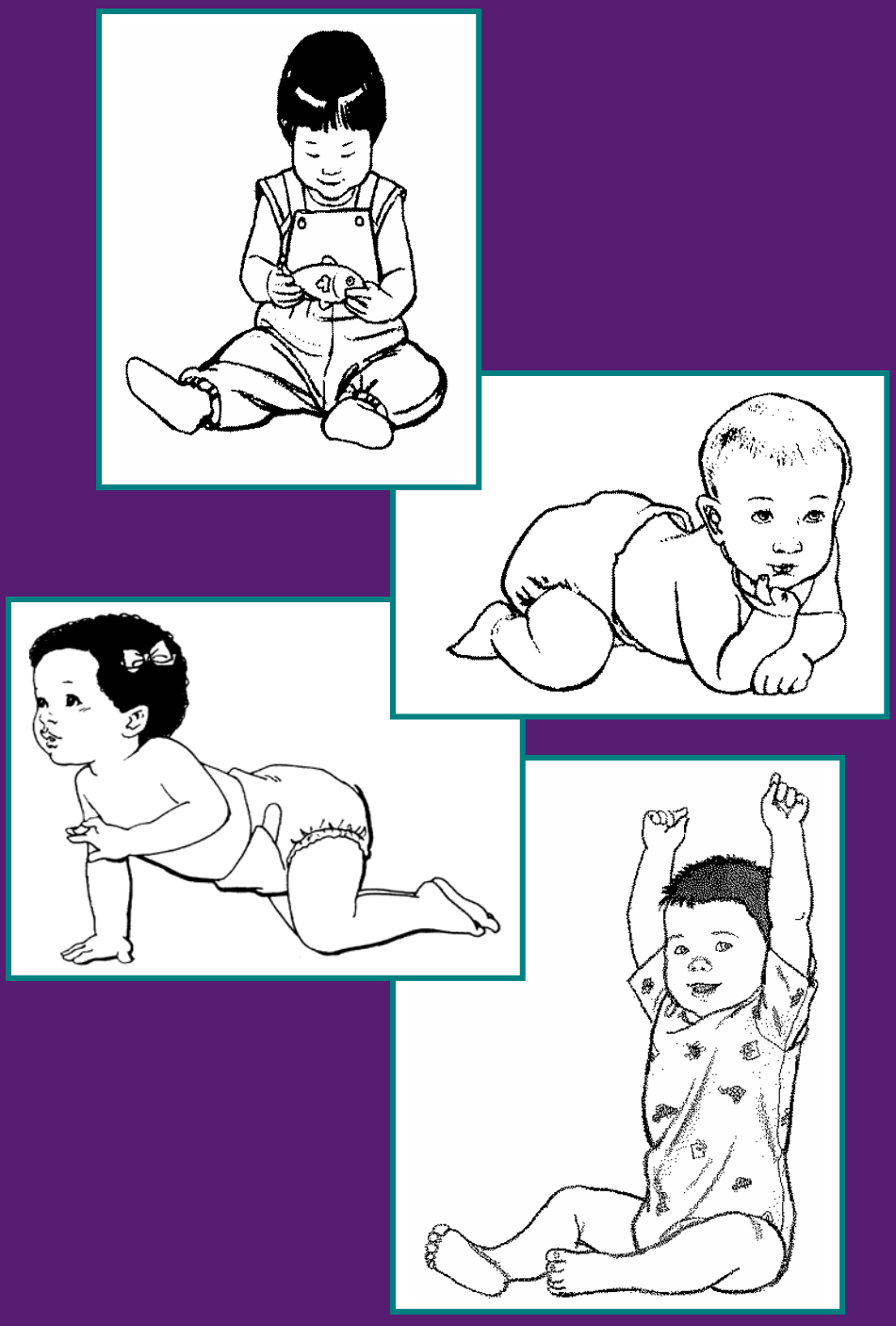
ORIENTATION TO PART C



Partnership for People with Disabilities
A University Center for Excellence in Developmental Disabilities
Virginia Commonwealth University

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Cheryl Beverly
Deana Buck
Carol Burke
Dana Childress
Laurie Cunningham
Rosalind Cutchins
Jaye Harvey
Cori Hill
Rosie Jarvis
Audrey Kane
Dianne Koontz Lowman
Katy McCullough
Susan Mitchell
Traci Morse
Beth Tolley
Mary Voorhees

The initial curriculum was written by Andrea Quigley from Child Development Resources in Norge, VA. Following piloting across the Commonwealth, the modules was modified and redesigned by Carol Burke and Cori Hill.

Editors: Cori Hill and Carol Burke

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Section I Part C Knowledge

Basic Competencies to be addressed in Section I:

- ✓ Basic knowledge of federal legislation, the Individuals with Disabilities Education Improvement Act and Part C provisions
- ✓ General knowledge of eligibility determination
- ✓ Basic knowledge of the early intervention process from referral to transition
- ✓ Basic knowledge of the Individualized Family Service Plan (IFSP)
- ✓ General knowledge of the roles and responsibilities of the service coordinator

THE INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT, PART C

Early Intervention is a federally mandated system of supports and services for infants and toddlers, birth to age three, and their families. This system operates under the **Individuals with Disabilities Education Improvement Act**, a law reauthorizing federal legislation that began in 1975 with P.L. 94-142 (The Education of All Handicapped Children Act). **P.L 94-142** is perhaps the most significant act in the history of education in regard to children with disabilities. With roots in the Supreme Court ruling on segregation, Brown vs. Board of Education, in which it was decided that "separate is not equal," P.L. 94-142 mandated a **free appropriate public education (FAPE)** for all children with disabilities from 5 to 21 years of age. Through a series of reauthorizations, FAPE was extended to children with disabilities from 3 to 21 years of age, and, in 1986, provisions were put in place through **Part H of IDEA** to provide incentives to states to provide services to children birth to three years of age. In 1997, IDEA (P.L. 105-17) was reauthorized and Part H became **Part C – Programs for Infants and Toddlers with Disabilities**. IDEA was reauthorized once again in 2004 as **the Individuals with Disabilities Education Improvement Act** also commonly referred to as **IDEA 2004**.

Federal Part C regulations require that a statewide system of early intervention services and state policy are in effect to ensure that the appropriate early intervention services are available to all infants and toddlers with disabilities and/or developmental delay and their families.

VIRGINIA'S EARLY INTERVENTION SYSTEM

In Virginia, the Part C system is called **"Infant & Toddler Connection of Virginia."** The **Lead Agency** is the organization that assures for each state that:

- a statewide system that meets the requirements of Part C is in effect
- the early intervention system makes available appropriate early intervention

services for all infants and toddlers with disabilities and their families

The Lead Agency of the Infant & Toddler Connection of Virginia is the **Department of Mental Health, Mental Retardation, & Substance Abuse Services (DMHMRSAS).** The Part C office is a component of the Office of Child and Family Services within DMHMRSAS. The Part C office has a variety of staff with responsibilities that include:

- the provision of statewide technical assistance to the local early intervention systems,
- monitoring and supervision,
- training, and
- the collection of data.

In addition, the Part C office maintains a website (www.infantva.org) that all early intervention service providers should visit regularly. Included on the website are statewide forms, policy and procedure guidance, minutes from meetings of state-level groups that guide the system, training opportunities, and resources for parents. One example of an important resource for families is the ARC of Virginia Family Involvement Project. Its purpose is to provide ongoing training and technical assistance to local systems, families and providers regarding strategies to enhance family involvement, as well as to share families' perspectives on service delivery strategies in Virginia's early intervention system. All providers should become familiar with the Family Involvement Project by calling 1-888-604-2677, extension 3 or visiting the website at www.arcfip.org.

There are forty local early intervention systems that are organized geographically according to the forty Community Services Boards' catchment areas. The Community Service Boards provide mental health, mental retardation and substance abuse services across Virginia. Each local system employs a "System Manager" who is responsible, along with the local lead agency, for ensuring that there is a comprehensive, coordinated system of early intervention in the locality that meets all local, state and federal Part C policies, procedures and regulations. While all forty local systems must provide early intervention services according to state and federal policies and procedures and meet the same state contractual requirements, each local system is unique due to the diversity across Virginia. For example, some local systems are set up to provide service coordination, special instruction, and physical, occupational, and speech therapy through their local lead agencies. Other local systems provide some or all services through contracts with public or private providers. These forty local systems are <u>all</u> part of the Infant & Toddler Connection of Virginia.

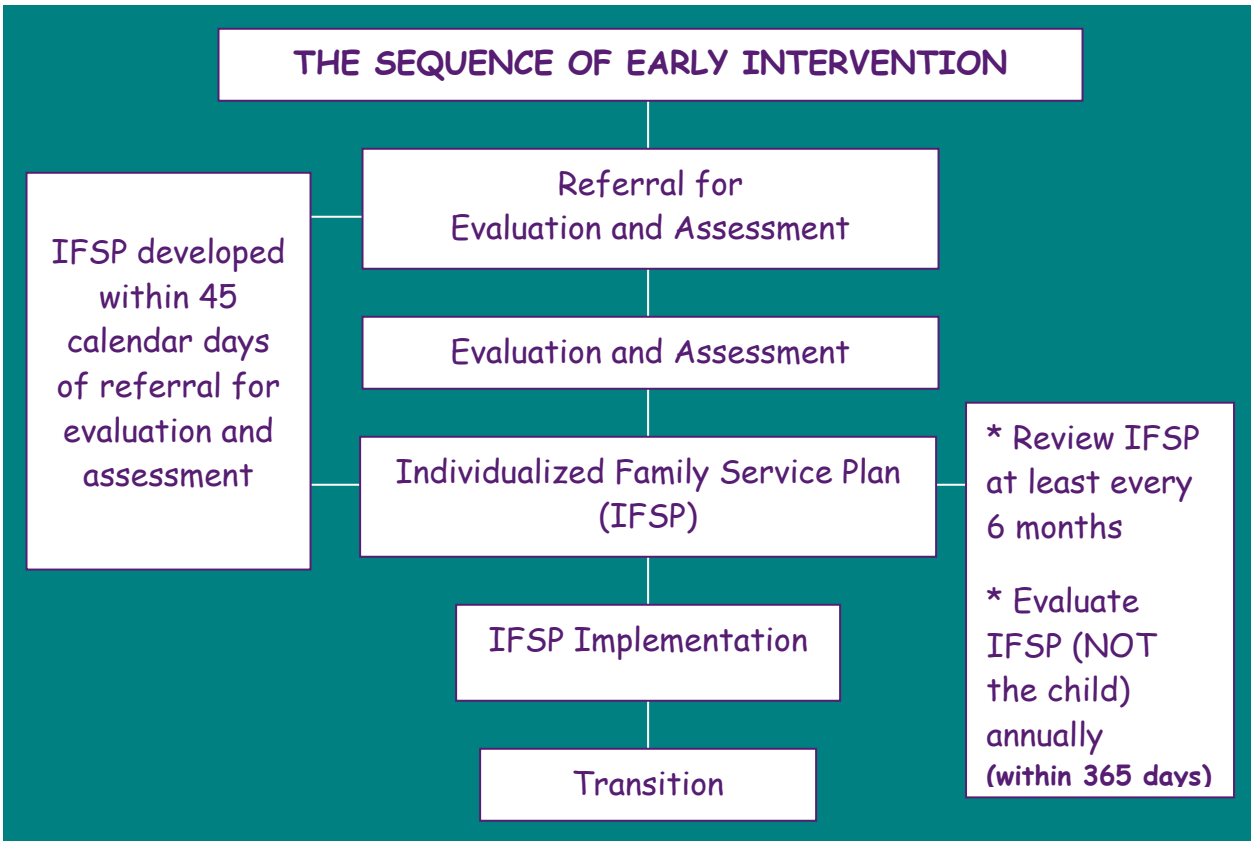
Regardless of how the local system is implemented, all children follow the same basic steps as they enter and then move through the early intervention process. The process begins with referral for evaluation and assessment and follows the child through the transition

process.

THE EARLY INTERVENTION PROCESS

The early intervention process moves sequentially through five large steps:

1. Referral for evaluation and assessment
2. Evaluation and assessment
3. Individualized Family Service Plan (IFSP)
4. IFSP Implementation
5. Transition



Included in the early intervention process are five key provisions of services under Part C of IDEA 2004 that must be available at no cost to families:

1. Child Find
2. Service Coordination
3. Implementation of Procedural Safeguards
4. Evaluation and Assessment
5. Development of the IFSP

STEP 1: Referral for evaluation and assessment

A primary referral source, such as a parent, pediatrician or health department nurse, "identifies" a child who may have a developmental delay or who may be in need of further evaluation. Referral sources often have concerns regarding development based on developmental screening results, observations, or a diagnosis that could potentially lead to developmental delay. The referring person or agency must make a referral to the Part C local Central Point of Entry **within two working days** after the child has been identified (VA Policies and Procedures, 2000, p. 49). Local lead agencies develop policies and procedures in their communities with referring health card providers and other agencies and individuals to ensure a quick response and to move towards the next step in the early intervention process.

EXTENDING YOUR KNOWLEDGE

"Child Find is the continuous process of locating and identifying all young children with special needs so they and their families can receive appropriate services at the earliest time in the child's development. Effective Child Find is a carefully planned community-based, interdisciplinary effort coordinated among providers, parents, agencies, and community organizations and tailored to the unique needs of the community" (Frank et al, 1999).

A referral is made to the **Central Point of Entry** in the local early intervention system. Anyone in the community can make a referral of a child that might be eligible for Part C services as long as they have parent/guardian permission. The Central Point of Entry collects the referral information and assigns a **service coordinator** to meet with the family to determine the next step in the process.

The **SERVICE COORDINATOR** has the important role of ensuring that children and their families within the Part C system receive the procedural safeguards and the services to which they are entitled throughout their experience in early intervention. At the first meeting with the family, the service coordinator explains the procedural safeguards and what they mean to the family. It is also during this first meeting that information begins to be gathered about family routines and daily activities which will later be used when outcomes are developed for the IFSP.

The **PROCEDURAL SAFEGUARDS** are policies and procedures to protect parents and children. Parents must give informed, written consent for all Part C activities, such as evaluation and changes in the IFSP. The procedural safeguards also include information related to confidentiality, which means that no one will share information about their child and family without written consent. Parents must be informed about these safeguards so that they can understand their role and their rights as services are provided to their

family.

When the service coordinator first meets with the family, she will inform the family of the evaluation and assessment process and the family will sign their first procedural safeguard "notice and consent form" which will give permission for the evaluation to be completed. Families do have the right to decline an evaluation. Should they choose to decline an evaluation to determine eligibility, they will be asked by the service coordinator to sign Virginia's "Declining Early Intervention Services" procedural safeguard form. No further action can be taken with the family who declines an evaluation unless and until the family chooses to grant written permission for the evaluation to determine eligibility.

The service coordinator is responsible for ensuring that the evaluation and the IFSP meeting are completed within **45 days of the time of referral for evaluation and assessment** of the child to the Central Point of Entry (34 CFR 303.342 (2)).

STEP 2: Evaluation and Assessment

Evaluation is the process used to confirm initial and ongoing eligibility for early intervention services. The evaluation must be provided at **no cost** to the family. (34 CFR 303.521 9b)(2)). Medicaid may be billed but private, third party insurance may not be billed. The evaluation is completed by a team that includes the family and at least **two professionals from different disciplines**. Existing evaluation and assessment information that is less than six months old should also be used. If existing evaluation records are used, only one professional may be required for the evaluation. In some cases, there may be enough information in the existing records, including documentation that the child was evaluated by two disciplines, to accept the records without completing a new evaluation and assessment. In those situations, it is imperative to discuss with the family what changes have occurred in the interim since that evaluation was completed.

During the evaluation, the team looks at <u>all</u> areas of a child's development to determine if the child has a delay and/or differences in development that might make him or her eligible for Part C early intervention services. Team members must use a variety of methods to determine whether a child is eligible as the federal regulations require that "no single procedure is used as the sole criterion for determining a child's eligibility" (34 CFR 303.323). These methods include parent report, informed clinical opinion, observation, and the use of evaluation tools.
Children are eligible to participate in early intervention services if they meet **one or more** of the following criteria:

1. They are **functioning at least 25% below their chronological or adjusted age** in one or more of the following areas:
   - cognitive development
   - physical development (including fine motor, gross motor, vision, and hearing)
   - communication development
   - social or emotional development
   - adaptive development;

2. They have a **diagnosed physical or mental condition** that has a high probability of resulting in delay (examples would include Down syndrome, hearing loss, and spina bifida);

3. They have **atypical development** that is demonstrated by one or more of the following criteria (even when evaluation does not document a 25% developmental delay):
   - abnormal or questionable sensory-motor responses, such as:
     - abnormal muscle tone
     - limitations in joint range of motion
     - abnormal reflex or postural reactions
     - poor quality of movement patterns or quality of skill performance
     - oral-motor skills dysfunction, including feeding difficulties
   - identified affective disorders, such as:
     - a delay or abnormality in achieving expected emotional milestones
     - a persistent failure to initiate or respond to most social interactions
     - fearfulness or other distress that does not respond to comforting by caregivers

Along with the evaluation is the process of assessment. **Assessment** refers to the ongoing procedures throughout a child's eligibility to identify:

- the child's unique strengths and needs
- resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler with a disability
- the nature and extent of early intervention services appropriate to meet those needs (34 CFR 303.322(b)(2))

The family is given the opportunity to participate at the level they desire in the evaluation and assessment process and also in meetings where evaluation and assessment information is discussed or interpreted. The "family assessment" must be "family directed." This means that the family determines which aspects of their resources, priorities, and concerns are relevant to the development of their child and which aspects they would like to share with the rest of the team. This assessment information, gathered through conversations with the family, helps the team identify child learning opportunities within the family's everyday routines and activities. The bountiful information that family members share about their child helps to identify "who" that child is outside of the "testing" situation. It gives the early intervention providers a glimpse into the child's life and provides the basis for understanding where and what kind of assistance is needed to increase his or her participation in family and community activities. From information that has been gathered from the time of the initial visit, throughout each step of the early intervention process, pieces of the family's life and the child's likes, dislikes, challenges, and celebrations are woven together to create a truly "individualized" family service plan.

STEP 3: The Individualized Family Service Plan (IFSP)

The IFSP is a written plan for providing early intervention services to a child who is eligible and his or her family. This plan:

- Is developed jointly by the family, the service coordinator, and others who may be providing early intervention services to the child and family
- Is based on the multidisciplinary evaluation and assessment of the child and the assessment of the resources, priorities and concerns of the child's family as determined by the family
- Includes outcomes, strategies, and services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child (34 CFR § 303.340(2)).

In order for families to participate fully in the IFSP meeting, the law requires that the IFSP meeting must be conducted in settings and at times convenient to families. The meeting and documents must also be in the native language of the family unless clearly not possible to do so.

A family may choose to have their child evaluated, the team may find the child eligible for Part C services, and then the family may decide that they do not want to take part in early intervention services. Should they choose to decline early intervention services, they will be asked by the service coordinator to sign Virginia's "Declining Early Intervention

Services" procedural safeguard form. No further action can be taken with the family who declines services unless and until the family chooses to grant written permission for services to begin. No family can receive services without a completed IFSP.

EXTENDING YOUR KNOWLEDGE

*The purpose of developing the **Individualized Family Service Plan (IFSP)** is to identify and organize formal and informal resources to facilitate achieving the family's outcomes for the child and for themselves. Federal law emphasizes the central role of the family in the development of the IFSP. Developing the IFSP begins at the moment the family enters the early intervention system. Gathering information from the family and other sources is a continuous process beginning during intake, child evaluation and assessment, and culminating at the initial and continuing IFSP meetings. The IFSP document is a legally binding promise to the child and family (McGonigel, Johnson, & Kaufmann, 1995).*

All early intervention programs in Virginia use the same IFSP form. Service coordinators are responsible for leading and facilitating the IFSP process. The IFSP form includes all of the components that must be included according to IDEA, 2004.

There are 8 Required Components of the IFSP:

1. A statement of **the infant's or toddler's present levels of physical development** (including fine motor, gross motor, vision, hearing and health status), **cognitive development, communication development, social or emotional development, and adaptive (self-help) development** based on objective criteria. *This can be listed as an age level or a range. This is usually stated something like "solid cognitive skills to the 10 month level with a scatter of skills to 16 months" or "gross motor skills solid to the 24 month level."*

2. A statement (with the family's permission) of the **family's resources, priorities and concerns** related to enhancing the development of the family's infant or toddler with a disability. *Priorities may include the hopes and dreams of the family for their child. It could also include information about how they would like their child to be able to more fully participate in family and community activities. Resources would include the people in the family's life with whom they rely upon and interact.*

3. A statement of the **measurable results or outcomes** expected to be achieved for

the infant or toddler and the family, including pre-literacy and language skills, as developmentally appropriate for the child, and the criteria, procedures and timelines used to determine the degree to which progress toward achieving the results or outcomes is being made and whether modifications or revisions of the results or outcomes or services are necessary. *The outcomes are statements about what the family wants their child to learn or do. For example, there might be an IFSP outcome that focuses on the child learning to sit at the table with the family at dinner and eat with a spoon, or walk around the block to the playground with the family in the evening, or say new words to tell the family what toys he would like to play with. "Individualized outcomes are* ***contextualized, functional and discipline-free*** *(i.e., outcomes are relevant for the family, focus on the child's participation in activity settings that are important to the family, and focus on the whole child)." (Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities, and Places, 2003)*

4. A statement of specific **early intervention services** based on peer-reviewed research, to the extent practicable, necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and method of delivering services. *Supports and services should be individualized to reflect the concerns, resources and priorities unique to the family, the strengths and needs of the child, and the outcomes on the IFSP. If a group of IFSPs were reviewed within a local system, the reviewer should see this individualization reflected with varying services and supports being provided from IFSP to IFSP instead of a standard service of, for example, one visit a week in the home on most or all of the IFSPs. Early intervention services include service coordination, speech therapy, physical therapy, occupational therapy, special instruction, assistive technology, and many others. All children must receive service coordination. Additional services are dependent upon many variables and often change over the course of the child's involvement in early intervention.*

5. A statement of the **natural environments** in which early intervention services will appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment. *Natural environments are more than just locations! Natural environments are* ***PLACES*** *where children live, learn and play, and also are* ***HOW*** *they learn in those natural places. As service providers consider supports and services, it is important to think about* ***WHAT*** *young children and families do at places such as the park, the grocery store, and library story time in order to incorporate those routines and activities into outcomes.*

6. The projected **dates of initiation of services** and **the anticipated length, duration and frequency of the services.** *Projected start dates must include the*

month, date and year.

7. The identification of the **service coordinator** from the profession most immediately relevant to the infant's or toddler's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this part.) *All families in early intervention have a service coordinator who is responsible for overseeing the IFSP, ensuring that all the IFSP services are provided, and that changes in the IFSP are made when necessary.*

8. The steps to be taken to support the **transition** of the toddler with a disability to preschool or other appropriate services. *This transition plan must be individualized for each child.*
(PL 108-446, Sec. 636(d)

EXTENDING YOUR KNOWLEDGE

"No two children or families have the same constellation of interests, needs, skills, challenges, resources, desired outcomes, etc. even when they have similar evaluation results. Therefore, a review of any group of IFSPs is expected to show a wide range of supports and services, service frequencies, service providers, service locations, and community resources being used to address individual child and family outcomes" (Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places, 2003).

Required Timelines

- A meeting to develop the initial IFSP must be conducted within **45 calendar days** of the date of referral to the Central Point of Entry for evaluation and assessment.
- A periodic review of the IFSP for a child and family is conducted **every six months** or more frequently if conditions warrant, or if the family requests such a review.
- An IFSP meeting must be conducted **annually** (within 365 days) to evaluate the IFSP and to revise its current provisions as appropriate. (34 CFR 303.343(a)(1). At this time in Virginia, the IFSP is completely rewritten each year.

STEP 4: IFSP Implementation

Once the IFSP is written and signed, services should begin within twenty-one calendar days. Service coordinators have an active role in overseeing the IFSP throughout the time early intervention services are provided. Some additional responsibilities of service coordinators include:

- Coordinating and monitoring all IFSP services and other services (such as well baby care) across agency lines, ensuring that the child and family are getting the services that they need in a timely manner
- Serving as the single point of contact in helping parents to obtain the additional supports and services they need
- Ensuring that the family is informed, as appropriate, of their rights and procedural safeguards
- Facilitating the development of a transition plan to preschool services, if appropriate, or to other appropriate services, if needed, that may be available

Early interventionists will be collaborating with the family as equal members of the team to implement the outcomes that have been determined. In order to ensure appropriate supports and services are delivered, open communication and teamwork are essential. These aspects of the early intervention process will be discussed in Section III.

EXTENDING YOUR KNOWLEDGE

"The IFSP is a promise - a promise that strengths will be recognized and built on, that needs will be met in a way that is respectful of beliefs and values, and that hopes and aspirations will be encouraged and enabled."

~ (Guidelines for Recommended Practices for the IFSP)
*-Adapted-NEC*TAS and ACCH*

STEP 5: Transition

Transition planning begins when a child enters the Part C system and continues throughout a child's and family's experience in early intervention. The service coordinator is responsible for exploring options with the family to prepare for the time when the child will leave Part C. For some children, their development will be at age level and they will not need additional services. For these children, the service coordinator may, if the family so desires, share information about local opportunities, such as playgroups and preschool programs. For other children who will still need some additional help, the service coordinator will work with the family to secure those services. Some children may go to an early childhood special education program in their public school system while others may receive private therapy services in a clinic-based setting and still others may attend their neighborhood preschool and receive specialized support while there. Regardless of where the child transitions, there may be an adjustment for the child and family when leaving the

Part C system. Early interventionists may help with this by discussing the process and being open to anticipate and answer any questions prior to transition. It may be helpful for some families to make a visit to the new destination to plan and prepare for leaving Part C.

VIRGINIA'S APPROACH TO EARLY INTERVENTION

The federal mandates from IDEA 2004 drive the provision of early intervention services for all states based on the law. It is, however, each state's decision to look at and determine their service delivery approach. Virginia's guidance document for our state's service delivery approach, "Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities, and Places," (September 2003) is an excellent resource and is available on the Infant & Toddler Connection of Virginia website (www.infantva.org)

When considering Virginia's approach to service delivery in early intervention, it is helpful to keep in mind two of the main tenets of Part C of IDEA:

- To enhance the development of infants and toddlers with or at risk for disabilities or developmental delays
- To enhance the capacity of families to meet the needs of their child

To achieve these goals, the Infant & Toddler Connection of Virginia focuses on building upon each child's strengths and interests to enhance his or her ability to participate in a way that is meaningful within his or her family and community. Consideration of family routines, activities and natural settings occurs throughout the early intervention process from child find, evaluation and assessment, and the delivery of entitled services (Edelman, 1999).

From the moment a family enters the early intervention system, service providers begin to explore family routines and daily activities. By asking questions during the initial meeting with the family such as, "How does Sally let you know when she likes an activity?" or "What is the hardest time of day in your house?", information is gathered that will later be used to help the family and providers generate outcomes for the IFSP. The use of natural learning opportunities and support to families enhances the family-centered focus of Virginia's early intervention system.

For example, if a family wanted their child to learn to say words so they would know what their child wanted and needed, supports and services would be provided to the family so that they would know how to work on this outcome during their daily routine – perhaps during meal time or while playing in the back yard – instead of having the family go to a

clinic or therapy center to practice speech activities. When early intervention providers and family members work together in natural settings during a child's daily routine to develop strategies to include speech activities, family competence and confidence are promoted as they learn ways to help their baby during their routine. In addition, children learn faster because they get to practice these skills naturally every day.

Key Concepts to Virginia's Approach to Early Intervention:

- Identifying and using natural learning opportunities
- Recognizing families as the primary agents of change in their children's development
- Using one primary service provider, as appropriate, to support the family and other caregivers as they implement IFSP strategies
- Individualizing frequency of services to meet each child's and family's unique configuration of interests, abilities, needs, skills, resources, priorities, and desired outcomes
- Using a consultative/coaching/teaching and support approach
- Using resources efficiently (Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities, and Places, 2003)

EXTENDING YOUR KNOWLEDGE

It is not what the service provider does in the home that will make the difference in the child's development; it is what the family, child care providers, etc. learn during the sessions and use during their activities and routines throughout the week that facilitates the child's learning and development (McWilliam2000 as cited in Sandall et al, 2000) .

SUMMARY

As early intervention providers, it is important to have a basic knowledge of the federal legislation and Part C. Equally important is an understanding of Virginia's approach to early intervention services. Key aspects of service delivery include the development of the Individualized Family Service Plan (IFSP) as well as the important role of the service coordinator. In the next section, we will learn what it means to provide family-centered services and why this approach is so critical to successful early intervention service delivery in Virginia.

Basic Competencies to be addressed in Section II:

- ✓ Knowledge of the family's role in early intervention
- ✓ General knowledge of family participation and self-advocacy
- ✓ Basic knowledge of federal natural environment requirements
- ✓ Knowledge to organize activities around daily routines

FAMILY CENTERED SERVICES

Families of infants and toddlers play the most important role during early intervention. They share information, give permission, participate in meetings, determine priorities, make decisions about services, and carry out activities within daily routines that address IFSP outcomes (Strengthening Partnerships, 2002). Since families know their children best, service providers must ask:

- How can we provide supports and services in ways that make it helpful for families to involve us in their lives?
- What kind of supports and services can assist parents to enhance their child's participation in family and community life?
- Who is the person on the team best able to assist the child and family in meeting the IFSP outcomes?
- When is the best time of day to schedule Part C supports and services to support parents in enhancing the child's participation?

(Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places, 2003).

EXTENDING YOUR KNOWLEDGE

Family-Centered refers to the recognition that the family is the constant in a child's life and that service systems and personnel must support, respect, encourage, and enhance the strengths and competencies of the family. The family's role in early intervention is defined as being the primary decision-maker for both the child and the family. (Shelton et al, 1987; National Center for Family-Centered Care (2004).

It is also critical for providers to understand who is involved in the child's life and what is included in the family's daily activities and routines. To begin this conversation with families, service providers might ask:

1. Who is in your family?
2. Who are the other caregivers for your child (e.g. extended family, child care providers, etc)?
3. Where are the places your child and family spend time?

4. What is a typical day like for your child and family? Tell me about your routines and activities. How are those routines working for you? Do you need help with bath time or dressing?
5. In what new routines and activities would you like your child and family to be able to participate? Are there activities that you used to do as a family that you are no longer able to do, but would like to?
6. What activities really interest your child? Which interest you?
7. What are the hard times of the day or the challenging parts of the day? What makes these times of the day hard?

(Adapted from: Jung, 2003; Campbell, 2003, McWilliam (in press) as cited in Bailey & Wolery, 1992, & New Mexico Technical Assistance on Natural Environments, 2002.)

It is so important when gathering this information to take the time to hear what the family has to say. Learn to be a good listener as well as a good information gatherer. By varying your questions, it will sound far less like an interview and more like a conversation; as a result, family members are not likely to feel bombarded or overwhelmed. The information collected during these initial contacts will be vital in developing individualized family-centered outcomes for the IFSP.

EXTENDING YOUR KNOWLEDGE

Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services. (Division of Services for Children with Special Health Needs 2005)

Principles of Family-Centered Services

The foundation of family-centered services is the collaboration between families and providers. The following principles help define this collaboration and explain the approach and intent of early intervention:

- Families and professionals work together in the best interest of the child and family
- Everyone respects the skills and expertise brought to the relationship
- Trust is acknowledged as fundamental
- Communication and information sharing are open and objective
- Participants make decisions together

- There is a willingness to negotiate (Division of Services for Children with Special Health Needs, 2005, adapted)

In putting the theory to practice, the collaboration between families and providers requires a partnership.

Family-centered practices:

- ❖ Acknowledge the family as the constant in a child's life
- ❖ Build on family strengths
- ❖ Support the child in learning about and participating in his or her care and decision-making
- ❖ Honor cultural diversity and family traditions
- ❖ Recognize the importance of community-based services
- ❖ Promote an individual and developmental approach
- ❖ Encourage family-to-family and peer support
- ❖ Develop policies, practices, and systems that are family-friendly and family-centered in all settings
- ❖ Celebrate successes (Division of Services for Children with Special Health Needs, 2005, adapted)

Each family is the primary decision-maker for their child and family. Service coordinators and service providers are **consultants** to support the family's efforts to meet the developmental needs of their child. In partnering with each family to address desired outcomes, providers join their developmental expertise with the family's expertise about their child and family in order to establish a shared understanding about how to support the child's ability to participate in family and community life (New Mexico Technical Assistance on Natural Environments, 2002).

Family Participation and Self-Advocacy

The intent of the Part C system is clearly written to emphasize the family's critical role in services. The collaborative process of all aspects of early intervention far outweighs the paperwork and "legalese" of the law. Families must understand their rights and feel supported in exercising their rights or **procedural safeguards**. While it is the service coordinator's responsibility to explain procedural safeguards to the family, all service providers should be aware of families' rights.

Families' rights include:

1. The opportunity for a multidisciplinary evaluation and assessment and the development of an IFSP within 45 calendar days from the date of referral for evaluation.
2. If eligible under Part C, the opportunity to receive appropriate early intervention services for their child and family as addressed in an IFSP.
3. The opportunity to receive evaluation, assessment, IFSP development, service coordination, and procedural safeguards at no cost.
4. The right to refuse evaluations, assessments, and services.
5. The right to be invited to and participate in all meetings in which a decision is expected to be made regarding a proposal to change the identification, evaluation or placement of their child, or the provision of services to their child or family.
6. The right to receive written timely notice before a change is proposed or refused in the identification, evaluation, or placement of their child, or in the provision of services to their child or family.
7. The opportunity to receive each early intervention service in natural environments to the extent appropriate to meet their child's developmental needs.
8. The right to maintenance of the confidentiality of personally-identifiable information.
9. The right to review and, if appropriate, correct records.
10. The right to request mediation and/or impartial due process procedures to resolve parent/provider disagreements.
11. The opportunity to file an administrative complaint (Notice of Child and Family Safeguards in the Infant & Toddler Connection of Virginia: Part C Early Intervention System, 2002).

Natural Environments

Federal Part C language states that **"natural environments"** are settings that are natural or normal for the child's same age peers who have no disability. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and other settings in which children without delays and disabilities participate (34 CFR 303.12(b)).

Natural environments for early intervention means much more, however, than a location where services are provided. Location of services, while integral to the approach, is only a

part of what natural environments means. For example,

- if an early interventionist goes into the home to provide supports and services but she brings special equipment that she takes from the home at the end of the visit (so then the family cannot use the equipment between visits) or
- if she "works with" the baby on the living room floor while the family watches from the sofa or makes dinner in the other room (so then the family does not have hands-on experience to know how to implement what the provider is doing) or
- if she gives suggestions but does not explain how the family could incorporate these suggestions into their routine (so then the family does not know what to do with their baby once she is gone),

then providing services in the home is no different than providing services in a center, clinic, or hospital.

Natural environments is a family-centered, community- and resources-based approach to early intervention in which the early intervention provider ensures that the provision of supports and services fit into the family's life and build effectively on the resources and supports already in place. As early interventionists focus on enhancing parent competence and confidence to maximize child participation in existing and desired activity settings, positive outcomes are achieved for children and caregivers. According to Trivette, Dunst, & Hamby, 2004, "children's participation in both home and community activity settings is related to children's developmental progress and a positive sense of parents' well-being." The natural environments approach helps children learn faster and builds the confidence and competence of families as they learn how to help their children learn new skills naturally during daily routines and activities.

For each child and family, the choice of location as well as the choice of time for supports and services is based on the outcomes that are being addressed (as identified on the IFSP). For example, if the outcome is for the toddler to eat breakfast with the family without help, then, ideally, the early interventionist would schedule the visit at breakfast time at the family's home.

While the child's home or child care center may be an appropriate setting for Part C early intervention supports and services for many children, other natural settings, such as a community center, a neighborhood park, the grocery store, etc. may also be appropriate depending on the activity settings and learning opportunities the family identifies as important to them (Individualized Part C Early Intervention Supports and Services in

Everyday Routines, Activities and Places, 2003). When the focus of intervention is to assist families through coaching about ways to help their child learn during daily activities and routines, positive long-term outcomes for the child and family occur (Dunst, Herter, & Shields, 2000, as cited in Sandall and Ostrosky,2000).

EXTENDING YOUR KNOWLEDGE

In Virginia, intervention that incorporates the natural environments regulations is referred to as "family-centered early intervention within the context of the child's and family's daily activities and routines" or simply "family-centered early intervention." This terminology better describes intervention that incorporates the natural environments requirements and the current research information about effective intervention – more than merely implying a location for services.

CONTEXTUALIZED LEARNING AND DAILY ROUTINES

Effective early intervention service providers understand the importance of implementing activities that are functional and appropriate in the context of the child's and family's life. Outcomes need to be relevant, make sense, and have meaning to families. A child can learn how to stack blocks or put a ring on a stacker but these have no functional purpose if they are not a part of the child's daily activities and the family's routines. Eating meals, participating in Sunday school, and riding a tricycle with a sibling are examples of the kinds of activities that may be meaningful and relevant to family members. The people and things in a family's life that are helpful and supportive are the family's resources that can be used to implement the IFSP activities and learning opportunities. These include:

- The family's everyday activities
- The people they see
- The places they go
- The activities they enjoy or would like to do with their child

Natural Learning Opportunities are experiences afforded as part of daily living, child and family routines, family rituals, and family and community celebrations and traditions that promote the child's learning and development. Service coordinators and providers help families find and use simple strategies in their daily routines to encourage the child's development. In walking through a family's daily activities and routines, the service provider can help the family identify what works well and where they would like assistance. Much of the information needed from families can be gathered through careful listening during conversations with families. Service providers may also use some of the questions

below to help families consider the outcomes most important to them:

1. What activities that your family already participates in are most important to you?
2. What new activities would you like to pursue?
3. Are there any activities that you have had to "give up" that you would like to start doing again?

Providers may serve as consultants or coaches to provide suggestions which can be incorporated into the family's activities to improve the child's ability to interact, explore, learn, and participate. By using materials that families have available in their homes, talking with caregivers about daily routines, problem-solving about challenges, and spending time with families in places where families spend their time, interventionists gain insight that helps them to provide effective coaching and modeling to families. Literature and research consistently support the use of natural learning opportunities to effectively promote a child's learning and to enhance a parent's competence and confidence in meeting the child's needs (McLean & Cripe, 1997(as cited in Guralnick,1997); Harbin, Mc William, & Gallagher, 2000 (as cited in Shonkoff &Meisels,2000); Trivette and Dunst, 2000 (as cited in Sandall et al). On the other hand, intervention to improve specific [motor or communication] skills without attention to their generalization in daily life skills is ineffective (Hanft and Feinberg, 1997, p. 29).

Below is an example of how to use "natural learning opportunities" written by a busy, working mother of a young child with cerebral palsy.

"When I woke Katie this morning, I said, "Good morning" and smiled. She smiled back and reached up to me. I scooped her up for a morning hug and was tickled by her squeaks and giggles. We hurried to the bathroom to wash up and get dressed. I started a peek-a boo game with the clean diaper as a distraction to keep her from rolling off the changing table. She grabbed the diaper – dropped it – looked at it on the floor and then looked at me as if to say "Gotcha! Now pick it up!"

Activity	Intervention Outcome
• Mom says, "Good morning" and smiles.	• Mom is modeling a greeting and social exchange.
• Katie smiles back and reaches up to Mom.	• Katie imitated a motor action and initiated a gestural request.
• Mom was tickled by Katie's squeaks and giggles.	• Katie took her turn in a social interaction and vocalized to show effect.
• Katie grabbed the diaper, dropped it and looked at it.	• Katie reached, grasped and released an object and established joint attention. She also showed early understanding of object permanence.

Adapted from "A Day in Our Life…" (November, 2000). Kansas University Affiliated Program and Florida State University TaCTICS: A Day in Our Life.." In New Mexico Family Infant Toddler Program (2002). Technical Assistance Document- Natural Environments. (www.health.state.nm/us/tsd/fit).

In the example above, the mother is "teaching" Katie within daily routines, and Katie is learning functional skills in meaningful activities. They are doing the activities of everyday

life and learning from them. In this approach, natural learning opportunities can be incorporated into the day doing things that families like or need to do.

In the chart below, it is evident that taking advantage of natural learning opportunities provides for more "practice time" than two or three sessions of therapy per week. In addition to the extra time, the practice is contextualized, that is, meaningful in the real life activities of the child.

Who practices his speech more?

Michael Miguel

DAY		MINUTES		MINUTES
MON			* Names his clothes while getting dressed and the food for breakfast with mom. * Labels stores during drive to childcare. * Tell friends "hi," sings songs and shares picture book at nap. * Plays car game with big brother after school. * Tells good night story to dad.	10 minutes 5 minutes 30 minutes 10 minutes 5 minutes.
TUES	Names picture cards and reads books with speech/language pathologist	30 minutes	* Names his body parts while getting dressed and the food for breakfast with mom. * Sings songs on tape during drive to childcare. * Tell friends "hi," sings songs and shares picture book at nap. * Plays outside with big brother after school naming toys. * Labels toys during bath.	10 minutes 5 minutes 30 minutes 10 minutes 5 minutes
WED			* Names his body parts while getting dressed and the food for breakfast with mom. * Labels stores during drive to childcare. * Tell friends "hi," sings songs and shares picture book at nap. * Plays car game with big brother after school. * Tells good night story to dad.	10 minutes 5 minutes 30 minutes 10 minutes 5 minutes
THU	Names picture cards and reads books with speech/language pathologist	30 minutes	* Names his clothes while getting dressed and the food for breakfast with mom. * Sings songs on tape during drive to childcare. * Tell friends "hi," sings songs and shares picture book at nap. * Plays car game with big brother after school. * Labels toys during bath.	10 minutes 5 minutes 30 minutes 10 minutes 5 minutes
FRI			* Names his clothes while getting dressed. * Orders breakfast at menu from McDonalds. * Tell friends "hi," sings songs and shares picture book at nap. * Plays card game with Grandpa. * Tells good night story to Grandma.	5 minutes 5 minutes 30 minutes 10 minutes 10 minutes
TOTAL TIME		1 hour		5 hours

Used with permission from Dr. Juliann Woods at FGRBI, a project of Florida State University.

In these examples about Katie, Michael and Miguel, a blending of natural environments, natural learning opportunities, and the supports and services approach that Virginia early interventionists are using with families are clearly demonstrated. Families are actively

involved in their typical routines, focusing on their child's development as part of their daily lives.

During each contact with the family it is important to determine whether existing services, supports and strategies are working. To celebrate successes, to identify any new challenges, and to determine if the current IFSP is meeting the needs of the family, the early intervention service provider may ask the family questions such as the following:

1. How have things been going? How did the strategy we talked about last week work? *It is important to regularly review progress on each IFSP outcome with the family to ensure that they have appropriate strategies in place to best help their baby. If a family says that a strategy is not working and they are not sure what to do, the early interventionist could offer to either model the strategy or observe as the family tries out the strategy during their routine and then, together with the family, consider alternative ideas if they are needed. If the early intervention provider and the family are unable to come up with a workable strategy, the early interventionist can contact the service coordinator to explore options for additional input. It is important for the early intervention provider to be supportive and positive about all the efforts the family is making even if successful strategies have not yet been determined.*

2. How are things going with breakfast, getting people ready for the day, etc.? Tell me about any time of day that's not going well for your child. *By regularly checking in on daily routines, the early intervention provider learns if there are any new challenges the family is experiencing. As babies grow and change, a part of the routine that went well a few months ago may not be going as well now. An IFSP review may be needed if the family has new concerns that the current IFSP outcomes do not address. If so, the early interventionist would talk with the family about reviewing the IFSP and, if they agree, then the early intervention provider would contact the service coordinator to set up an IFSP review.*

3. Did you have any appointments for your baby? Any coming up? *Sometimes families need assistance in preparing for an appointment. For example, they might want some help in making a list of what questions to ask at the appointment or they might need to brainstorm about transportation options to get them to the appointment. In addition, it is helpful to the rest of the team to know the appointments that the baby has. If, for example, a child is seeing his primary physician or going to a developmental clinic, there may be information from that*

appointment that may assist the team in developing new strategies to assist the family with their IFSP outcomes. The early intervention provider should alert the service coordinator about appointments the family mentions so that she, with written permission from the family, can request records from the appointment that may be helpful to the team.

4. Do you have enough to do with your child? Too much? Is there anything else I can help you with? *While we want to be sure we are providing enough supports and services that help each family during their daily routine with their child, we also want to be sure that they are not feeling overwhelmed by our services. By asking these questions, we invite families to honestly share their feelings about the supports and services we are providing to them.*

5. What should we focus on next time we get together? Is there any information I can bring you? *The answers to these questions will help the early intervention service provider prepare for the next visit and will also determine when during the family's routine the provider should come. Perhaps the family will say that they have been wondering about preschool programs in their community and they would like to work on the IFSP outcome for their child that involves mealtime skills. Then the early interventionist knows to schedule the visit at a time the child will be eating and to bring along a list of community preschools.*

(Adapted from New Mexico Technical Assistance on Natural Environments, 2002).

SUMMARY

Family-centered practices are essential in early intervention services. The collaboration and partnership between families and providers guides the process and helps families as they develop their advocacy skills. Services and supports are provided within the natural environment, incorporating families' daily routines and children's natural learning opportunities, helping families gain competence and confidence as they help their children gain new skills. As we move into Section III, we will continue to explore collaboration skills and begin addressing communication.

Section III Effective Communication and Collaboration Skills

Basic Competencies to be addressed in Section III:

- ✓ Knowledge of effective communication skills, including active listening
- ✓ Knowledge of the roles of providers and families in the team process
- ✓ Knowledge of the collaborative approach to EI service delivery
- ✓ General knowledge of the necessary paperwork related to Part C Service provision
- ✓ Basic knowledge of the need for supervision and/or mentorship

Effective communication is the cornerstone of the successful provision of early intervention services. From the first contact with the family to the final days of transition, the use of effective communication skills enables the early intervention service provider to understand the concerns and priorities of the family. Then, along with other members of the IFSP team, the early interventionist partners with the family to develop and implement an IFSP that includes the services and supports that will best assist the family in achieving their goals. Clear, open, and effective communication along with shared vision and trust are essential ingredients of successful early intervention partnerships.

Building blocks for effective communication include:

- Honesty
- Dependability
- Recognition of and appreciation for diversity
- Respect for all opinions
- Non-judgmental attitude

Open communication…

- Requires good listening
- Is critical for decision-making
- Provides information, opinions, and ideas
- Promotes feedback about contributions, feelings, and behavior
- Enhances personal and professional relationships

Questions to Consider for Effective Communication:

- What information do we really need to share with each other?
- Who else needs to be involved?
- What and how often do we communicate?
- What are the best ways to exchange specific types of information?
- What are the best times?
- Which are the most effective strategies?

- What information do we gather and how?
- How do I keep things confidential? (Frank, 2001)

Effective Communication with Families

While early intervention service providers have knowledge of early childhood development and the impact of delay and disability on development, each family is the expert on their child. To be successful, the early interventionist and the family must put together their knowledge and expertise as they develop and carry out the IFSP. While some families are very willing to share their thoughts, concerns, and dreams for their children, other families may be more hesitant. Strategies to consider with all families that help to lay the groundwork for good communication include the following:

- Prepare the family ahead of time. For example, at the initial phone contact after the referral is made, explain to the family what will happen during the first visit so they know to expect not only some paperwork but also an opportunity to talk about their child and family.
- Ask what names you should use for family members.
- Use "People First" language. For example, say "he has Down syndrome" rather than "he is a Down's baby." Say "a child with autism" rather than "an autistic child" or "an autistic." People First language is more respectful, recognizes that we are **all** people first, and emphasizes that disability names or medical conditions are just one small part of a person's identity and should not be used to define a person.
- Explain the purpose of forms that are being filled out, questions that are being asked, and any notes that are being taken. If a family was referred to early intervention because their child is not yet walking, they may wonder why a service provider is asking about eating, playing, or talking. And never assume that it is obvious to a family why a form has to be filled out.
- Remind the family that what they share will be kept confidential among the team.
- Explain any jargon, abbreviations and acronyms (or just don't use them!)

Once the groundwork has been laid, many early intervention providers use **active listening** strategies in their conversations with family members. An active listener is truly focusing on what is being said, reading non-verbal cues, and actively engaging in the process. Active listening is characterized by:

- A non-judgmental attitude
- Verbal and nonverbal behaviors that indicate the listener's attention (for example, focused attention without writing or checking a cell phone)
- Verbal responses that follow a family's comments
- Giving advice or suggestions only when requested
- Allowing enough time to listen to a family

To be an effective active listener, early intervention providers must have the ability to:

- Recognize a family member's feelings.
- Structure questioning in a way that promotes understanding of the family and family decision-making.
    - Effective questioning includes using some open-ended questions (for example: "What are mornings like in your house for you and your baby?" or "What do you and your child do for fun?")
    - Using both broadly- and narrowly-focused questions (a broadly-focused question might be: "Tell me about your bath time routine" and a more narrowly-focused question might be: "Describe how you position your baby in the tub.") (Winton & Bailey, 1988, 1990-adapted)
- Restate the content of a family member's message briefly and concisely.
- Perceive and reflect feelings back accurately and sensitively.

Although it may seem unnecessary to reflect back what you heard a family member say, reflecting or rephrasing will strengthen your communication and will give the family a chance to correct anything that you might have understood incorrectly.

In the example below, the service provider and family are working to identify the best times during the family's routine to focus on the IFSP outcomes…

The Early Intervention Provider begins: *"You said that you would really like Lucy to talk more. Let's talk about her day and possible ideas to include that may help her tell you what she wants and needs."*

The Family Responds: *"Our days are so full that I can't think of any time we have to set aside to help Lucy learn and practice anything new! We really want to help her learn to talk but I just don't see how we can find the time. Instead, I think that I need someone to come out here a few times a week to teach her how to start saying a few words."*

The Early Intervention Provider hears the family's concern and rephrases it as she

responds: *"It sounds like your lives are really hectic and that it would be hard to find free time to teach your baby new things. In early intervention, we have an understanding of how busy families are. We realize that free time is almost impossible to find. That is why we don't expect families to set aside time to "teach" their babies. Instead, we can help you choose natural learning opportunities within your daily routine. For example, we can give you ideas that can help Lucy learn to say new words while you are giving her a bath, driving her to the sitter's, and helping her get ready for bed. Not only will this* ***not*** *require extra time for you but we know that she will learn the best and the fastest this way, by you teaching her during her daily routine. So let's talk a little about a typical day for Lucy. Then we can begin to think about how we can include some new ideas that won't take up any extra time but will help her learn to talk."*

EXTENDING YOUR KNOWLEDGE

All of the conversational approaches to identifying family concerns, priorities, and resources require that professionals have finely tuned listening skills. Turnbull and her colleagues (1991) identified several "pointers for listening" that can be used to guide professionals when listening to families.

- *Listen for cultural and family values that are important to the family.*
- *Listen for the names of family members, friends, and professionals who are already in the support network and whose support has been particularly valued.*
- *Listen for interests, needs, and strengths that might link the child and family with a wider network of supporters.*
- *Listen for the coping strategies that the family uses and any expressed desire for expanding coping strategies.*
- *Listen for how the family has typically approached solving problems in the past.*
- *Listen for concerns, hopes, and plans that the families have concerning transitional issues.*

A Team Approach

The early intervention system relies strongly on a team approach to service delivery. Families are integral team members, therapists and/or educators provide consultation and coaching, and service coordinators collaborate to make the process cohesive. Some benefits of the team approach include:

- Bringing together needed skills and expertise
- Bringing together resources from multiple agencies
- Providing opportunities to share information across areas of expertise

- Providing opportunities to resolve differences of opinion
- Eliminating duplication of efforts
- Eliminating gaps in information, planning, and services (Frank, 2001).

When teams work well together and there are regular opportunities for collaboration, the early intervention process runs very smoothly. In many systems, however, there may be multiple agencies providing services, a limited number of therapists or educators, inadequate resources, and/or little time for collaboration. Additional common barriers to effective collaboration may include technical limitations, interpersonal tensions, and competitiveness among providers (Kaleidoscope, New Perspectives in Service Coordination, 2003). These are the everyday challenges facing the early intervention team. This leaves an often daunting task for **service coordinators whose two key responsibilities include:**

- Coordinating all early intervention services and
- Serving as the single point of contact to help parents access the services and assistance they need (34 CFR 303.23 (a) (2)

The service coordinator, responsible for guiding the members of the team through the process of developing the IFSP, has a chance with each IFSP meeting to develop and refine his or her team-building skills. There are additional opportunities for team-building outside of the IFSP meeting that all early interventionists might want to consider, including scheduling monthly or quarterly team meetings, creating a staff newsletter, and participating in after work gatherings.

The Primary Service Provider Model – Where Does Everyone Fit?

In Virginia's approach to early intervention, one primary service provider typically works with the family. This method of service delivery is consistently recommended in the literature (Hanson & Bruder, 2001; Harbin, McWilliam, & Gallagher, 2000 (as cited in Shonkoff & Meisels, 2000); McWilliam, 2000 as cited in Sandall et al, 2000; McWilliam & Scott, 2001; Shelden & Rush, 2001).

Families have shared that they appreciate having a primary provider. In years past in early intervention, many families had multiple visits a week – sometimes by the same provider (for example, the speech therapist may have visited three times a week) and often by more than one provider (for example, the educator, the speech therapist, and the occupational therapist may have all visited on a regular basis). When there were multiple providers, it was challenging for them to have a chance to communicate with one another on a regular basis and, even when they did, it was still a challenge for them to give consistent information to families. As a result, families often received suggestions from

different providers and, in general, too many suggestions from too many people! Families have shared that they often felt overwhelmed having so many visits a week from different early intervention staff, yet believed that if many services were offered, they should accept them, thinking that "more is better" when it came to helping their child grow and develop. At the same time, each provider felt that it was important to work directly with the child and family, often feeling a reluctance to share their discipline-specific knowledge with other team members.

The early intervention system in Virginia is now embracing the primary provider model. By listening to families, studying the research, and learning about what really makes a difference for young children and their development, we now know that "more is not better" when it comes to the number of visits a week and the number of providers working directly with families. Most families in early intervention now have a primary service provider working with them but still have the benefit of other team members who consult with the primary provider and the family, when needed, to suggest strategies and techniques to enhance progress towards family-identified outcomes. Communication with the family is significantly enhanced when just one primary provider is working with the family to implement appropriate supports and services. In addition, families have more time to devote to other interests and needs when they don't have multiple visits a week. And, most importantly, research shows that a primary service provider model is a very effective way to help families help their young children grow and develop. The use of a coordinated, integrated approach to services, with one primary service provider, supports the focus on the natural flow of the family's life within everyday routines, activities, and places and also recognizes that natural learning opportunities belong to the children and family rather than to any one discipline. (Adapted from New Mexico Technical Assistance document on Natural Environments, 2002).

For a team to successfully implement the primary service provider approach, several key elements are required. All team members must:

- be committed to the approach
- trust and respect each other's professional abilities
- have strong communication and collaborative skills
- continue to learn and expand their knowledge and expertise

Even for the most cohesive teams with the best skills, however, differences of opinion can arise. It is during these times that problem-solving skills become essential.

Problem-Solving

Members of successful early intervention teams know that there won't always be agreement. When working with families and developing intervention strategies, there are often multiple ideas, each with its own merits, which can sometimes lead to conflict among team members. Effective collaboration includes the ability to negotiate and resolve this conflict. Having effective problem-solving skills is helpful in formal meetings, like an IFSP meeting, and also during less formal discussions, within the same agency and across agency lines, among all the team members or just between two individuals.

Following these simple problem-solving steps can help collaborative efforts:

- **Define the issue** or problem by collecting information, offering perspectives, and exploring interpretations.
- Invite team members to **share differing opinions** during the problem-solving process.
- Outline possible goals to work on and then **set priorities**.
- **Assign responsibility** for who will do what and when.
- **Try out** the strategies and monitor the work together.
- Communicate continuously and **provide feedback and encouragement.**
- Examine the process and **revise the course of action** to achieve goals together.

These same steps used for problem-solving a variety of issues are also used by IFSP team members with every child and family as IFSPs are developed and implemented. At each IFSP team meeting, all the collected information about the child and his or her family is shared. Team members, including the family, offer their views and then together they develop IFSP outcomes, based on the family's priorities. A primary service provider is selected and responsibilities for other team members are defined. The service coordinator monitors progress and keeps all lines of communication open among the team members as services are provided. At 6 months, if not before, the team will meet again to review IFSP progress and make changes, if necessary. While any team member, including the family, may recommend a change in or review of the IFSP at any time, the IFSP can only be changed during a formal IFSP review meeting that includes the family and the service coordinator and, if needed, other members of the team. The IFSP process gives team members regular practice in working together and reaching consensus in order to develop and carry out an IFSP that provides the appropriate services and supports to each family.

When those occasions arise when team members disagree, they know that professionals

with competence in negotiating and resolving disagreements will:

- Use an unconditionally constructive strategy for communicating and negotiating where you maintain your positive approach regardless of the approach of other parties. (Harvard Negotiation Project, 1989)
- Seek to understand the other person's point of view before trying to convince them of your own point of view. (Covey, 2000)
- Focus on interests rather than on the people or personalities. (Harvard Negotiation Project, 1991)
- Formulate options that will satisfy all team members if possible.
- Use objective criteria to evaluate options. (Harvard Negotiation Project, 1991)

When early intervention professionals ensure that the priorities of the family are also their priorities when working through disagreements, disagreements often disappear. For example, if the speech therapist thinks that the child really needs to work on learning to talk and the physical therapist really thinks that the child should be focused on crawling, but the family would like their child to be able to eat independently before anything else is addressed, the disagreement between the two therapists becomes irrelevant. In early intervention, the family's priorities become the goals on the IFSP. While the physical therapist and the speech therapist have a professional responsibility to share their views with the family so the family can make fully informed decisions, the family ultimately sets the priorities for their child and the rest of the team respects and supports their decisions.

Documentation

Accurate and effective written communication is as important as effective spoken communication. Written communication is used to share information among IFSP team members and with other agencies and providers, including health care professionals, who are involved in caring for the child who is receiving Part C services. Written communication also provides a lasting record of services provided to each child and family in the Part C system. There are agency guidelines, insurance requirements, and Part C local, state, and federal regulations that must be met when paperwork is completed as the family moves through the Part C system.

The service coordinator is responsible for overseeing the completion of the IFSP, all IFSP reviews, and the completion of official documents related to the Part C Procedural Safeguard Requirements. Service coordinators and/or other early intervention providers may complete paperwork for insurance-related requirements and additional agency-related documentation. This typically includes documentation of any contact the provider and service coordinator may have with the family. All of this information should be included in the child's early intervention record. The early intervention record should serve as a

reflection of the child's experience in early intervention, from the time of referral to discharge. The IFSP, procedural safeguards forms, release of records, progress notes and other documentation are typically included in the early intervention record.

It is important to remember several issues related to documentation:

1) If it is not written, there is no evidence that it occurred. For example, each early intervention record must include documentation that each early intervention service promised on the IFSP was delivered. If the IFSP says that a family will have a visit at home from the physical therapist for one hour every other week for two months, there should be documentation in the chart every other week that verifies that the family received this service. If an appointment is missed, for any reason, the reason why the appointment was missed should be documented in the early intervention record.
2) All documentation should be written objectively knowing that families can review their record at any time.
3) Documentation should be relatively jargon-free to allow sharing of information across disciplines.
4) Documentation serves as legal "proof" in the event of a court hearing or subpoena.
5) Documentation errors and omissions are costly to the early intervention system. Third party payors will not provide reimbursement for therapy and other services if the documentation does not meet the requirements.

Strategies for Ensuring Accuracy in Completion of Documents

Every professional develops an individual work style for keeping information organized, accurate, and completed in a timely fashion. Below are some strategies that have been demonstrated to be effective in documenting information from families and completing necessary early intervention paperwork:

- Develop a checklist or log that lists each document to be completed. Record the date as each document is completed and filed.
- Schedule time at the end of each home visit or contact with the family to make notes on the information collected.
- Identify locations (public library, coffee house, other public buildings) on your visiting route where you can complete your paperwork after each family contact.
- Explain to the family how important accuracy is, and request their permission to make notes during your conversations.
- Schedule time each week to review files, enter information, and identify additional needs.
- Keep a diary, telephone log, and/or contact sheet for each family with whom you interact.

- Develop a "scrap book" with the family to record contacts and events.
- With the family's written permission, take instant photos, digital photos and/or videotaped recordings of activities.
- Use the previously described techniques for active listening, rephrasing, and structured questioning to clarify information.
- Work with your peers and/or supervisor to identify strategies or problem-solve around particular record-keeping issues or challenges.
- Keep paperwork that includes confidential information in a secure location at all times in accordance with your agency policies and procedures.

Supervision and Mentoring

Early intervention service delivery, including effective communication and collaboration, is a complex and often challenging task that requires knowledge and skills that may or may not have been part of a provider's formal education or training. Supervision and mentoring are key resources for both the entry-level service provider and the seasoned professional in expanding their skills in early intervention service delivery.

Agencies establish a system of supervision to assist with administrative and management responsibilities as well as clinical supervision. In addition to that supervision, it is sometimes necessary for the service provider to seek particular expertise around issues or problems that need to be addressed. **Mentoring** is a strategy to meet this need in early intervention service delivery.

Mentoring is founded on peer support. The mentor provides:

- Guidance
- Advice
- Support

and encourages the protégé (the service provider) to

- Take risks
- Meet new challenges
- Develop their professional goals

The service provider can enhance professional growth and development through:

- Part C Office Technical Assistance
  - provision of up-to-date systems information from the State
  - clarification of Part C policies, procedure, and their implementation
- Department of Education Training and Technical Assistance Centers (T/TAC)
  - loan EI materials and resources to providers

  - offer workshops on topical issues
  - may organize early intervention special interest groups for networking
- Professional organizations
- Training opportunities provided by Federal training projects

Other general strategies may include:

- Attending local, state, and national conferences on early intervention and early childhood
- Reading professional journals (electronic and print)
- Searching the Internet
- Joining professional list-serves
- Signing up for notification of updates from websites such as NECTAC
- Attending in-service trainings
- Seeking out mentors
- Identifying other peer support opportunities
- Developing and implementing individualized staff development plans with supervisors and/or mentors

SUMMARY

Strong communication and collaboration skills are essential in early intervention. Knowledgeable interventionists seek to improve their communication styles, vary their methods with the multitude of families with whom they work, and learn from their colleagues, mentors, and supervisors. Teamwork is also a critical component of Virginia's primary service provider approach to early intervention supports and services.

Basic Competencies to be addressed in Section IV

- ✓ Awareness of own culture, values, and attitudes
- ✓ Works well with families of diverse backgrounds by
  - o Recognizing that culture impacts the family structure and family membership
  - o Understanding and recognizing values and cultural expectations of individual families
  - o Identifying issues related to working with families from diverse backgrounds

Culture

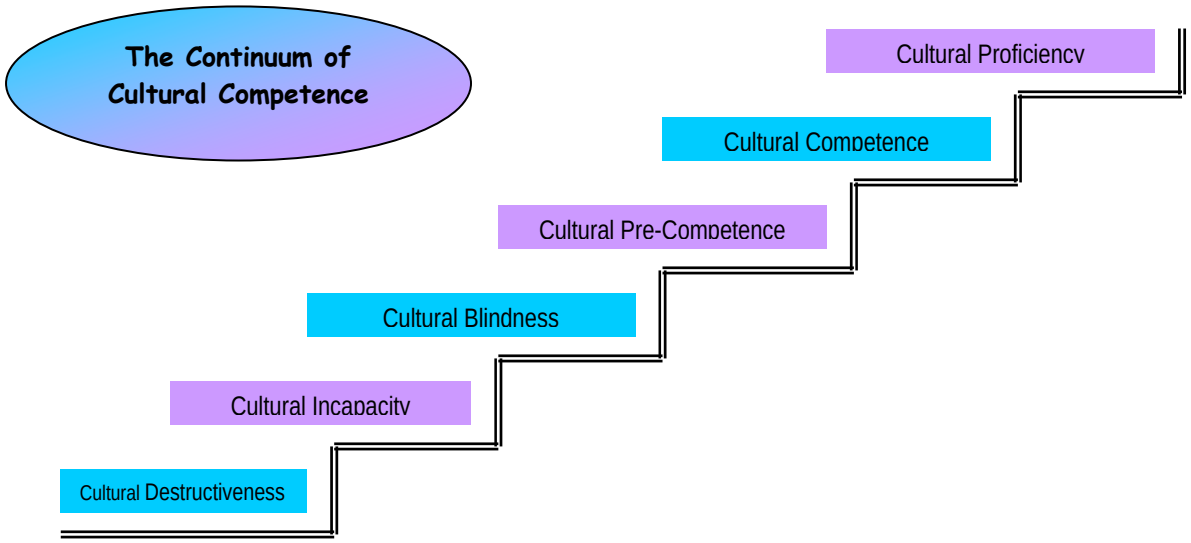
Culture has been "defined as people's values, religion, ideals, language, artistic expressions, patterns of social and interpersonal relationships, and ways of perceiving, behaving and thinking" (Balthrop & Coleman, VAECE Presentation, 2003). Every family has culture! Additionally, regardless of skin color, ethnic background, or where or "how" people live, each family develops an individual culture (Kaleidoscope, Level I: New Perspectives in Service Coordination, 2003). Their culture identifies "who" they are as a family and "how" they identify themselves as a family.

Every early intervention provider also has his/ her own culture that affects their interactions and relationships with families. As providers meet diverse families and begin to establish rapport, a wide range of skills is required to effectively provide supports and services. Cross, Bazron, Dennis, & Isaacs (1989) have developed a 6-stage continuum of cultural competence. They emphasize that individuals, agencies, and systems can move both forward and backward along the continuum From negative to positive, the stages, when applied to our work in early intervention, are:

- **Cultural Destructiveness** – An early interventionist at this first stage would intentionally and consciously act in destructive ways toward specific cultural groups.
- **Cultural Incapacity** – At this second stage, the early intervention provider has no knowledge or capacity to serve culturally diverse groups but does not behave in a destructive manner.
- **Cultural Blindness** – At this most common stage on the continuum of cultural competence, the early intervention provider tries to "treat everyone the same."
- **Cultural Pre-Competence** – An early interventionist who has reached this fourth stage recognizes that not everyone is the same and also recognizes that he or she, as an individual, has significant weaknesses in terms of effectively reaching and

- serving culturally diverse groups.
- **Cultural Competence** – At this fifth stage, the early intervention provider is developing the skills, knowledge and abilities that competently meet the needs of diverse populations.
- **Cultural Proficiency** – At this final stage, the early intervention provider is able to add to the knowledge base of the field of culturally competent early intervention service delivery. This is the ultimate end of the continuum but rarely, if ever, seen in "real life."

In reviewing the chart below, it is important to note that moving toward cultural proficiency is a process. The steps along the continuum require time and experience. In actuality, very few people truly become "culturally proficient." What early interventionists must strive toward is heightened awareness, understanding, and respect for all cultures, all individuals, and all families.



Cultural Diversity

Each time a child is referred to the early intervention system, the early interventionist is presented with a new opportunity to practice and further develop his or her skills in cultural competence. Respect for family diversity ensures that early intervention supports each family's efforts to care for their young child while, at the same time, attends to the needs of the entire family. Accepting and respecting family diversity means learning to recognize the strengths and resources present in *all* families.

Cultural competency experts often use an iceberg analogy to emphasize that the "visible" cultural qualities (differences in appearance, language, dress, food, etc.) are only the "tip of the iceberg" in understanding diversity. It is actually the less "visible" aspects of culture that have a far greater impact on a person's behavior, practices, and beliefs. It is also a mistake to overemphasize cultural differences. Identifying "common" characteristics of a particular cultural group is inherently dangerous in that it can actually promote stereotyping because there is greater diversity *within* than *between* cultural groups. Therefore, as early interventionists learn about the cultural characteristics that are common within a particular group, it is essential to be conscientious that this knowledge offers only a "starting point" for exploring beliefs, values, priorities, and perspectives for a given family as each new family will be different from all the families the early intervention provider has met before (Kaleidoscope, Level I: New Perspectives in Service Coordination, 2003).

Lynch and Hanson (1998) provide a cultural continuum for understanding value differences that families place on key factors in their lives. Conceptualizing these differences as a continuum rather than opposite sides of a scale helps to emphasize that different people will place different values in their approach to living:

- **Extended vs. Nuclear Families** – Families vary widely in how they structure themselves. Some families consider their "family" to be the immediate biological family members (for example, the "nuclear family," which is commonly defined as a mother, father, and children). Other families define their families much more broadly; their extended family members may include most or all of their biological relatives plus neighbors and close family friends. How a family defines itself greatly influences who needs to be involved in early intervention planning and service delivery.
- **Interdependence vs. Independence** – How families make decisions also varies widely. Typical American culture values a level of independence and assertive decision-making among each member of the family. In many other cultures, however, decision-making is based on what is best for the family or the group. This value on the continuum is known as "interdependence." Family members may need to consult with other members of their family before making IFSP decisions. For example, a grandmother may actually be the decision maker in a family with a teen mother. If that is the case, the early interventionist needs to be sensitive to the fact that the teen may want to include her mother as the IFSP is being

developed.

- **Nurturing vs. Independence -** Also in American culture, there is a tendency to value children becoming independent as quickly as possible. In many other cultures, there is not such a hurry to see children move towards independence. Therefore, as early interventionists, caution must prevail, especially when discussing outcomes.
- **Time** - Different perceptions of time may also be a factor as early intervention services are planned and carried out. Some people place a high priority on promptness while others prefer a more leisurely lifestyle. When early interventionists are stretched by tight schedules and billable hour requirements, missed appointments can be a source of frustration. Many families from other cultures, however, may not understand the constraints under which providers work. It is important to discuss family routines and identify times of the day that work well for families in order to schedule mutually satisfying intervention visits.
- **Tradition vs. Technology** - We live in a world of high technology! Many early intervention providers are excited about the newest assistive technology or cutting edge adaptive equipment. This might be very overwhelming to a family who relies on "Grandma's remedies." Therefore, the early interventionist must be sensitive to families who are on the traditional end of this continuum, as they may show less interest in advanced switch toys or computerized adaptations even if those things may help their baby learn a new skill. Additionally, this continuum of "tradition vs. technology" can also help providers understand families who interpret their child's disability in spiritual terms rather than physical or scientific terms.
- **Individual vs. Community ownership** - In many cultures, community ownership is very common. What belongs to one person or one family is shared by all. In the United States, individual ownership is more common. Early intervention providers may be surprised to find that they loan something to a family from a "lending library," such as a piece of assistive technology, and they come back the next week to find the family passed the item to the child next door, simply because the child liked the toy!
- **Rights vs. Responsibilities** - This continuum is most commonly seen with regard to differences in gender roles. Many early intervention providers struggle with their observations of gender role definitions in other cultures and have a desire to "liberate" women when, in actuality, these roles may be very comfortable and acceptable for these women and their families. This continuum also affects how families respond to advice from others. For example, some families may hold people they view as authority figures, such as physicians (and, perhaps, early

interventionists), in high esteem and they will not question them or disagree with them. If they do not understand and/or like the advice they are given, they may nod in agreement or say they understand but perhaps never follow through with the recommendation.

- **Control vs. Harmony** - In many cultures throughout the world, individuals strive to live in synchrony or harmony with their surroundings or circumstances. In mainstream United States culture, there is more of a tendency to try to control our surroundings and circumstances. The nature of early intervention supports and services may be seen by some cultures as an attempt to control the harmony they seek to maintain. (Kaleidoscope, Level I: New Perspectives in Service Coordination, 2003).

EXTENDING YOU KNOWLEDGE

Definition of Family

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. A family is a culture unto itself, with different values and unique ways of realizing its dreams; together, our families become the source of our rich cultural heritage and spiritual diversity. Our families create neighborhoods, communities, states, and nations.

House Memorial Task Force on Young Children and Families (1990).

Meet the Lopez Family

The Lopez family was referred to early intervention after visiting a clinic at a large metropolitan hospital. Their child, Christian, experienced severe complications at birth and was now having seizures and a significant developmental delay. The family came to the United States from their home in Haiti because Mr. Lopez believed that they could find better care for Christian here.

The service coordinator, Mary Flanagan, was having a difficult time reaching the family by telephone to set up a visit. She had left several messages with someone who answered the phone, but she had difficulty understanding the person and was not sure that the family had gotten her message. Finally, worried about regulations and timelines for responding to referrals, Mary decided to stop by the apartment.

Mrs. Lopez answered the door and, when Mary explained who she was and why she was there, Mrs. Lopez asked her in. The apartment was small and very crowded with furniture. Mrs. Lopez sat on the sofa with the baby, Christian, lying across her lap. There was not

another seat in the room. Mary could hear voices and people moving around in a back room.

Mrs. Lopez patted the cushion and nodded for Mary to sit down. Mary began to ask some questions and Mrs. Lopez became quieter and seemed very hesitant to answer. She looked towards the back room several times. Mary, sensing Mrs. Lopez's uneasiness, asked Mrs. Lopez to tell her about the people in her life and who was most important to her. Mrs. Lopez immediately brightened and began talking about her relatives in Haiti, about how she missed her mother, and that she was now living here with her grandmother and some other relatives. Mary said that it must be nice to have a grandmother to talk to. Mrs. Lopez smiled and agreed, saying that, in Haiti, grandmothers had everything to say about how to raise the children. Mary asked if her grandmother was at home. Mrs. Lopez said, "Yes, in the back room." Mary suggested that, if Mrs. Lopez would like, she could invite her grandmother to join their visit. Mrs. Lopez's shoulders relaxed and she said that would be very nice.

When Christian's grandmother joined the visit, Mrs. Lopez seemed much more comfortable. As the three women began to interact, the grandmother provided many small pieces of information that helped Mary understand more about the Lopez family. Mary felt like this knowledge would be very helpful to her as she planned for future visits.

Culturally Skilled Service Providers

In a family-centered, culturally-competent early intervention system, policies and practices promote meaningful participation by all families, regardless of race, ethnicity, religion, socioeconomic level, or geography. At the local level, culturally-competent programs offer services and supports that match a family's language, culture, and community activities. For example, in communities across Virginia, it may be a priority for a family to have their child participate in activities around the farm or at the beach. In these communities, service providers may help families consider strategies to encourage the child's participation in the family's daily routines, which may include building sand castles, riding on a hay wagon, or playing in the yard.

Becoming a culturally skilled service provider takes experience and dedication. As you meet new families with new customs or traditions with which you are unfamiliar, do not hesitate to ask questions. Identified below are suggestions to help early interventionists improve their skills in working with all families:

- Become familiar with a family's cultural background, family structures, beliefs, traditions and values as they relate to the provision of early intervention services

- Recognize and respect each family's values and religious or spiritual beliefs and view them as strengths
- Value bilingualism and do not view another language as an impediment to the early intervention process
- Define goals and utilize strategies that are consistent with the life experiences and cultural values of the families with whom they work
- Integrate parent beliefs and priorities into early intervention planning and practice
- Recognize and incorporate cultural practices, behaviors and routines in assessments
- Modify and adapt conventional approaches to accommodate cultural differences
- Know about support systems and resources and how to help families connect with them
- Send and receive both verbal and nonverbal messages accurately and appropriately
- Utilize interpreters in a manner that enhances rather than diminishes the relationship building with a family and the family's early intervention experience (Welch, 2000; Sue, et al, 1990, adapted).

EXTENDING YOUR KNOWLEDGE

Individuals who work with children must respect, value, and support the culture, values, and languages of each home and promote the active participation of all families…Individualized services begin with responsiveness to differences in race, ethnicity, culture, language, religion, education, income, family configuration, geographic location, ability, and other characteristics that contribute to human uniqueness. (DEC Responsiveness, 2002)

Working with Interpreters

Language barriers are common challenges in the early intervention system. Using an interpreter is never the ideal solution as nuances of language can be hard to translate and miscommunication and delays in the flow of the conversation may occur. The opportunity to build rapport and trust is often diminished as well. Nevertheless, if bilingual early interventionists are not available, interpreters are often necessary.

Interpretation is a skill that requires training and practice. Many early interventionists are concerned when they say a long sentence explaining something to a family and then the interpreter tells the family something in the native language that appears to be a much more condensed version. Therefore, when hiring an interpreter, it should be made clear that you expect him or her to interpret exactly what is said. Additionally, interpreters

must be fluent in the regional vocabularies and dialects of the family for whom they will be interpreting.

When using interpretation services, the quality and the skill level of the interpreter are essential. Unfortunately, in some situations, older siblings of the child eligible for Part C are sometimes considered as interpreters for their family because they typically learn English more quickly than adult family members and because they are readily available. This practice should be avoided. While these older children may use English at school and their native language at home, they should not be expected to understand and explain the procedural safeguards, the IFSP process, and technical and medical terminology to their parents. Using children in this capacity may also alter the child's role in the family and may become a source of tension or power struggle between these older siblings and their parents. When formal interpreters are not available, service coordinators should work with the family to identify extended family members, neighbors, church members or other supportive adults who speak both languages fluently and who could assist with interpretation.

Additional Tips when an Early Intervention Provider uses an Interpreter:

- Speak directly to the family, not the interpreter
- Allow extra time for the meeting
- Discuss any cultural or language issues with the interpreter prior to the meeting
- Be aware of non-verbal communication (body language, gestures, eye contact)
- Avoid technical jargon

Remember, an interpreter is a bridge to effective communication with families for whom there is a language barrier. The competent early intervention provider will work collaboratively with the interpreter to ensure that the family fully understands their rights and their role in the early intervention system.

EXTENDING YOUR KNOWLEDGE

Principles for Culturally Competent Services:

- *Every child and family is rooted in culture.*
- *The cultural groups represented in the communities and families served by early intervention programs are the primary sources for information about what constitutes culturally competent programming.*
- *Culturally competent programming requires early intervention providers to have accurate information about the cultures of the families that are served and to discard stereotypes.*
- *Addressing cultural relevance is necessary to developmentally appropriate practice.*
- *Every individual has the right to maintain his or her own cultural identity while acquiring the skills required to function in our diverse society.*
- *Effective services for children with limited English speaking ability require continued development of the primary language while the acquisition of English is facilitated, but only if the family desires to learn to speak English.*
- *Culturally competent and diverse practices should be incorporated in all program components and services*

Adapted from *National Head Start Bulletin*, Issue # 37, U.S. Department of Health and Human Services,

On the following page is a checklist that will help you explore your cultural competency skills. Take a moment to answer the questions.

INSTRUCTIONS: **This checklist is intended to heighten awareness of culturally competent service delivery.** Please select A, B, or C for each item below.

Things I do:

A = frequently B = occasionally C = rarely or never

Communication Styles

_____ 1. For children and families who communicate in a language other than my own, I attempt to learn and use key words or signs in their language so that I am better able to communicate with them.

_____ 2. When interacting with children and families who do not speak my language, I always keep in mind that: the communication difference is in no way a reflection of their level of intellectual functioning and their inability to use my language has no bearing on their ability to communicate in their own language.

_____ 3. I ensure that interpreters are available for meetings, events, or other situations at which some children and families may have language barriers.

_____ 4. I accept and recognize that the language used at home may be different from the language used outside the home.

_____ 5. I encourage and invite families to participate in activities regardless of their ability to speak my own language.

Values/Attitudes

_____ 1. I avoid imposing values, which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 2. I discourage children, families, and co-workers from using racial and ethnic slurs by helping them understand that certain words can "hurt" others.

_____ 3. I participate in activities that help me learn about and accept the differences and similarities in all people.

_____ 4. I intervene in an appropriate manner when I observe children, families, or co-workers engaging in behaviors which show cultural or ethnic insensitivity.

_____ 5. I recognize and accept that individuals from ethnic/racial minorities may desire varying degrees of adaptation to the dominant culture.

_____ 6. I accept and respect that male-female roles in families may vary significantly from one culture to another.

_____ 7. I accept each individual or family as the ultimate decision-maker.

_____ 8. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 9. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program.

There is no "passing score;" however, if you frequently responded "C," you may want to explore your methods of service delivery and gather more information related to practices which promote cultural competence.

Adapted from: Goode, T.D. (2002). *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings.* Washington, DC: Georgetown University UAP, Child Development Center.

SUMMARY

Cultural competency is a process. Early interventionists must first understand their own culture and explore their traditions, practices, and beliefs. With each new family, early intervention providers have the opportunity to gain invaluable experiences, broaden their knowledge, and strengthen their skills on the continuum of cultural competence.

Section V — Knowledge of Financial/Ability to Pay Requirements

Basic Competencies to be addressed in Section V

- ✓ Basic knowledge of Virginia's Ability To Pay (ATP) system
- ✓ Understands the key definitions of the Ability to Pay practices
- ✓ Awareness of the key components of the Ability to Pay practices
- ✓ Awareness of how the Ability To Pay process is implemented
- ✓ Awareness of the Ability To Pay appeal processes

As providers in the Virginia early intervention system, it is important to have an understanding of the Ability to Pay procedures. Not only will this knowledge assist you in your professional setting but it will also provide you with a better understanding of the financial implications of early intervention for the families with whom you are providing services.

In Virginia, there is a statewide Ability to Pay system that ensures a uniform process for determining family fees for early intervention services. This process is consistent for all public and private Part C providers. Part C providers sign contracts, interagency agreements, or memoranda of understanding indicating that they will comply with the Ability to Pay system. This ensures that every family in Virginia's Part C system has access to the same Ability to Pay policies and procedures.

The ATP process is structured to:

1) Meet individual family needs
2) Assure that services are provided in a manner that will not create unnecessary financial hardship on families

The Ability to Pay process is designed to make sure that no one is denied services due to an inability to pay.

Important Definitions

In order to better understand the varying aspects of the Ability to Pay system, there are some key words that are important to know.

Ability to Pay - The process used to reduce the charge to a lesser amount when full payment for early intervention services would create a financial hardship for a family as authorized by the federal Part C regulations and the Virginia code.

Charges - The rates established by providers for each service. This charge is typically the cost of the service. These charges must be the same for all families. For example, a provider may have a charge of $100 an hour for physical therapy.

Financial Hardship - A personal economic condition that may prevent a family from obtaining full and necessary services. Virginia established the statewide Ability to Pay system in order to ensure that a family experiencing financial hardship would still be able to afford to access early intervention services for their child.

Sliding Fee Scale - A matrix utilizing taxable income in conjunction with family size to determine the fee to be paid that is less than the full charge, e.g., a family's monthly cap.

Monthly Cap - The maximum amount, as determined by the sliding fee scale, that a family will be required to pay per month for early intervention services regardless of the charge(s) or number of different types, frequency or intensity of services a family receives.

No Charge Services - Services that are free to families. The following services are established as "no charge" services:

- Child Find Activities, such as screenings
- Evaluations and Assessments
- Service Coordination
- Administrative and coordinative activities related to:
    a) the development and review of IFSPs
    b) implementation of procedural safeguards

The Ability to Pay Process

When a child is initially referred for evaluation and assessment, a financial intake is typically conducted prior to the completion of the IFSP. Service coordinators provide families with their rights and procedural safeguards related to evaluation and assessment and also provide detailed information related to the cost of early intervention services and the Ability to Pay process. Included in this information is a pamphlet entitled, "Infant & Toddler Connection of Virginia: Facts About Family Fees," a list of charges for services from all Part C providers in the family's locality, and the sliding fee scale. The steps below outline more specific details related to the process:

Step 1 Initial Part C Intake

At the first visit, families receive the following documents:

- Notice and Consent for Initial Evaluation and Assessment
- Facts About Family Fees

Step 2 Part C Financial Intake

The financial intake must include providing families with the following information:

- A list of chargeable services as well as services for which there are no charges
- Charges and/or fees for the chargeable services
- Financial Agreement Forms
- Fee determination procedures and forms
- Sliding Fee Scale
- Use of private insurance benefits relative to the Part C system
- Procedures for filing an appeal

Use of Private Insurance or Medicaid

- Families have the right to deny access to their private insurance if, in the family's determination, a financial loss (e.g., decrease in available lifetime coverage, discontinuation of the policy, increase in premium) would be incurred. This decision does not affect their option to access the Ability to Pay scale.
- If the child is covered by Medicaid or FAMIS Plus, or if the family income makes the family Medicaid or FAMIS Plus eligible, then the family's Ability to Pay is determined to be $0. The family will not have to pay for early intervention services.

Sliding Fee Scale

- The Sliding Fee Scale is based upon taxable family income and the number of family members. Taxable income takes into consideration typical living expenses including medical costs associated with the child's special needs.
- In order to access the sliding fee scale, the family must provide proof of their taxable income by presenting a copy or transcript of their prior year's Federal 1040 tax return or another acceptable form of documentation as described in Commonwealth of Virginia, Policies and Procedures for Part C of IDEA, 2001, Part C Ability to Pay Practices.
- The Sliding Fee Scale shows what the family's monthly cap will be.

Step 3 Financial Agreement Form

The Financial Agreement Form:

- Clearly identifies the specific responsibilities of the parent(s)
- Documents the choices parents have made regarding the manner in which they will pay for their services (i.e., use of insurance, full charge vs. monthly cap)
- Identifies and includes the financial information used to determine the amount of the monthly cap
- Serves as a written agreement from the parent(s) to pay for their early intervention services within their financial ability

The Financial Agreement Form must be re-assessed **annually**, typically at the annual IFSP review. More frequent reviews depend on changes in the:

- Family financial situation
- Child's medical insurance coverage

Once the Financial Agreement Form is completed, families are better able to make informed decisions about the financial impact of the anticipated supports and services. This is the reason the **financial intake should always be completed prior to the completion of the IFSP**. The family's service coordinator will be a continuing resource to assist them with Ability to Pay and other financial questions throughout the early intervention process.

Fee Appeal

There are three occasions when the fee appeal process could be used. First, a family may request to access the fee appeal process when their monthly cap on the sliding fee scale is not affordable to them. The fee appeal system provides an opportunity for individual consideration of a family's financial circumstances, including documentation of extraordinary expenses, such as medical or other expenses related to the child's delay or disability.

Second, a family may use the fee appeal process when they do not have access to last year's federal tax return information. Third, a family may use the fee appeal process when last year's tax return information no longer reflects their family's financial situation (maybe a parent recently went back to work or recently stopped working).

The basis for the fee appeal is **disposable income**. Taxable income is not used as part of the fee appeal process. Disposable income is determined by subtracting a family's

monthly expenses from their net monthly income. When using the fee appeal, the monthly cap for the family is 10% of their disposable income.

Inability to Pay vs. Refusal to Pay

A family's inability to pay is different from a family's unwillingness to pay. A family's inability to pay must not result in the denial of services to the child or the child's family. Virginia's Ability to Pay system should protect all families from being denied services based on inability to pay.

However, if a family has been given access to the sliding fee scale and the Ability to Pay fee appeal process but is **unwilling to pay** for services that have been delivered, then participating agencies and providers may proceed with their own agency's process for the purposes of collecting delinquent accounts.

EXTENDING YOUR KNOWLEDGE

The financial intake must be completed by the designated individual, as determined by the local early intervention system, prior to the development of the IFSP unless extenuating circumstances, which are clearly documented, occur. Under no circumstance should this delay the initiation of services.

SUMMARY

The state of Virginia has an Ability to Pay system that is affordable and fair to families. Families who have children eligible for Medicaid or FAMIS Plus receive early intervention services at no charge. Other families may choose to pay the full charge for services or they may have a monthly cap determined based on their taxable income. An appeal process is also built into the system.

Families alone do not financially support Virginia's early intervention system. There are multiple funding sources, including Medicaid, FAMIS Plus and third party insurance payors, federal, state, and local funding, and grants and donations, with fees from families making up a very small portion.

Competency Test

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