As Chair of the EI SIG, I am humbled by the therapists working in EI and the professionals in our Association advocating for EI. As states struggle with the financial constraints of the system of services, therapists strive to meet the needs of children and families and develop solutions and resources to enable high quality care. This year our SIG has posted on our website a power point presentation on the role of PT in EI that members can use to educate others about our unique contribution. For those practicing in states using a primary service provider approach, we have posted a resource fact sheet on our website and have recorded a panel discussion on the topic and posted it as a You Tube video. I encourage you to share our Facebook page with your EI agency administrators so they can benefit from the information and resources the SIG shares through this social media venue.

Over the next year we hope to meet more of the EI SIG members at one of the upcoming conferences: Advanced Clinical Practice Course in Denver Colorado; SoPAC in Anaheim, CA; APTA CSM in Las Vegas Nevada; and APTA NEXT in Charlotte, NC. If you have the opportunity to attend one of the conferences, please reach out to one of the EI SIG leadership team members or speakers to introduce yourself and share your perspectives. If you are not able to attend a meeting we hope you can join us for one of our SIG teleconference business meetings, a Google hangout, or a twitter live discussion "chat". We will send an email blast to all members to announce these events.

Thank you to those who completed the survey regarding your state practice act. We are currently compiling the results and will develop a handout on how to communicate with your state licensing board and your EI agency regarding practice issues. This year we will be collaborating with the School-based SIG to develop a resource to facilitate the transition from EI to preschool services. I encourage you to become actively involved on the IFSP team to improve the transition process for children and their families. Please email me any strategies that have been successful and I will compile them to share with our members.

As always, we welcome anyone to participate in the EI SIG activities. Please do not hesitate to contact me to discuss various opportunities.

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Tips for EI Practice: Talking to Families About Routines

by Jamie Holloway, PT, DPT, PCS

Best practice recommendations for early intervention services include embedding developmental strategies into daily routines and activities that are already occurring in a child's life. Routines allow for increased opportunities for a child to practice and learn a skill within a familiar context. This allows for optimal learning and carryover. While all families have routines, it is not always easy for providers to gather information about these routines. Included below are some tips that can be used to gain more information from families about their daily routines and activities:

- Provide background information about the purpose of your questions. Families may be more willing to provide information when they know why they are being asked.
- Remember that a routine is not the same as a schedule. Routines are activities that happen in a predictable sequence. All families have routines, even though they may not have a set schedule of when certain routines occur each day.
- Expand your definition of a routine. Getting the mail, washing hands, and helping to prepare meals are predictable, functional activities that each contain multiple opportunities for learning.
- Use open-ended questions! Ask the family what works well within the routine and what does not.
- Can you show me? Observing the routine as it typically happens will provide an opportunity to ask follow-up questions and problem solve with the family for solutions.
- Use coaching strategies to guide questioning. Ask questions to help the family come up with an answer that works for them. Avoid suggesting alternatives without family input.
- Ask the family regularly about their interests. For example, the routines in which a family participates over the summer time are likely very different than the routines of the family during the holiday season.
- Observe items and objects in the family's home that may provide clues to the family's routines. For example, by observing a baseball hat and glove near the back door, you may learn, after questioning, that the family spends the entire weekend at the ball park watching a sibling play baseball. Embedding strategies into the family's ball park routine might be beneficial for this child.
- Be respectful. Routines vary greatly from family to family. It is important for providers to keep an open-mind when working with families.
- If a formal tool such as the Routines-Based Interview (RBI) has been used to complete the IFSP, consider using the information obtained from the RBI to guide follow-up questions with a family.
- Published instruments such as the Assessment, Evaluation, & Programming System (AEPS) and the Hawaii Early Learning Profile (HELP) Family-Centered Interview can also be used for routines assessment. In addition, simple questionnaires and handouts to guide conversations with families are available online. Visit [http://tactics.fsu.edu/modules/modOne.html](http://tactics.fsu.edu/modules/modOne.html) for more information.

Finally, remember that routines assessment is an ongoing process. The routines of a family will change over time just as intervention strategies will change as the child's strengths and needs change. By knowing how to gain information about a family's routines, providers can offer
meaningful strategies for a family and increase the child's participation in activities.

Further Reading:


EI SIG Journal Club

by Jessica Young, SPT at Touro University, Nevada


Purpose of the paper:
To support the proposition that early intervention (EI) targeting key perceptual-motor behaviors can facilitate a young child's current level of function and participation, as well as advance future ability across developmental domains.

Content of the paper:
In this perspective article, the authors defend the concept of grounded cognition, or the idea that cognitive development is created, shaped, and maintained by everyday perceptual-motor experiences within environmental, social, and cultural contexts. First, the authors conduct a review of the literature and the results demonstrate that there is a clear gap in the current knowledge regarding which interventions facilitate the best outcomes for young children. The concept of grounded cognition is already embedded in the ecological and dynamic systems theories of development, and the authors discuss the potential for physical therapy interventions to be redesigned on the basis of these theories.

Staying within this theoretical framework, the authors present object interaction, sitting, and locomotion as early perceptual-motor behaviors that allow infants to explore their environment and acquire knowledge through experience, thereby serving as models for grounded cognition. The ability to perform perceptual-motor behaviors and examples drawn from research demonstrating how the behaviors broadly facilitate development are also discussed. The next section of the paper provides evidence suggesting that infants, toddlers, and children with delayed exploratory behaviors are at risk for global developmental impairments. Potential interventions are introduced to improve perceptual-motor behaviors and are characterized by the following: a focus on exploration; active trial and error hypothesis testing and variability of practice; high frequency of practice; and caregiver education and involvement. Lastly, the authors recommend that the concept of grounded cognition be actively incorporated into physical therapist practice, education, and
research, and offer suggestions to successfully accomplish this goal.

**Concluding remarks:** This article offers a broad perspective on development, and demonstrates the interrelationship of all developmental domains, especially in EI. All too often, physical therapists and physical therapy students solely concentrate on the concepts of motor learning and development without taking into account the implications that come along with improvements in this area. The evidence provided in this article suggests that improved motor skills and exploration of objects and the environment are related to improved cognition, language development, social interaction, and quality of life for infants and toddlers who receive EI services. This article challenges physical therapists and physical therapy students to rethink optimal interventions as those that enhance perceptual-motor experiences.

If you have questions, please contact Jessica Young, student physical therapist, at dpt14.jessica.young@nv.touro.edu or the lead author of this paper, Michele Lobo, at malobo@udel.edu.

**Legislative Topic: Family Cost Participation - Sliding Scale Fees**

by Deborah Crandall, JD

**Sliding Fees**

Under 20 U.S.C. 1432 (a)(4)(B) and 1437(a)(3)(A), also known generally as Part C of the Individuals with Disabilities Education Act (IDEA), infants and toddlers with disabilities are to be provided early intervention (EI) service "at no cost except where Federal or State law provides a system of payments by families, including a schedule of sliding fees." Whether parents or legal guardians will have to pay for any services for a child depends on the individual state's payment policies in which the child is domiciled. Each state's system of payments must be made publicly available and parents or legal guardians must be provided a written copy.

Under Part C of IDEA, the following services must be provided at no cost to families: Child Find services; evaluations and assessments; development and review of the IFSP; and service coordination. Depending upon the state, families may be billed for other services. Parents or legal guardians may be charged a "sliding-scale" fee if the state implements that type of payment policy. This means that the fees are based on the family's income. Some EI services may be covered by health insurance, by Medicaid, or by Indian Health Services. The IDEA Part C state administrator is required to request permission to access a family's public or private insurance in order to pay for the EI services the child receives. For EI services, health insurance - whether public (Medicaid) or private - cannot be used without the express, written consent from the family. However, if consent is not provided, the child's services may not be limited or denied due to an inability to pay for those services.

**Family Cost Participation - Sliding Scale Fees**

Some state payment policies allow for family cost participation (FCP) in paying for non-Medicaid services. The sliding scale fee is an example of an FCP policy. Sliding fees may apply to families that are ineligible for Medicaid. Providers must inform these families of the sliding payment scale. The maximum fee that is charged to these families cannot exceed the fee-for-service rate for
services provided to Medicaid beneficiaries. A state typically assigns the determination of the fee scale to a payment assessment committee. The fee that the provider charges the parent or legal guardian cannot exceed the state payment scale. Providers are usually responsible for making reasonable efforts to collect fees from these families.

The law allows for states to determine payment policies that meet federal law and the administrative methods for payment and collection, therefore, families' costs vary from state-to-state. States processes vary based on: whether costs are based on a per service charge; whether extenuating circumstances are also considered to reduce a family's liability and whether family fees include enrollment or annual fees.

A few state examples are provided below:

**Connecticut**
Connecticut's sliding fee schedule is legislatively mandated to be based on family income. Currently, any family that has an annual income of $45,000 or more whose child is enrolled in an EI program and is ineligible for Medicaid must be charged fees. The family is required to make monthly payments for services beginning with the first full month of service. The determination of the amount owed utilizes a sliding fee scale which factors in the adjusted gross annual family income, family size, and a family's consent to bill health insurance. If a family has more than one child enrolled in the EI program, only one fee is charged. Families have the opportunity to request an adjustment in fees based on "specific extraordinary expenses."

**Texas**
Texas Early Childhood Intervention (ECI) programs serve families with children from birth to 36 months with developmental delays or disabilities. The ECI program has a Family Cost Share methodology for these services. Texas provides the following ECI services at no cost to families: evaluation and assessment; development of an Individualized Family Service Plan (IFSP); case management; and translation and interpreter services, including sign language. Although families do not have to pay for these services, they may be asked for permission for the EI program to bill their insurance.

For ECI services that are not free, the amount a family will pay each month is based on both family income and size. A sliding fee scale is used to calculate the monthly maximum payment. Only one monthly maximum payment each month is required if families have more than one child enrolled for ECI services. The monthly maximum payment will be $0 if the following criteria are met: a family's adjusted income is at or below 100% of the Federal Poverty Level; a family receives Medicaid; or the child is in foster care. The ECI program considers deducting allowable expenses from a family's gross income.

An ECI program service coordinator is required to:

- Explain Family Cost Share to a family and answer questions
- Inform the family of their rights
- Work with the family to determine the monthly maximum payment
- Bill for services as agreed upon in the Family Cost Share Agreement
- Meet with the family when requested to review changes that may impact the amount of the Family Cost Share
On the state website, Texas provides examples (based on the 2012 Federal Poverty Guidelines) of the cost share different families may be responsible for paying, such as (1) "[a] family of four with an income below 100% of the Federal Poverty Level (for example, $30,000) would not have a monthly maximum payment" and (2) "[a] family of four earning between 250% - 350% of the Federal Poverty Level (for example, $60,000) would have a monthly maximum payment of $20 per month."

The Texas program will consider the following deductions that may reduce overall gross income:
- Medical or dental expenses that are not reimbursed by insurance
- Debt payments for medical or dental expenses
- Some child care and respite expenses
- Adoption expenses
- Some child support payments

Additionally, any co-payments, deductibles or co-insurance collected count toward a family's monthly maximum payment. If a family decides not to provide the state program information about the family's income, then they will be responsible for paying the highest cost share on the sliding fee schedule.

**Utah**

Utah has a legislatively imposed sliding scale fee system. Utah includes a notice to families of its family fee payment procedures which include, but are not limited to, that:
- Services will not be denied because of an inability to pay.
- Families will receive an annual review of their family fee or may request a review at anytime.
- Families have the right to appeal the amount of their family fee through their program's conflict resolution procedure.
- Families are entitled to receive uninterrupted services during the appeal process.
- Fee eligible services may be suspended if unpaid charges exceed 90 days past due.

Utah utilizes a matrix to determine its sliding fee schedule. To determine the family fee that is payable for services, the matrix is based on a family's modified annual income along with family size. The sliding fee schedule begins at 185% of the current federal poverty guidelines and ends at 700% and above. The schedule is implemented to meet state and federal laws as non-discriminatory, uniform, and that reasonable charges are "consistently and evenly applied."

**Conclusion**

Not all states utilize a sliding fee scale for family cost participation in the provision of EI services. Additionally, states that use a sliding fee scale typically make administrative adjustments from year-to-year. Any physical therapist that provides EI in a sliding fee scale state should check their state health department's website regularly for changes and notices that may impact these services.

Please contact Deborah Crandall, JD, APTA staff attorney in regulatory affairs (deborahcrandall@apta.org) with any questions.

**Resources:**

http://www.birth23.org/families/fcp/
Teaming in Early Intervention: The "State" of the Nation - New York & Nevada

New York

by Meghan Devine Condron, MPT, PCS & Susan Rabinowicz, PT

Meghan Devine Condron, MPT, PCS has been a physical therapist for 11 years and has worked in pediatrics for the last 9 years. She has practiced home and center based early intervention services for the past four years in Westchester County, New York.

Susan Rabinowicz, DPT, MS has been a physical therapist for 33 years. She had been a provider for the Nassau County Department of Health Early Intervention Program for 18 years. Susan is currently pursuing a doctorate degree. To obtain information from physical therapists across New York State an e-mail was distributed via the Pediatric section member list of the New York State Physical Therapy Association. Responses were submitted by 4 therapists that represent different regions of the state; Orange, Finger Lakes, Westchester and Nassau counties. A member of the
New York State Early Intervention Coordinating Council, Roy Grant, also participated in the conversation.

**Q) What approach to teaming in early intervention are you using in your state?**

*Meghan:* New York State uses an interdisciplinary approach in which the parents, the initial service coordinator, the early intervention official and evaluation team all participate in developing the IFSP. Providers on a single case are encouraged to communicate with each other to complement services provided and documentation of this communication is required. If this cannot be accomplished during face-to-face contact a communication notebook may be used. Parents may ask for collaborative meetings during which all members of the team meet in the child's home or center based program to discuss progress with the family and address a family's concerns. This meeting is a separate billable service in addition to 1:1 early intervention sessions and must be indicated on the child's IFSP.

*Susan:* The respondents described the individual approach that their county uses. A common thread among the respondents was the term 'teaming'. Strategies that enabled teaming included, (1) sending the team together for the initial evaluation, (2) use of a communication notebook, (3) contact via phone or secure email, (4) in person weekly meetings in center based programs, (5) acknowledging that parents are an integral member of the team, (6) collaborative meetings upon parent request, (7) formal indication of collaboration on forms, and (8) teaching families.

**Q) Why did your state decide to use this approach?**

*Meghan:* This model was selected to ensure that the program mission and goals set forth by New York State Early Intervention Program are successfully achieve.

"The mission of the New York State Early Intervention Program is to identify and evaluate as early as possible those infants and toddlers whose healthy development is compromised and provide for appropriate intervention to improve child and family development."


There are six goals designed by New York State Early Intervention, the most important of which is (1) creating a family centered program, which supports parents in enhancing their child's development. The other five include; (2) create community-based opportunities for children with disabilities, (3) coordinated services, (4) use high quality outcome based services, (5) complement the child's medical home, and (6) "assure equity of access, quality, consistency and accountability in the service system."

*Susan:* The council member responded by saying that both New York State and New York City fully recognize the importance of a coordinated team approach to EI service delivery. The reimbursement structure, however, has not sufficiently taken into account the amount of time necessary for inter-disciplinary meetings.
Q) What are some of the biggest challenges facing early intervention in your state?

_Meghan:_ The biggest challenge facing the Westchester area is the state budget and the drastic cuts to the Early Intervention system over the past three years. The reimbursement rate for services has dropped nearly 20% since 2010 for both agencies and direct service providers. Unfortunately some have adopted the philosophy "quality costs money and there is no money for quality". Many agencies and direct service providers struggle to find the balance between providing high quality services while receiving lower reimbursement rates. As a result prominent experienced agencies and direct service providers have terminate early intervention services, leaving some children waiting for services or electing to go to center based rather than having services in the natural environment of their home.

_Susan:_ The respondents were in agreement that the biggest challenge facing the state is related to the budget. Individual responses included, (1) due to a change in the payment system reimbursement has been slow, (2) change over from municipalities being fiscally responsible to a state fiscal agent, (3) decrease in the number of agencies providing early intervention services as well as loss of physical therapists, (4) decrease in provider rates. One respondent also indicated that standardization of policies and practices has been a challenge for the state.

The council member echoed the sentiments of the PTs with regard to the financial situation: as a result of the decrease in reimbursement rates, some providers and agencies reportedly have opted out of Early Intervention. He identified an additional challenge that was shared during the interview: in part because of federal requirements, New York State has increased the proportion of children receiving home and community-based rather than group developmental interventions. This has made it more difficult for team meetings to occur because team meetings are easier to arrange among agency staff members than among individual providers. Recently, however, the state EICC completed a Task Force on group developmental services and the Department of Health is poised to work on increasing the availability of group developmental services. This may facilitate interdisciplinary team meetings and have the additional benefit of increasing the number of agencies that participate in EI.

Q) What are some of the challenges in early intervention related to physical therapists in your state?

_Meghan:_ The greatest challenge facing early intervention physical therapists at this time is reimbursement rate. It is a fee for service position as there are very few salaried EI positions for physical therapists in the Westchester area. As a result physical therapists must choose between working with birth to three population or finding a salaried position with health benefits. Other challenges include (1) limited ability to learn from peers as an early intervention therapist is often isolated as they travel from home to home as well as (2) frequent policy and procedure changes resulting in learning new paperwork and systems.

_Susan:_ Respondents had a variety of different answers to this question, (1) difficulty obtaining assistive technology devices and the requirement to approach the insurance company first before working through the EIP, (2) constant changes in paperwork requirements, along with inefficiency in distributing updated forms, (3) attendance and family commitment to the program.
Q) What makes early intervention successful in your state?

*Meghan:* At its core, EI is a family centered system therefore when all providers and agencies are focused on meeting the needs of the family it is incredibly successful. New York State does an excellent job of providing trainings and evidence based information for a variety of certain diagnoses and disabilities. In addition the Department of Health website is extremely informative to both families and providers. During the past 4 years I have worked with many amazing providers from a variety of disciplines who truly care about the whole child and their family. Despite the financial hardship, New York State continues to provide a system that allows parents direct access to help their children. I am proud to be a physical therapist in the New York State Early Intervention System and am hopeful that the system will survive the drastic budget cuts.

*Susan:* The respondents were in agreement that New York State has had a history of being "generous", "liberal" and "fair" with the amount of services they authorize for families. The PT (from the Finger Lakes region) responded to this question by citing parent education as a contributing factor to the success of the individual children. The PT (from Westchester) is quoted as saying, there are amazing therapists who love the work, the families, and who provide services above and beyond what they need to do. It is always my pleasure to work with a family when their child begins to walk for the first time.

The council member responded by saying: New York State has the largest EI program in the country and provides among the most generous arrays of services. The New York City EI Program is larger than all but a few state programs. There programs maintain high clinical standards and are national models that other states should emulate.

**Nevada**

by Sarah Cwiak, PT, DPT

Sarah Cwiak, PT, DPT is a pediatric physical therapists and Director of Kideology, an Early Intervention program in southern Nevada.

Q) What approach to teaming in early intervention are you using in your state?

Nevada has joined other states in striving to apply the transdisciplinary model (Primary Service Provider approach) to our teaming when it comes to service delivery. However, assessments are approached within a multidisciplinary framework.

Q) Why did your state decide to use this approach?

The reason Nevada opted for a transdisciplinary approach can be surmised from Nevada's Effective Practice Guidelines which describe the mission and guiding principles of EI in Nevada. The basis for application stems from both IDEA requirements and literature identifying the effectiveness of this model when specifically applied to the unique population we serve. DEC's recommended practices also play a role. Practically and philosophically speaking, a transdisciplinary approach promotes the communication amongst team members (including the family) that is vital to building the positive relationships with families needed to achieve the best possible outcomes for them.
Q) What are some of the biggest challenges facing early intervention in your state?

Nevada has challenges both in common with other states and unique unto itself. As with other states, Nevada has a shortage of qualified personnel from all disciplines, constraints of budget allocations, and a crisis of identity perpetuated by overly complicated regulation and insurance industry practices.

In Nevada there are 3 distinct regions, each with its own inherent cultural and geographical challenges including a vast rural and frontier region and a large, transient, international community with all of the cultural and language barriers that accompany such a population. Nevada, specifically, faces the challenge of creating policy and general guidance that best meets the needs of an extremely diverse part of the country.

Q) What are some of the challenges in early intervention related to physical therapist in your state?

For a variety of reasons, the transdisciplinary model is very difficult for many providers to embrace. For physical therapists, the primary reason, in my opinion, is that this model is seemingly incompatible with the visions of autonomous practice and utilization of physical therapists as the provider of choice that has been promoted over the past decade. Early intervention is a very rewarding, but unique setting and many highly skilled therapists are simply unprepared to adapt to the differences that exist here. Due to the habilitative vs. rehabilitative nature of therapy work in this setting, early intervention is also seemingly incompatible with local reimbursement practices.

Other financial challenges exist, as well. Although compensation of therapists in early intervention is greater than the average for the state as a whole, caseloads can be unstable and a compensation ceiling exists in the current payment structure that limits earning potential for more experienced practitioners, thereby indirectly discouraging long-term retention.

Q) What makes early intervention successful in your state?

There are a lot of great things about the way Nevada approaches early intervention. For starters, Nevada lawmakers recognize the importance of the work at hand and show their support in budgeting efforts. Fiscal responsibility paired with the general philosophy of the Bureau of Early Intervention Services and commitment to the autonomy afforded their partner agencies, provide Nevada children and families with the foundation to achieve lifetime success through education and empowerment.

For the most part Nevada does not blindly follow the herd or make policy related to early intervention in reactionary context. Issues are thoughtfully addressed and stakeholders are given the opportunity to speak. Nevada is not afraid to take a second look at things and course correct. Right now, Nevada is filled with opportunity...opportunity for change, progression, and innovation.

It is refreshing to work in a statewide environment that emphasizes the importance of relationships. It is an attitude that extends beyond the family home and allows for more humanity in my work. No other practice setting will get you invited to so many birthday parties or allow for so much hugging...and sometimes crying. I love the diversity of Nevada.
In an era when so many are so overwhelmed, under informed, and generally apathetic, I am particularly proud to be a part of a statewide group that, although understaffed, are by and large smart, dedicated, talented and passionate individuals who actively advocate for the families of this state, even at the risk of being unpopular.

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Programming Update

By Tricia Catalino, PT, DSc, PCS

The Fourth Annual Section on Pediatrics Annual Conference (SoPAC) will be held November 8-10, 2013 (preconference courses November 6-7) at the Disneyland Hotel in Anaheim, California. Programming at SoPAC that may be of particular interest to early intervention providers include: multiple sessions on infant mental health; collaborative models of early intervention; clinical guideline presentation on congenital muscular torticollis; and working with families to name a few. Registration and programming can be found here: http://www.sopac.us/.

The Combined Sections Meeting (CSM) of the APTA will be in Las Vegas, Nevada February 3-6, 2014. Programming will include sessions targeted to pediatric physical therapists and the EI SIG will hold a business meeting open to all members. Information about registration for CSM can be found here: http://www.apta.org/csm/.

Starting in 2014, APTA's annual June conference will have a new name and attitude. The new name is NEXT and will take place in Charlotte, North Carolina June 11-14, 2014. The Pediatric Section and the EI SIG submitted proposals for this conference.

Looking ahead, SoPAC 2014 will be held in St. Louis, Missouri October 23-25, 2014. The SoPAC planning committee is seeking proposals for presentations on the provision of EI services such as the transition from early intervention to the school setting, innovative models of service delivery in EI, the role of the EI physical therapist in wellness for infants and toddlers, and assistive technology in EI. Proposals submission begins September 1, 2013. Please contact Tricia Catalino, PT, DSc, PCS for more information about submitting a proposal for SoPAC 2014. Tricia.Catalino@tun.touro.edu

EI Resources

by Priscilla Weaver, PT, PhD, DPT, PCS


http://pediatrics.aappublications.org/content/early/2013/05/22/peds.2013-1056.abstract

Centers for Disease Control and Prevention: New resources on spina bifida including videos, articles, and fact sheets.  
http://www.cdc.gov/ncbddd/spinabifida/multimedia.html

**Early Intervention SIG Leadership**

- Chair, Lisa Chiarello, PT, PhD, PCS, lc38@drexel.edu; Pennsylvania
- Vice Chair, Tricia Catalino, PT, DSc, PCS, tricia.catalino@tun.touro.edu; Nevada
- Secretary, Priscilla Weaver, PT, PhD, DPT, PCS, pweaver@fsmail.bradley.edu; Illinois
- Executive Committee liaison to the EI SIG: Rachel Brady, PT, DPT, MS, SOP Secretary
- Practice Committee liaison to the EI SIG: Lynn Jeffries, PT, PhD, PCS

**Upcoming Events**

Fourth Section on Pediatrics Annual Conference (Anaheim, CA, November 8-10, 2013): Be sure to check out the SoPAC 2013 schedule for preconference and conference programming at  
www.sopac.us/.

Combined Sections Meeting of the American Physical Therapy Association (Las Vegas, NV, February 3-6, 2014)  
www.apta.org/CSM/  

Annual Conference of the American Physical Therapy Association (Charlotte, NC, June 11-14, 2014)  
www.apta.org/Conference  

Fifth Section on Pediatrics Annual Conference (St. Louis, MO, October 21-22, 2014)