costs and outcomes of tele-intervention when serving families of children who are deaf/hard-of-hearing. *International Journal of Telerehabilitation*, *5*, 3–10. https://telerehab.pitt.edu/ojs/index.php/Telerehab/article/view/6129

This resource is a journal article describing a randomized study of the use of tele-intervention versus routine in-person home visits for EI with 27 families of infants and toddlers with varying degrees of hearing loss. Pre-and post-measures of child outcomes, family and provider satisfaction, and costs were collected. Findings included significantly higher expressive language scores, higher scores on a measure of parent satisfaction, and better cost savings as the intensity of service delivery increased for the tele-intervention group compared with the in-person group. Most families and providers also described tele-intervention more positively, but there was a lot of variation in these positive ratings.

Camden, C., Pratte, G., Fallon, F., Couture, M., Berbari, J. & Tousignant, M. (2020) Diversity of practices in telerehabilitation for children with disabilities and effective intervention characteristics: Results from a systematic review, *Disability and Rehabilitation*, 42(24). https://doi.org/10.1080/09638288.2019.1595750

This resource is a review article that describes the characteristics and effectiveness of pediatric telerehabilitation interventions with children 0–12 years old or with their families. This systematic review included randomized control trials published from 2007 to 2018 involving at least one rehabilitation professional providing services remotely. Out of 4,472 screened articles, 23 were included. Most studies were published after 2016 and included outcomes related to the child's behavior (*n* = 12, 52.2%) or to the parent (*n* = 10, 43.5%), such as parental skills or stress. Overall, about half of evaluated outcomes improved following telerehabilitation. The authors reported that "[e]ffective interventions tended to target parents, centered around an exercise program, used a coaching approach, focused on improving children's behavioral functioning, lasted >8 weeks and were offered at least once a week."

Cason, J. (2009). A pilot telerehabilitation program: Delivering early intervention services to rural families. *International Journal of Telerehabilitation 1*(1). http://telerehab.pitt.edu/ojs/Telerehab/article/view/6007

This resource describes the findings of a study using telerehabilitation as a service delivery model for EI services to two families in rural Kentucky. This study indicates that service providers may serve more children without increasing costs (see Figure 6 in this article), and service provider shortages can be reduced without increasing costs to programs (see Figure 3 in this article). The findings from this study show positive results for future use of telerehabilitation as a method to deliver EI services and that this service delivery method may meet the therapeutic needs of children and families living in a rural area.

Cason, J. (2011). Telerehabilitation: An adjunct service delivery model for early intervention services. *International Journal of Telerehabilitation 3*(1). https://telerehab.pitt.edu/ojs/index.php/Telerehab/article/view/6071

This resource is an article states can use as part of the research base about the feasibility of using telehealth to deliver Part C EI services. This article summarizes existing research in EI, includes case examples of the potential applications of telehealth, and describes the benefits of telehealth related to selected Office of Special Education Programs (OSEP) performance indicators. It also includes considerations for the technology infrastructure needed. The author found only five articles about the use of telehealth in EI, with limited rigorous research. Nevertheless, the existing studies support that the use of telepractice is feasible, and there was a high level of family satisfaction. The focus of studies at the time this article was published in 2011 was to address provider shortages particularly in rural areas. The author cited a larger body of research in pediatrics. For example, in a large project to evaluate telemedicine for doing evaluations for children with special needs in rural Iowa, high levels of satisfaction, improved access to services, and significant economic savings were found. Other studies have found that telehealth services can facilitate co-treatment with specialists and local providers. The author

also summarized potential benefits of telehealth for improving performance on many of the OSEP indicators (see Table 3 in this article).

Cason, J., Behl, D., & Ringwalt, S. (2012). Overview of states' use of telehealth for the delivery of early intervention (IDEA Part C) services. *International Journal of Telerehabilitation 4*(2). https://telerehab.pitt.edu/ojs/index.php/Telerehab/article/view/6105

This resource is a report of the findings from a survey about telehealth distributed by the National Early Childhood Technical Assistance Center (NECTAC) to Part C coordinators in 2012. States can use this report as part of the research base about reimbursement for provider type and services and barriers to implement a telehealth service delivery model. A total of 26 states responded to the survey, and at that time, nine used or planned to use telehealth. Those doing so were looking at telehealth as a method to provide services in rural areas driven by personnel shortages; they paid for the services with IDEA Part C funding, Medicaid, and private insurance; and they identified several barriers and concerns including security issues, quality of service delivery, and limited evidence of efficacy of telehealth for service delivery.

Cole, B., Pickard, K., & Stredler-Brown, A. (2019). Report on the use of telehealth in early intervention in Colorado: Strengths and challenges with telehealth as a service delivery method. *International Journal of Telerehabilitation* 11(1), 33-40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6597149/

This resource is a report of the findings from a qualitative study that used surveys and focus groups with Part C program administrators, service coordinators, providers, and caregivers in the state of Colorado. States can use the information as part of research around the value and benefits of telehealth, potential barriers of using telehealth, and as a way to inform the development of state policies. States can use or adapt the questions used by Colorado to design their own state data collection activities. The results in the report served to identify next steps in the implementation of telehealth in Colorado's Part C EI program. Prior to the study, EI could be delivered via telehealth, but data from 2017 and 2018 showed that it was only used for about 45 children and less than 1% of all services delivered. Data were mainly from providers and service coordinators, and multiple benefits were identified: flexibility (visits can be during real situations like dinnertime); access in rural areas where there are provider shortages; program administrators can support providers in using a family coaching model by seeing sessions remotely; increased parental involvement in the sessions (reduces a 'hands-on clinical model"; helped program administrators support providers in using a family coaching model by seeing sessions remotely. Some key barriers were identified: technology set-up; comfort of providers and families; limited internet connections, particularly in rural areas; attitudes about telehealth (less personal); providers suggesting that families will not like it (preconceived notions).

Cole, B., Stekler-Brown, A., Cohill, B., Blaiser, K., Behl, D., & Ringwalt, S. (2016). The development of statewide policies and procedures to implement telehealth for Part C service delivery. *International Journal of Telerehabilitation, 8*(2),77-82. http://telerehab.pitt.edu/ojs/index.php/Telerehab/article/ view/6206/6668

This resource is an article that describes the process taken by the state of Colorado to develop the requirements and supports for using telehealth for EI services. States can use this resource as an example of how one state implemented a telehealth protocol for use in EI. In this work, Colorado created a task force and developed training materials to support use of telehealth in EI. The authors suggest that states thinking of using telehealth need to dispel certain myths that providers may have. For instance, they found that some providers feel that EI delivered in this way cannot be as high quality as in-person visits (even though they note that some research supports that child outcomes are better); some feel that providers cannot build rapport with parents; and some feel that technology is too expensive and difficult to use. Colorado developed four modules as guidance and developed a checklist of 18 items for local programs about using telehealth.

Kelso, G.L., Fiechtl, B.J., Olsen, S.T., and Rule, S. (2009). The feasibility of virtual home visits to provide early intervention: A pilot study. *Infants & Young Children*. *22*(4):332–340. https://journals.lww.com/iycjournal/Abstract/2009/10000/The_Feasibility_of_Virtual_Home_Visits_to_Provide.9.aspx

This resource describes a small study about four families receiving Part C EI services in a rural program that participated in a pilot study to test the feasibility of receiving EI services over the internet with a 2-way audio and video system. They found that both parents and early interventionists were highly satisfied with this remote service delivery. These authors also discussed implications for EI programs in savings in travel time and mileage costs.

Smith, S., Ferguson, D., Burak, E.W., Granja, M.R., & Ortuzar, C. (2020). *Supporting social emotional and mental health needs of young children through Part C early intervention: Results of a 50-state survey*. National Center for Children in Poverty, Bank Street Graduate School of Education. https://www.nccp.org/wp-content/uploads/2020/11/Part-C-Report-Final.pdf

This report examines and shares the results of a 50-state survey conducted by the National Center for Children in Poverty (NCCP) and Georgetown University Center for Children and Families (CCF) of state Part C Coordinators about their programs' policies and procedures related to screening, evaluation, eligibility, services, and financing that affect the programs' capacity to meet the social and emotional needs of infants and toddlers.

Tanner, K., Bican, R., Boster, J., Christensen, C., Coffman, C., Fallieras, K., Long, R., Mansfield, C., O'Rourke, S., Lindsey, P., Pauline, G., & Marrie, J. (2020). Feasibility and acceptability of clinical pediatric rehabilitation services. *International Journal of Telerehabilitation*, *12*, 43–52. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7757654/

This resource is a review article that summarizes research about the use of telehealth in pediatrics. It includes articles that look at feasibility and acceptability of pediatric telehealth services for speech-language therapy, developmental occupational and physical therapy, sports, and orthopedic therapies. Outcomes included patient satisfaction surveys collected in 2019 and 2020. The authors found that they are feasible to implement and highly acceptable to the patients (almost 100% of patients gave positive ratings). The article contains a clinical implementation planning model that may be helpful for states that includes: build the foundation for telehealth (documentation in medial record); make billing decisions; establish technology; develop initial messaging to caregivers and staff); initiate telehealth that ensures space and equipment for providers; provide staff education about how to do visits; develop targeted messaging to caregivers/recipients; begin initial roll-out of visits; and refine telehealth (refine and tailor staff education, including data collection; expand and refine services; integrate into long term model of care (see Figure 1). The article also identified data collection considerations – counts of visits; service descriptions; patient satisfaction (surveys).

Vigil, J., Kattlove, J., Litman, R., Marcin, J., Calouro, C., & Kwong, M.W. (2015). *Realizing the promise of telehealth for children with special health care needs*. Lucile Packard Foundation for Children's Health. https://www.cchpca.org/sites/default/files/2018-10/Realizing-the-Promise-of-Telehealth-FINAL_0.pdf

This report explores the use of telehealth to meet the needs of children with special health care needs including identifying and eliminating barriers to use and providing recommendations to expand access. States can use this resource as part of their research to develop state policies.

Wallisch, A., Little, L., Pope, E., & Dunn, W. (2019). Parent perspectives of an occupational therapy telehealth intervention. *International Journal of Telerehabilitation, 11*(1),15-22. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6597151/

This resource is a description of a study that explored the lived experience of parents following a 12-week occupational therapy telehealth intervention with parents and their children with autism, ages 28–79 months old. Parent perceptions provided insight into how coaching delivered via telehealth was compatible with daily life, and the authors noted that the strategy was "grounded in a collaborative parent-

therapist relationship and supported parents to feel empowered." Interviews with parents revealed that they felt their goals and priorities guided the interventions with a coaching model visit; therapists had a better understanding of their daily life and routines; and they had more collaborative partnerships with the therapists. States can use this resource as part of the research base about the value and benefits of telehealth.

Other relevant resources that can be used by states in their planning to use telepractice for EI include the following:

Edelman, L. (2020). *Planning for the use of video conferencing for early intervention home visits during the COVID-19 pandemic*. Denver, Colorado. Planning_for_the_Use_of_Video_Conferencing_in_EI_during_COVID-19_Pandemic.pdf

The purpose of this document is to suggest key topics to be addressed and provide information and resources to assist in planning how to use video conferencing for home visiting. States can use this resource to help inform plans and policies regarding how to use video conferencing for home visiting.

Public Consulting Group (2020). *Use of telehealth in early intervention (IDEA Part C): Resources to consider during the COVID-19 public health emergency*. https://www.publicconsultinggroup.com/news-perspectives/use-of-telehealth-in-early-intervention-idea-part-c-resources-to-consider-during-the-covid-19-public-health-emergency/

This resource is a list of articles, with links, about states that used telehealth to provide Part C EI services prior to the COVID-19 pandemic. (Details about findings in individual articles are described in this Appendix D.)

About Us

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