



TECSNews— For the Allied eHealth Resource Network

Special points of interest:

- Family involvement— information & practical ideas

- Perspectives from providers
- Information from Provider Relations
- Provider Survey

For All Providers Working with 0-3

Issue 5

August 2007

IFSP Services with infants and toddlers— what all providers should know about family involvement

- **What's new in service delivery with infants and toddlers?** We know that services should be family-focused and related to everyday activities (e.g., Rosenkoetter, 2000; McLean, 1993; Noonan, 2006; Nelson, 2007). **What is relatively new is that an increasing part of time in direct services should support families/caregivers to enhance their children's learning**— what matters is not the hours of direct or face-face service but the amount of practice or integration *throughout the day* (e.g., Jung, 2003; Noonan, 2005). We can support this with “home programs” and by involving families and others when we work with the child— this newsletter has several articles on ways to do this. The amount of time and type of involvement with families depend upon the child's and family's needs.
- **What does the literature say about how to involve families and other team members in treatment plans for young children 0 – 3 years of age?** There are numerous practice recommendations from our literature for ways to *increase time with families and other caregivers in services* for infants/toddlers. Continued on the next page are some recommended methods. Ideas from various authors are included on the next few pages.

Continued on page 2. References on page 4.

New!

A blog for allied ehealth providers! Link to <http://tecsalliedehealth.blogspot.com/>

to learn, share information— starting with info on how to write IFSP goals that will involve families.

About this issue

This issue spotlights the changing focus of IFSP services to one that increasingly involves caregivers/families. *It includes practical ideas and perspectives on ways to involve caregivers more often, from the professional literature, other states, and providers.* This issue also includes recommendations on how to work with adult learners (e.g., families and other caregivers), information about involving families throughout the BabyNet process, information to share with families about assistive technology, and more.

Finally, note the new provider blog at <http://tecsalliedehealth.blogspot.com/>, & if you haven't already, please *complete the short provider evaluation at <http://CTLSilhouette.wsu.edu/surveys/ZS64847> to help guide future issues & other products for you!*

In this Issue:

Involving families— practice recommendations, examples, & ideas	2, 3, 4
Involving families in home programs	5
Working with adult learners	6
Involving parents in assessments	7
Involving families throughout the BabyNet early intervention process	8, 9
Information for families about AT	10
Information from Provider Relations	11
Upcoming workshops	12

IFSP Services with infants and toddlers— what all providers should know

CONTINUED from page 1



Practice Recommendations and Examples for Involving Families

Here are some ways to involve families in IFSP services more often:

1. **Write intervention plan objectives that help your child participate in specific daily routines, are doable for the family, and are important to them** (Rosenkoetter, 2000; McLean, 1993; Noonan, 2006; Polmanteer, 2000). The following excerpt from a therapist in Grangeville, Idaho, shows some of the challenges to overcome when working with families and routines (excerpt from TACTICS newsletter, by Jan Struder):

“It was always hard to go to Mark’s house. I was scheduled to come when the other siblings were just getting home from school. Mark’s mother would always excuse herself for about 10 minutes to get the children started on their after-school chores. Mark would want to be where everyone else was. He was very interested in the kitchen where one child had to put the dishes away from the dishwasher and the other had to feed and water the cats and dog. After months of trying to get Mark to finish the activity that we were working on before the others arrived, I just moved him into the kitchen and thought that we could continue my sorting activity in the middle of the kitchen. Mark wanted more. I asked Mom if Mark could sort the flat wear. Mark has cerebral palsy and getting him to crawl at that time was a challenge. We placed the clean forks, spoons and butter knives on a towel on the floor and took the tray out of the drawer. Mark was very excited because he had a job like everyone else. As the weeks progressed Mark would crawl to the kitchen, get up on his elbows and put the flat ware in the tray that was now in the bottom drawer all the time. Mark is now in school. Dad reported to me that the flatware is now moved to the middle drawer and Mark can support himself on his knees to put away cleaned silverware.”

2. **In each visit, with the child and family present, solicit input from the family and address their priorities and specific strategies to meet current needs. Explain and try strategies, demonstrate with the child, and together select strategies that help the family and child** (Stredler Brown, 2005). However, many parents and child care providers do not have the time, confidence or ability to automatically embed intervention into everyday activities (TACTICS, 1993-1998). Here’s what Florida programs recommend providers do as we increasingly involve families in services with 0—3 year olds (excerpts & adaptations from TACTICS, training modules):

It’s important that we spend adequate time explaining to families the plan to involve them in service delivery, and problem solving on “how to” make it a part of their lives. One of the most important things that we, as interventionists, need to do is identify how much has been communicated to the family about their role in the intervention process. We need to ask: Do caregivers understand “natural environments” and their role as team members in their child’s intervention? Was the importance of their role in their child’s development fully communicated?

Having a conversation with caregivers about their role and expectations can go a long way to clarify what early intervention is about, but... it may not be enough. It will take time and repetition of information to help the caregiver understand why participation is essential. The following problems have been identified at TACTICS workshops with some practical solutions. This is often a planning issue that can be overcome by including families or other caregivers in planning during each visit— for example, ask mom what she would like to focus on during your visit. Very often parents are not used to being included with service providers in planning interventions. If a child’s physical therapy has not been done yet, problem solve with mom about how to integrate it into her routines. For example, the child could follow her up and down the stairs as she puts away laundry to work on climbing. Very often, parents don’t realize that embedding intervention into routines gives their child practice and does not add to their schedule.

The time you visit may also make a difference— if you come while mom is preparing dinner, chances are that she will not be able to focus on interacting with the child because of competing priorities. Check with her if she prefers to move the intervention to another time. Or better still, consider what chores the caregiver is doing-- is there a way that the child could participate? For example, setting the table for dinner may be a great way for an older child to work on following directions and increasing his receptive vocabulary. Or the younger child can help stir or pour ingredients to help mom cook! Sometimes the caregiver genuinely needs at least part of your visit to get a few things done. Another family may develop a special routine for siblings to help the child work on his vocabulary. Family guided services allow them to choose their own role— follow their lead.

Continued on page 3

IFSP Services with infants and toddlers– what all providers should know

CONTINUED from page 2

3. **Discuss with caregivers the activities in which to use the new strategy.** This supports teaching during natural learning opportunities. It can be helpful to develop a schedule of when caregivers are to use the new strategies; if you do this, it is most successful when caregivers decide the time of day they are best able to implement (Noonan, 2006).

For example, at 6:30 am, Mom felt she could facilitate sitting, reaching, taking part in dressing, & vocalizing:

	Sitting	Reaching	Dressing	Toy play	Take turns	Vocalize	Receptive labels	Point to choose or request
6:30-6:50 am Wash up Diaper Dressing	X	X	X			X		
6:50-7:15 am TV with brother					X			
7:45 – 9 am Playpen (Mom's chores) Diaper change				X		X		

4. **Along with caregivers, informally assess (e.g., Stredler Brown, 2005; Noonan, 2006).**

For example, together with the family, identify the child's skills before, during, and after implementation of the specific strategy. Also assess how the caregivers did; this can include asking how they felt about the strategy (e.g., was it comfortable, was it helpful, etc.). At the end of the visit, discuss the session's activities and solicit feedback on the techniques used and the child's and family's reaction. Incorporate this feedback into future plans.

More Sample Guides and Helpful Resources for Involving Families

(note that the term “outcomes” used in these materials refers to what we now call **IFSP goals**):

- **Sample intervention guides** for involving families in IFSP services (note that the term “outcomes” refers to IFSP goals) - <http://www.parsons.lsi.ku.edu/facets/pdf/InterventionPlanningSheet.pdf> and http://www.waisman.wisc.edu/birthto3/ALYSSA_FEEDING_ROUTINE.PDF
- **Intervention planning** that includes family involvement: click on <http://tactics.fsu.edu/Family.html> and click on each child to see their intervention planning
- **Sample Service Notes** form that incorporates family involvement - <http://tactics.fsu.edu/pdf/HandoutPDFs/TaCTICSHandouts/Module3/HomeVisitNotes.pdf>
- **Checklist** for successful inclusion of families (from information about adult learners) - <http://tactics.fsu.edu/pdf/HandoutPDFs/TaCTICSHandouts/Module3/AdultLearner.pdf>
- **A physical therapist's view of therapists' role** in early intervention and ideas on how to implement services— from Maximizing Your Role in Early Intervention by Michelle Vanderhoff, APTA 2007, downloaded 8-1-2007 from <http://www.apta.org/AM/Template.cfm?Section=search&template=CM/HTMLDisplay.cfm&ContentID=8534>

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More Ideas for Involving Caregivers, Daily Activities, and Everyday Materials

More ideas for involving families, other caregivers, daily activities, and everyday materials— more often

(adapted from TACTICS Module 3, <http://tactics.fsu.edu/modules.html>)

1. **Functionally Assess:** With the family, identify materials/toys available at home and other routine settings. Plan ahead to incorporate those materials/routines into the next meeting.
2. **Use Existing Social & Daily Routines:** Join caregivers & child in activities occurring in the household/center when you arrive.
3. **Plan Future Visits:** *With the family*, plan activities/routines for your next visit before leaving. Joint identification supports problem solving, partnerships, & allows choice of any necessary materials.
4. **Use community Based Training:** Plan a special activity with caregivers: make pudding, having outdoor activities such as trip to the park, walking around the block, gardening.
5. **Include Peer Mediation:** Organize a play date with other children and caregivers.
6. **Try Milieu Strategies:** At home, with permission of the family, ask the child to show or get toys/preferred objects in the bedroom, toy room, or other area of the house where child's things are and routines occur. Follow the child's lead and move into other areas.
7. **Include Fading Strategies:** Decrease the number of "therapy materials" you bring or use— use only 1-2 therapy materials that support acquisition or generalization of specific goals/objectives. Also include items available at home or from other routine settings.
8. **Systematically Desensitize others to use fewer "therapy materials" as needed:** At home or other settings, leave "therapy materials" by the door. Join the child's activities; use "therapy materials" only when & if needed.
9. **Use Other Approaches to encourage use of items available in routine settings:** *Such as—* **Forgetfulness:** Walk in empty handed. Say, "I forgot my toys. What else should we do? What do we need?" **Choice Making:** Put therapy materials common to the household in the toy bag. Ask the child (caregiver), "Isn't this like yours? Should we use yours or mine? Show me how you do it?" **Sabotage:** If the child really likes therapy materials or toy bag approach, take in an empty bag and fill it with child-preferred objects of interest/toys.
10. **Generalize:** First demonstrate use of a toy that allows practice of a skill such as putting objects in small spaces (e.g. putting pieces into Mr. Potato Head). Then use or look around the home for toys or other items that could provide more practice for the same skill.

Families can choose to be involved in intervention in different ways. Some options families have chosen include (Dunst, 2004; Vanderhoff, 2007):

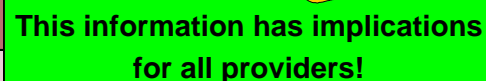
- Making suggestions about materials or strategies for a childcare provider to use during routines at a center
- Completing a schedule matrix for one or two activities at home
- Involving grandma and grandpa in routines at their house
- Developing a special routine for the siblings
- Embedding targets within one routine (e.g. diapering) throughout the day
- Observing the child's ability to use a new skill in a different situation

REFERENCES

- Dunst, C.J. (2000). Revisiting "Rethinking Early Intervention." Topics in Early childhood Education, Summer 2000.
- Jung, L.A. (2003). More is better: Maximizing natural learning opportunities. Young Exceptional Children, 6(3), 21-26.
- McLean, M. & McCormick, K. (1993). Assessment and evaluation in early intervention. In W. Brown, S. Thurman, & L. Pearl (Eds.), Family-centered early intervention with infants and toddlers: Innovative cross-disciplinary approaches, Baltimore: Brookes Publishing.
- Nelson, N.W. (2007). "Be-Attitudes" for Managing change in School-Based Practice, The ASHA Leader, June, 19, 2007, pp. 20-21, Vol. 12.
- Noonan, M.J., & McCormick, L. (2006). Young Children with Disabilities in Natural Environments, Methods & Procedures, Baltimore, MD: Brookes Publishing.
- Polmanteer, K. & Turbiville, V. (2000). Family-Responsive Individualized Family Service Plans for Speech-Language Pathologists, Language, Speech, and Hearing Services in Schools, 31, 4-14.
- Rosenkoetter, S.E., & Squires, S. (2000) Writing outcomes that make a difference for children and families. Young Exceptional Children, 4 (1), 2-8.
- Stredler Brown, A. (2005). The art and science of home visits, The ASHA Leader, Jan. 18, 2005, pp. 6-7, 15.
- TACTICS training modules and archived newsletters (1993-1998). Therapists as Collaborative Team Members for Infants/Toddler Community Services, Florida State University, Tallahassee, Florida, <http://tactics.fsu.edu/modules.html>
- Vanderhoff, M. (2007). Maximizing your Role in Early Intervention, APTA 2007. Downloaded 8-1-2007 from: <http://www.apta.org/AM/Template.cfm?Section=search&template=CM/HTMLDisplay.cfm&ContentID=8534>

Helping Parents Become Active Participants in Early Intervention Home Programs

by Ann Barton, PT, MS, PCS

 This information has implications for all providers!

A distinguishing characteristic about early intervention services is that an Individualized *Family* Service Plan guides the services. Early intervention is therefore explicitly “family-centered.” This is in contrast to school-based services which are “child-centered.”¹ Barbara Connolly, PT, EdD, FAPTA, states that “When a physical therapist is successful in teaching a parent how to work with their child, the child is more likely to develop the necessary skills.”¹ It follows that empowering parents is critical to the early intervention process. In order to achieve a successful outcome, the therapist should take into account family functioning when determining family readiness to utilize home programs. She further cautions physical therapists to remember that “it is not our *hands* that makes the difference it is our *brains*.”¹

Parents’ journeys of adjustment and their individual capacity to participate in home activities with their child are quite variable. There are two reported phases of adjustment. The first phase “coming to grips” is where parents begin to face facts about their child’s condition. This can be a survival mode phase.² The duration of the first phase may be relative to whether or not the child has an established developmental disability such as Down syndrome, autism or cerebral palsy.

A key responsibility of the physical therapist includes educating the parent about their child’s condition with respect to both the parents’ and the child’s needs. Educating parents with the use of accurate and current information, lays the groundwork for communicating expectations with regards to using home programs. Providers can typically come up with lots of home recommendations. At times, fewer, targeted recommendations may actually achieve better results. Parents have reported that when personal insight is gained with their child and/or when improvement is seen, that this leads to the second phase: “striving to maximize”.² At this time parents may be better positioned to incorporate more home activities into the child’s routine.

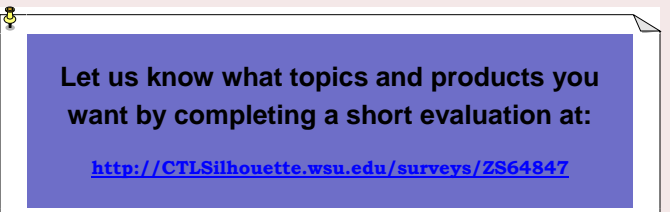
Therapists need to utilize keen listening skills in establishing an open and frequent communication channel with the child’s family. By asking questions and listening to parent’s concerns, a PT can

positively reinforce home strategies.¹ Providing a flexible service structure that is responsive to both the parents’ journeys, as well as the children’s needs, can make a critical difference in helping to empower the parents and instill confidence in their own competence. Therapists must therefore focus both on family functioning and the function of the child when developing home programs.²

The bottom line is that families want to be involved. At times there are complex issues in helping parents embed therapeutic strategies into the child’s daily routine. In early intervention, physical therapy services are provided not only for remediation but also as a support to the family to help manage their child.¹ Physical therapists often feel a strong need to assist parents with the daily routines, but the job of the PT includes teaching parents to advocate for their child.¹ When the physical therapist maintains an eye on family functioning, intervention is typically best optimized to benefit both children and parents. This parental confidence can then translate beyond the early intervention years and continue to serve the family well in other venues including the more child-centered, school-based program.

References

- Vanderhoff, M. (2004). “Maximizing Your role in Early Intervention,” Physical Therapy, December, pp. 48-54.
- Imms, C & Fossey, E. (2004). Critically Appraised Paper “Parents Become Active Participants in Home Therapy Programs, Striving to Maximize Gains for their Children with Cerebral Palsy, Given Time to Come to grips with their Situation,” Australian Occupational Therapy Journal , 51, 112-113.
- Rapport, MJ, McWilliams, R.A. Smith, BJ (2004). “Practices Across Disciplines in Early Intervention,” Infants and Young Children, Vol. 17 No.132-44.

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Helping Parents Learn, Remember, & Use Intervention Strategies

by Suzan Albright, M.Ed., TECS Technical Assistance Specialist

When parent-child interactions address IFSP goals during everyday activities, the power to enhance development in children is amplified. Achieving family-identified goals is a “shared family/professional responsibility”— collaborative work between professionals and families is a recommended practice (Sandall, 2005); and parent training is part of the general role of every Part C service provider (CFR Sec. 303.12(4)(c)(2)). Providing early intervention services for infants and toddlers necessarily involves working with adult learners. This article briefly reviews some assumptions about adult learning and adult learning principles that can be used to help parents learn, remember, and use intervention strategies in early intervention activities.

In parent training discussions, assumptions about adult learning can be helpful. Some basic general assumptions are that adults (1) prefer to move from dependency to self-directedness, (2) possess prior experience and knowledge which can be applied to new learning, (3) are interested in learning that is associated with their social roles, and (4) are oriented toward immediate application of new information and skills (Knowles, 1980). Therefore, discussions that involve parents may center on how strategies they are learning relate to their various roles as a parent (e.g., as communication partner, security figure, playmate, groomer, referee, etc.); discussions may also explore both long-term benefits for their child and immediate utility of intervention strategies in routine care-giving tasks, such as feeding, bathing, changing, or transporting their child. Leib (1991) has identified motivations, reinforcement, retention, and transference as key considerations for ensuring adult learning. These can be applied to planning for parent training in early intervention.

Parents' motivation to learn new intervention strategies can be enhanced in several ways. The tone of the parent training can affect motivation. Trust and respect are critical to successful parent-professional partnerships (Turnbull, 2006). Mahoney and MacDonald (2007) offer three suggestions for interventionists to establish rapport at the outset of a session: (1) greet the parent with warmth and enthusiasm, (2) give the parent a chance to talk about him- or herself, the child, or the family, and (3) encourage the parent to tell you how the family was able to follow through with strategies presented in the previous session. As partners, professionals and parents can share their perspectives of the *level of importance* that the training objective has for attainment of IFSP goals. Obviously some techniques and strategies may be more critical than others. Parents need to clearly understand both how important specific strategies are and how the strategies relate to their concerns and priorities for their child and family. For instance, the interventionist may need to explain how the strategy of imitating the child's vocalizations will address the parent's desire for her child to talk. Another motivational factor to weigh is the *level of difficulty*. Interventionists can invite parents to voice their feelings about how difficult the strategy is for them and help them to identify specific areas that are problematic for them. Techniques that a parent finds difficult to learn may need to be introduced gradually, reviewed, or adapted so that the learner does not become overwhelmed or frustrated before becoming competent and independent.

Reinforcement is a second consideration when parents are learning new techniques. Perhaps the greatest positive reinforcement for parents is their own observation of their child's successful demonstration of new behaviors and skills. Meanwhile, professionals can provide reinforcement in the form of *feedback*. Mahoney and MacDonald (2007) offer several recommendations for giving feedback to parents: (1) carefully observe how the parent is performing the strategy, (2) offer suggestions only when there is something the parent can do to become more successful, (3) identify and emphasize the positive things parents are doing, (4) provide only very minimal negative feedback, and (5) offer feedback that is specific rather than general.

Retention of learned skills, or the ability to retain new information and behaviors, is influenced by the amount of opportunity to practice (Leib, 1991). Mahoney and MacDonald (2007) recommend that after the professional introduces and demonstrates a strategy, 5-10 minutes during the intervention session should be devoted to guided practice by the parent. This practice time can be followed by some planning with the parent about when, where, and how often the parent might practice the strategy independently. Interventionists may also leave printed descriptions of the strategy for parents to review or use.

Transference refers to the learner's ability to use the new information in a variety of settings. Addressing this consideration with parents may involve planning together about places where the parent is able to practice the strategy with the child in one or more different settings during the coming week. For example, if the strategy relates to an IFSP goal that the child will “walk on a variety of surfaces,” dad may plan to practice the strategy with the toddler at the Little League complex while his older son warms up with the team. During follow-up discussions with the parents, the interventionist can provide enthusiastic support for the parent's efforts in new settings and assist with problem-solving if needed. For instance, the interventionist and parent may discuss what happened when mom practiced using the conversational turn-taking strategy while she drove her child to and from the store last week.

Because early interventionists are responsible for helping both children and adults acquire new skills and knowledge, it is important that sessions include practices that are “developmentally appropriate” for everyone involved. Applying principles of adult learning during parent training may go a long way toward helping parents learn, remember and use intervention strategies. As parents do so, they can amplify the effects of intervention on their child's IFSP goals and outcomes.

References:

- Knowles, M. S. (1980). *The Modern Practice of Adult Education (Revised and updated)*. Chicago, IL: Associated Press.
- Leib, S. (1991). *Principles of Adult Learning*. VISION. Downloaded 3Aug2007 from: <http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-2.htm>
- Mahoney, G., & MacDonald, J. D. (2007). *Autism and Developmental Delays in Young Children*. Austin, TX: Pro-ed.
- Sandall, S. H., M.L., Smith, B. J., McLean, M. E. (Ed.). (2005). *DEC recommended practices: A comprehensive guide for practical application*. Longmont, CO: Sopris West.
- Turnbull, A., Turnbull, R., Erwin, E. J., & Soodak, L. C. (2006). *Families, Professionals, and Exceptionality: Positive Outcomes Through Partnerships and Trust* (5 ed.). Upper Saddle River, NJ: Pearson.

Engaging Parents in Speech-Language Assessments

by Patty Quattlebaum, MSP, CCC-SLP



**This information has implications
for all providers!**

We all know that IDEA Part C mandates that caregivers be included in all aspects of early intervention beginning with the assessments. On the surface, this seems easy enough for speech-language pathologists (SLPs) and other therapists. In fact, there are lots of things we already do that might seem to meet this standard:

- We get the parents to fill out the history form.
- We let them observe the testing.
- Then we discuss what we found.

These activities represent one level of parent involvement, but it is clear that SLPs are in charge and that parents are expected to allow us to share our knowledge with them in a tightly controlled manner. Although most of us have been trained in this medical model and have probably experienced a reasonable amount of success using it, the authors of IDEA are challenging us to do more (Stredler Brown, 2005). Change is always tough, and moving toward a collaborative model may feel like a risk. However, the real risk is that caregivers and other interventionists will think that communication happens only with the SLP or in certain practice activities arranged by the SLP.

In the work that we do, we cannot afford to be solely responsible for what happens to children with communication difficulties. There is too much work to be done! It is essential that we work with caregivers and other interventionists to develop a shared view of the child's communication disorder and a plan for treatment (Polmanteer, 2000; ASHA, 2004; Crais, 1995).

The starting point for this may begin with our initial observation and other assessment activities, discussing what we're doing and seeing in a manner that requires parents to contribute their insights. Examples: "Johnny seems (quiet, social, active, vocal, etc.) today. Is this what he is like at home?" "He seems to look at what he wants. Have you noticed that at other times?" For every observation, try to get feedback from the parents about how typical this may be of what they see at home and other settings. Crais (1995) describes several other ways that we can involve families, including having a family member: administer a certain test item (e.g., "Please try to get your child to choose a toy"), perform observations of their child in various contexts (e.g., play, mealtime, bath time), or describe the family's routine daily activities and the child's types of participation (Crais, 1995). Also, it is important to discuss with parents what they would like to see their child do differently in their everyday routines and settings as a result of intervention (Polmanteer, 2000).

Descriptions from families should become part of our assessment report and help guide our thinking about intervention (Crais, 1995). Sometimes parents have views about their children that seem incompatible with our observations. We have to view these differences as an opportunity to learn more about what the caregivers are thinking while we guide them in learning about what evidence leads us to the conclusions we are making.

Showing appreciation for families' knowledge about their child, encouraging their active participation in the assessment, and being responsive to them will make it much easier for us to become effective partners in addressing the child's communication difficulties.

REFERENCES

- American Speech-Language-Hearing Association (2004), Preferred Practice Patterns for the Profession of Speech-Language Pathology, #12 "Communication Assessment—Infants and Toddlers."
- Crais, E. (1995). Expanding the Repertoire of Tools Techniques for Assessing the Communication Skills of Infants and Toddlers. *American Journal of Speech-Language Pathology*, 4, 84-105.
- Polmanteer, K. & Turbiville, V. (2000). Family-Responsive Individualized Family Service Plans for Speech-Language Pathologists, Language, Speech, and Hearing Services in Schools, 31, 4-14.
- Stredler Brown, A. (2005). The art and science of home visits, *The ASHA Leader*, Jan. 18, 2005, pp. 6-7, 15.

Family Involvement Throughout the Early Intervention Process

by Stephanie Hicklin, B.S., TECS Technical Assistance Specialist

The following information highlights some of the ways in which families should be involved in the BabyNet system. It is based on information taken from the SC Policy & Procedures manual, IDEA Part C regulations, and selected recommended practice sources.

Intake	At intake, families should provide the service coordinator with all necessary information to assist the eligibility team in determining the child's needs. Families should explain their views of the child's current health, physical, and developmental status and should also discuss their concerns, resources, and priorities. If the child is eligible for IFSP services, it will be the service coordinator's responsibility to ensure that the IFSP reflects these resources, priorities, and concerns and that services take place within the family's routines, activities, and places.
Assessment	<p>The child's interactions with his or her family or other caregivers should form the cornerstone of assessment. It has been reported that children generally reveal their highest level of skills in the context of routine, spontaneous, motivated interactions with caregivers; the evaluator can then build on these interactions.</p> <p>As noted above, families' presence and participation in assessment often helps children demonstrate optimal capacities; children do best when they are with those who make them feel safe and secure. Assessment results are also more accurate if assessment occurs in a place where the child is comfortable and relaxed with familiar objects, toys, and materials. Meaningful assessments also include information about the family's needs and preferences as it relates to their child.</p>
IFSP Preparation	<p>Suggestions for families to think about in planning for their child's IFSP meeting, and what families may want to talk about with their IFSP team:</p> <p>How would you describe your child to others? What is working well for you at home? What do you need help with? What help do you want for your child? What type of information do you need (information on diagnosis, child development, etc.)? What activities do you want your child to take part in? What does your current schedule look like? How could services be integrated into your everyday routines, activities, and places (RAP's)?</p>
IFSP Goals	<p>The family should be provided an opportunity to share their wishes and goals for their child for the next six-month to one year period. What they have tried and what they want to see happen is important in determining IFSP goals. It is the family's role to decide what is a priority need after hearing from other team members what they determine as important. With family involvement, the family may feel a commitment or interest in the plan because it addresses their needs (). **For ideas on how to write family-centered goals, visit http://tecsalliedehealth.blogspot.com/</p>
IFSP Services	<p>Once IFSP goals are determined, service coordinators inform families of their right to select and request changes to providers if necessary. IFSP services should involve families in various ways, such as in learning strategies to help their child develop and participate in activities throughout the day. By actively participating in sessions, families are also able to remember more of the intervention strategies. This helps them be able to practice the strategies in the child's everyday RAP's when providers are not there.</p> <p>It is important for service providers to discuss the child's progress with the family each visit and at least quarterly. This information should be reflected in service notes and Quarterly Progress Notes. Discussion gives families a chance to explain any changes in development they have noticed in their child. Communication between providers and primary caregivers is key to ensuring that children are getting the most out of their early intervention services (especially when interventionists provide services in the child's early care center or when the child is with a caregiver other than the child's parent).</p>

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Family Involvement Throughout the Early Intervention Process continued

Child Outcomes	Team members other than families are typically able to observe and interact with children in limited situations; the family's input is therefore vital in helping the team understand how the child progresses and functions across various settings and situations as a result of IFSP services. Families' observations are critical in the final process of assigning ratings to each child outcome. **Link to http://uscm.med.sc.edu/tecs/childandfamilyoutcomes.htm for more information/resources about child outcomes.
Six Months and Annual IFSP Reviews	Service coordinators should take this time to review goals, services, adaptations/ accommodations, etc. Parents/caregivers should assist the IFSP team in reviewing their child's developmental progress and new or continuing needs. By this time, parents/caregivers are somewhat used to the early intervention process; they have participated in services for at least six months and have learned how to better help their child's developmental progress. They should continue to take an active role in determining new, modified, or continuing service goals.
Transition	Service Coordinators begin the transition planning process at the initial IFSP. Parents should be notified of transition options and the transition process, and additional information is offered to parents as needed. Prior to the child turning two-years, six months, a discussion with parents takes place to assess the families' needs regarding transition. Parents have the right to determine the type of information sent to Part B (school) programs. They also have the right to have or decline a transition conference with Part B. Parents should understand that if their child is not eligible for Part B services, their service coordinator is still responsible for assisting them in meeting their needs regarding transition from Part C services into other community programs.
Family Outcomes	<p>There are three Part C family outcomes (listed below), which were developed by OSEP to measure the family's view of services received through all Part C systems. Prior to a child's third birthday, a family survey, which has questions related to these outcomes will be mailed to the family. The completion of this survey will help programs measure the effects of their early intervention systems on families.</p> <p>Family outcomes relate to families: 1) knowing their rights, 2) effectively communicating their children's needs, and 3) helping their children develop and learn.</p>

For additional information or references, please contact Stephanie Hicklin at TECS, at hicklins@comporium.net.

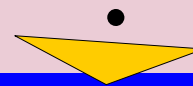


A blog for allied ehealth providers!

Link to [http://](http://tecsalliedehealth.blogspot.com)

tecsalliedehealth.blogspot.com

to learn, share information, ask questions and more— starting with info on how to write IFSP goals that will involve families.



Let us know what topics and products you want by completing a short evaluation at:

<http://CTLSilhouette.wsu.edu/surveys/ZS64847>

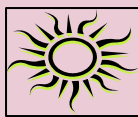
Information to Share with Families about Assistive Technology Benefits for Infants/Toddlers through Transition to School—Helping Children Learn and Develop

By Dr. Elizabeth Bagley, Assistive Technology Specialist, SC Assistive Technology Project and State Department of Education

Many people (including some professionals) are reluctant to allow young children to use assistive technologies (AT) because they believe that it will prevent the learning of new skills. Research shows that using AT devices may actually encourage young children to learn skills rather than prevent learning (The Early Childhood Comprehensive Technology System – Project ECCTS). Most of us benefit from AT in our everyday lives. We might not realize that curb cuts or closed captioning at the gym are all AT.

Early childhood includes a number of critical learning opportunities for a child to acquire necessary skills to meet developmental milestones. *Research demonstrates that even young children with disabilities can learn many valuable skills through the help of AT (Project ECCTS).* AT allows children to communicate and function more independently, and often decreases negative behaviors resulting from frustration (Abrahamsen, Ronski & Sevcik, 1989; Silverman, 1980). *If children are introduced to assistive technology early, they will be enabled to function closer to age appropriate behavior.*

A new study by the National Institute on Child Health & Human Development illustrates the powerful impact family life has on development and learning through age four. Children who receive better quality care are better able to think, respond and interact. In addition, these children have somewhat better reading and math skills (ADVANCE for Speech-Language Pathologists & Audiologists, 2007). These data suggest that the more proactive parents are in acquiring supports for their young children, the better equipped kids will be when entering school.



sunny

Assistive technologies can assist in making the transition into school and community settings much easier for young children (Van Tatenhove, 1987).

Before entering school, most young children are already performing certain skills and are communicating, even if it is a frustrated squeal or motioning towards a desired object. To make the transition from home to school easier, AT must be incorporated into the child's daily activities and routines at home and in the community. For example, some children can use a special keyboard or computer mouse to participate in early literacy activities with other children.



Trackball (n-ABLER Rollerball)

Starting school is a major disruption in normal routine, and the introduction of AT at the same time could be overwhelming. If AT is already a part of the child's life, the transitioning may proceed more smoothly. "Teachers and parents often judge a child with communication impairments as socially and cognitively less capable than their peers. This results in lowered academic expectations and, frequently, decreased academic achievement (Rice, 1993)" (from Augmentative and Alternative Communication (AAC) Connecting Young Kids (YAACK) website).

If your child's delays are not significant enough to be eligible for the Individuals with Disabilities Education Act (IDEA) early intervention services, he/she may still benefit from using assistive technology. Many organizations, such as the South Carolina Assistive Technology Program, have an equipment loan library where you can borrow AT devices or test drive computer software free of charge. Once you have chosen AT that is best for your child, you may get funding through private insurance, Medicaid, or a community organization.

The two most common types of AT used with young children are: Switches and Augmentative and Alternative Communication (AAC) devices. Switches are used to help reinforce cause and effect learning as children activate battery-operated toys and devices. Switches come in many different types, shapes, colors and sizes and a child can use different parts of his/her body to activate them. AAC devices allow children to communicate when they have difficulty with natural speech. AAC devices range from object or picture communication boards to electronic devices with pictures and voice output.



Research has shown that using AAC often improves natural speech (Berry, 1987; Daniels, 1994; Ronski & Sevcik, 1993, Konstantareas, 1984; Silverman, 1980). In addition, there are no known cognitive or other prerequisites that are necessary for a child to use AAC (Kangas & Lloyd, 1988), which means *all young children can benefit from communication supports.*

Rather than looking at what a child cannot do, it is exciting to see skills a child can accomplish and perform. Simple and/ or more complex AT supports can easily be included in IFSP services to help young children and their families carryout and meet their early intervention goals and achieve more age-appropriate outcomes.

Link to <http://www.sc.edu/scatp/resourcecenter.htm> to learn more about equipment for loan and services that benefit providers offered by SCATP!

For references or additional information, please contact Dr. Elizabeth Bagley at SCATP:

Elizabeth Bagley
803-935-5337

lizzardbagley@gmail.com



Information from Provider Relations **For You!**

Provider Update

Robin Morris and I sent out letters regarding new requirements for being a BabyNet Provider. The requirements are as follows. Effective August 1, 2007, all Private Providers contracted with South Carolina Department of Health and Environmental Control to provide BabyNet Services will be required to provide BabyNet Central Office (BNCO) with a background check. The background checks, at minimum, must include reports from the Office of Inspector General (OIG), the Sex Offender Register, a Nationwide Criminal Report, a Social Security Number Verification and Residency History Check, and a Professional License Verification. All current providers, including those with individual contracts and those under a hospital or group contract, will be required to submit their first background check by February 29, 2008. After the initial background check, providers will only be required to submit a new background check at the time of contract renewal (currently 2011 and every 5 years thereafter). Background checks are necessary to ensure that Individuals with Disabilities Education Improvement Act (IDEIA) Part C services are provided to South Carolina's children and families by qualified staff in a safe and worry-free environment. To prevent unnecessary cost to the provider, BNCO will accept background checks completed between August 2006 & August 2007, providing the check includes reports from or on all of the areas listed above. Background checks should be sent to Robin Morris at 1751 Calhoun Street, Columbia, SC, 29201.

The next requirement is for Interpreters only, who have not taken or submitted their Interpreter Qualification testing certificate. A letter was sent to all BabyNet Interpreter's in September letting them know that they must meet DHEC Interpreter Qualification to continue serving BabyNet children. The deadline to have the qualification certificate in was April 30, 2007. We know that some Interpreters have had a problem getting into a class so we have extended the deadline to October 1, 2007. If you are an Interpreter and your contract was signed after June 30, 2007, you have a year from the effective date of your contract to get your qualification certificate in to our office.

In order to be qualified as an Interpreter, you must attend and successfully complete the testing/training program. The training teaches the role of the interpreter, oral interpreting skills, sight translation skills, some specialized terminology in social services and public health, the impact of culture on interpreting, and the ethics of interpreting. On the last day of training, participants are tested on all training content and on their interpreting and translating abilities. Participants must sign an interpreter Code of Ethics. The code defines the professional standards that agency interpreters are expected to observe. In order to register for the Qualification Project you may e-mail or call the Minority Health office at stanleag@dhec.sc.gov or 803-898-3808.

Thanks for all you do for the children and families of South Carolina. Should you have any questions or concerns about this requirement, please contact Robin Morris preferably by email at MORRISSRH@dhec.sc.gov or me at mccoydm@dhec.sc.gov. You may also contact us by phone at 803-898-0781 or 803-898-0591.

Sincerely,

Debra M. McCoy, PHD, LMSW, BabyNet Provider Relations Coordinator, and
Robin Morris, BabyNet Provider Consultant

Mark your calendars!

Some Upcoming Workshops

- Pharmacology for Physical Therapists, presented by Peter C. Panus, PT, Ph.D., on **September 8 and 9, 2007**. Location: Durham, NC, Duke University medical Center. CE credit available. For more information, call 1-800-999-2782, ext 3395.
- 2007 Scottish Rite Pediatric Language Conference: Young Developing Bilinguals and Primary Language Impairment: Assessment and Intervention. Presenter: Dr. Kathryn Kohnert, Ph.D., CCC-SLP. **October 3** at the John I. Smith Rite Care Center in Greenville, **October 4** at the E.C. Singleton Rite Care Center in Columbia, and **October 5** at the Charleston Scottish Rite Center. CE credit available. For more information, call (803) 776-5454 or email ecscottishrite@hotmail.com.
- Evaluation and Treatment of the Clumsy Child, presented by Barbara Connolly, PT, Ed.D., Motivations, Inc., **October, 5 and 6, 2007**. Location: Columbia, SC. CE credit available. For more information, call (803) 802-5454 and visit <http://www.motivationsceu.com/>.
- 2007 SCSHA Fall Workshop: Leading Best Practice in Communication, Language, and Literacy, presented by Dr. Wayne Secord, Ph.D., CCC-SLP, on **October 12**. Voice Therapy Unwrapped, presented by Marina Gilman, MM, CCC-SLP, on October 13. Location: Columbia Metropolitan Convention Center, Columbia, S.C. CE credit available. For more information, call 1-888-729-3717 or visit www.scscha.com.
- Tongue Thrust, presented by Sandra R. Holtzman, M.S., CCC-SLP, Motivations, Inc., **November 2, 2007**. Location: Providence Hospital, Columbia, SC. CE credit available. For more information, call (803) 802-5454 and visit <http://www.motivationsceu.com/>.
- Connections: Treatment of Sensory Processing disorders...Integrating the Neurobiology of Brain-behavior in the Pediatric Population, presented by Kim Barthel, BMR, OT, Motivations, Inc., **November 16 and 17, 2007**. Location: Columbia, SC. CE credit available. For more information, call (803) 802-5454 and visit <http://www.motivationsceu.com/>.
- **Numerous workshops** sponsored by the South Carolina Assistive Technology Project (SCATP). Various topics and presenters. For more information, link to <http://www.sc.edu/scatp/trainingschedule07.html> or call (803) 935-5263.

*Please send
in*

**ideas to exchange &
topics to publish**



Team for Early Childhood Solutions / The Center for Disability Resources / A University Center for Excellence

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TECS is contracted by the IDEA Part C lead agency (DHEC-BabyNet) to provide a comprehensive statewide system for personnel development and technical assistance.



If you need paper copies of the newsletter, have any questions about this newsletter, or would like to submit your ideas, please notify Leah Perry at 803-935-5227.

Lily Nalty, M.A., CCC-SLP
Newsletter Editor, Allied
eHealth Network

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Mailing Label