BEST PRACTICES GUIDELINES

PURPOSE OF GUIDELINES

The primary purpose of these guidelines is to assist service coordinators, providers and families in designing quality intervention for children using evidence-based best practices.

COMMON THEMES: Review of Literature

Based upon current literature and research in early intervention, there are a number of key themes that underlie the provision of high quality early intervention services. These common themes are as follow:

- Children learn best when:
  - participating in natural learning opportunities that occur in everyday routines and activities of children and families and as part of family and community life; and
  - interested and engaged in an activity, which in turn strengthens and promotes competency and mastery of skills.

    (Dunst, Bruder, Trivette, Raab & McLean, 2001; Shelden & Rush, 2001; McCollum & Yates, 1994)

- Parents have the greatest impact on their child's learning since parents know their child best and already intervene in their child's development everyday through planned or naturally occurring learning opportunities.

  (Jung, 2003)

- In translating these concepts into what happens during implementation of early intervention services, research shows that learning opportunities facilitated within the context of family and community life have greater impact on a child's progress than intervention sessions. (Jung, 2003; Dunst, 2004; Hanft, Rush & Shelden, 2004)

- Parents prefer interventions that are easy to do, fit into their daily lives, and support their child in learning skills that help them be a part of family and community life.

  (Dunst & Bruder, 1999; Dunst, Bruder, Trivette, Hamby, Raab & McLean, 2001; Dunst, Bruder,

Trivette, Raab & McLean, 2001;Dunst, Hamby, Trivette, Raab & Bruder, 2002;)

- Embedding instruction in routines selected and preferred by families will greatly increase the likelihood that the family will practice therapeutic activities independently. (Hanft & Pilkington, 2000; Woods, 2004)

- There is a direct correlation between families' perceptions of themselves as competent and empowered with the families' level of follow-through in facilitating learning opportunities throughout daily activities and routines. (Jung, 2003)

- Frequency and intensity of services need to be based on the amount of support the family needs in using natural learning opportunities throughout everyday routines and activities of family and community life. Visits provided too frequently can be disempowering or send the message that the parent is not competent. (Jung, 2003; Dunst, 2004)

- Providing early intervention through a primary provider approach does not preclude other team members from consulting or interacting with the family or caregivers. (McWilliam, 2004)

- Team consultation and collaboration, regardless of the service delivery model, are critical to support family and caregiver competence, confidence and empowerment related to child learning. (Jung, 2003; McWilliam, 2003)

- Supports and services need to be tailored to meet the unique needs and characteristics of every child and family. (Zhang, C. & Bennett, T., 2000)

- "More is better". This means more learning opportunities NOT more services. Learning is what happens between intervention visits - through child initiated play during everyday routines and activities, through multiple repetitions and lots of practice - in the way that all young children learn and participate with families and friends in their community. (Jung, 2003)

These themes are not necessarily new to those who have been practicing early intervention. What has changed is how these themes are translated into practice. Effective early intervention services are not achieved by "taking clinical practice" into the child's home. In fact, the roles of early intervention practitioners have changed. The practitioner is no longer viewed as "the expert with the toy bag" but as a resource and partner for families and caregivers, who are enhancing their child's development and learning. In this new role, the practitioner shares his/her

knowledge and resources with the child's parents/caregivers and provides support to them in their day-to-day responsibilities of caring for their child and in **doing the things that are important to them**. The focus of each individual intervention session is on enhancing family capacity and competence in facilitating their child's learning and **participation** in family and community life. Intervention sessions no longer focus only on the specific skills of the child but on **what's working and what's challenging for the child and family's participation in their everyday routines and activities of community life**. Therefore, effective early intervention services incorporate opportunities to:

1. reflect with the family on what is working;

2. problem solve challenges;

3. help the family adapt interactions, actions, routines, the environment, their schedule and apply successful strategies to their challenges.

According to Hanft, Rush and Shelden (2004), using these key strategies during intervention sessions can significantly enhance the family's capacity and competence in successfully implementing strategies to meet IFSP outcomes.

The shift in early intervention practice is reflected throughout all contacts with children and families, beginning with the initial contact and continuing throughout evaluation and assessment, development and implementation of the IFSP, and early intervention services and supports. Implementing high quality IFSP services and supports is dependent on the quality of information gathered from early family contacts, team input during development of the IFSP, and the quality of information contained in the IFSP, especially in choosing outcomes and strategies based on interests and priorities of the child and family. The literature and recommended practices provide numerous frameworks and concepts for ensuring provision of high quality early intervention services.
(adapted from: Effective Practice Guidelines, Nevada Early Intervention Services, 2005)

PRIMARY SERVICE PROVIDER APPROACH: An Effective Method of Teaming and Providing Early Intervention Services

The approach to service delivery in which one primary direct services provider works with the family is consistently recommended in the literature as the preferred method for the provision of early intervention services. (Hanson & Bruder, 2001; Harbin, Mc William, & Gallagher, 2000; Mc William, 2000; Mc William & Scott, 2001; Schelden & Rush, 2001). Other team members consult with the primary provider and/or with the family to suggest strategies and techniques to enhance progress towards outcomes. Determination of service provider is based on a match between the family's ability, priorities, needs,

concerns, and IFSP outcomes and the provider's ability to assist the family (Guralnick, 1998).
(adapted from: Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places, Infant and Toddler Connection of Virginia, September, 2003)

When using the primary service provider approach, team members can play several roles. Usually one member (the primary service provider) will provide direct services and support to the family and other caregivers who are involved with the child. Other team members consult with both the family and each other. They do this by sharing their knowledge and resources and by helping each other, the family, and other caregivers learn new ways to support the child's learning and functional participation in everyday routines and activities. Current studies have shown that the primary service provider approach works well with young children and families in early intervention services (Shelden & Rush, 2004; McWilliam, 2001).

When families learn new ways to work and play with their child during normal daily activities and routines, new skills can be practiced with the child many times every day. The child and family do not always need to see many different specialists, but those specialists are available when needed as determined through the IFSP process. The IFSP team can decide when specialists are needed to help. This will usually happen when the team needs help in deciding what to work on next or determining what strategies will be most effective to achieve outcomes.

It is important to remember that although the family will be working with one primary service provider, the other team members will also provide support, consultation, and direct services based on the individual needs of the child and the parents, to meet the child's and family's outcomes.
(adapted from: Effective Practice Guidelines, Nevada Early Intervention Services, 2005)

The frequency of services is individualized to meet each child's and family's unique configuration of skills and interests, resources, priorities and needs including the family's need for guidance in relation to their child's development and current desired outcomes. Hanft and Feinberg (1997) note, "Research has been equivocal, and there has been little documentation that specific frequencies of intervention yield particular results on standardized developmental measures "(p. 29). Dunst et al. (2001) illustrates that formal early intervention service may not necessarily led to better outcomes for the child. In fact, frequent visiting and a focus on direct therapy by the service provider with the child can be counterproductive. A focus on direct therapy may lead a family to believe that only early interventionists can make changes in the development of their child and that separate instructional time, outside of their daily routine is needed in order to accomplish outcomes (Jung, 2003). Believing such, a family may

perceive little reason to follow through with strategies suggested by the visiting professional.

A common misconception is that the approach to early intervention services delivery described above somehow means less service or poorer quality service for children and families. On the contrary, this approach IS real intervention; and research indicates that it leads to real gains in child development; improvement in the family's feeling of competence in meeting their child's developmental needs; and attainment of meaningful functional outcomes for children in the context of their family and community.
(adapted from: Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places, Infant and Toddler Connection of Virginia, September, 2003)

Guidelines for Best Practice Service Delivery

Using current scientific research, it is not possible to accurately predict the optimal number of hours that will be effective for any given child. Effective services can and should vary from child to child and family to family. Additionally, the quality of the instructional exchanges, the competence of the interventionists and the degree of continuity across interventionists and settings may be more important than the total number of hours (Strain. et al., 1998).

Research does indicate that effective intervention requires involvement from both professionals and families. Following recommendations from other states and research, modifying them for Louisiana's Early Steps System, and with consensus of the SICC Service Delivery Committee, Louisiana has set the following guidelines regarding service provision.

The IFSP team must plan Early Steps supports to each eligible child and the family according to this Best Practice Guidelines process:

1. The IFSP team will design the IFSP by utilizing the Family Assessment of Concerns, Priorities and Resources (with parent's voluntary concurrence) and other developmental assessment information obtained in the eligibility/assessment process.

2. The IFSP team decision-making process for early intervention services delivery will be focused on supports necessary for the family to meet the child's developmental needs.

3. The IFSP team will follow the "Strategies to Achieve IFSP Outcomes" and "Determining Early Intervention Services" from the Early Steps Practice Manual (Chapter 6, Individualized Family Service Plan Development) to determine strategies and activities to achieve IFSP outcomes. Outcomes are family-directed, based in family routines and in natural environments only. They are focused

on increasing the functional capability of the child as a family member and not on skill acquisition.

4. The IFSP team may identity up to 24 hours of service for a 6-month period for all direct early intervention services (excluding those services for which there is no cost to parents, for example, evaluation/assessment for eligibility and service coordination).

5. The IFSP team will utilize the Service Level Justification for adjustments beyond the recommended service delivery levels. Note: No service delivery level above the Best Practice level of 24 hours per 6 months will be paid without completion of the justification by the IFSP team at an IFSP meeting.

Questions & Answers

Who determines intensity and frequency needs?

The members of the IFSP team determine decisions about the intensity and frequency. Members of the team include the family members, service coordinators, early intervention providers, evaluation/assessment team members, other Early Steps professionals and persons requested by the family. Information, assessments and recommendations from physicians, and other professionals outside of Early Steps are considered with all other information and clinical opinions. Ultimately, the intensity and frequency of services must be what a child needs to meet the outcomes set forth in the IFSP. Therefore, it will be crucial that the team identifies and writes appropriate and relevant outcomes and objectively monitors progress for each.

Intensity/frequency recommendations also must consider the total hours per week that a child and family participate in activities, which in and of themselves provide opportunities for active engagement and learning (e.g. peer play groups, family recreation).

Why 24 hours per 6 mo period?

The Service Delivery Committee of the SICC undertook a thorough examination of the relevant research on early intervention best practice, discussions with stakeholders and examination of other state recommendations regarding questions of frequency and intensity. It was the conclusion of the committee that for most children in Early Steps, up to 24 hours of direct service per 6 mo. period will constitute an appropriate plan and will be sufficient to meet the outcomes identified by the IFSP team. Therefore, it is expected that most initial IFSPs will be written for no more than 24 hours of direct service per 6 mo. period.

If an IFSP team identifies and is in agreement that there is a need for more than 24 hours of service, a justification must be completed. Once the justification is completed, it is attached to the IFSP service page and a copy of the justification is submitted to Early Steps Central Office. The updated IFSP is then in effect.

The justification format is contained in Appendix A of this document.

(adapted from Service Guidelines for Children with Autism Spectrum Disorders, New Jersey, July 2003).

Appendix A

Early Steps
SERVICES OVER 24 HOURS PER 6 MONTH PERIOD
Justification of Need Procedure

1. The IFSP team discusses the NEED for additional services by addressing these justification questions: (helpful hint: addressing these questions in order will provide you with an outline for the team discussion and the final written justification)

1. *Who is recommending or requesting the additional service hours?*

2. *How have the child and family adapted* to *intervention services?*

3. *Does the family feel services above 24 hours will be manageable for the child and family?*

4. *What identified outcomes will be addressed by additional service hours?*

5. *Are these <u>new</u> outcomes identified by the family and team or outcomes that*
   are to be continued?

6. *What level and/or rate of progress does the measurement of current outcomes indicate? Is the team in agreement that progress towards identified outcomes is <u>consistent and meaningful</u> at the current level of service? Team should provide individual child data regarding the measure of progress toward outcomes.*

** IF THE ANSWER TO QUESTION 6 INDICATES THAT CONSISTENT AND

MEANINGFUL PROGRESS IS BEING MADE, THE IFSP IS MOST LIKELY APPROPRIATE

AT THE CURRENT LEVEL OF SERVICE **

2. If the answer to question 6 indicates that progress could be improved, continue the discussion with the following questions:

7. *What methods and strategies are currently successful for which outcomes?*

8. *What is currently <u>not</u> successful?*

9. *What modifications have been considered or implemented to replace ineffective strategies?*

10. *Can existing service hours been redistributed or modified to meet the outcomes? (Example: will changing session time help with outcome achievement?)*

11. *How is the family currently supported in their ability to engage the child on a daily basis?*

12. *Does the entire team agree that an increase in service hours is needed?*

3. If the entire team is in agreement that services above 24 hours per 6-month period are needed, the IFSP is then written to reflect the agreed upon level of service.

4. Services are then initiated to reflect the updated IFSP.

5. Each team must decide which team member will be responsible for writing and submitting the final justification. There is no specific form however; an outline of the above questions should be followed. Typed justifications should be sent to Early Steps Central Office for a review of the strengths and limitations of the team's justification process within 10 days of the IFSP meeting. Technical assistance will be provided on an as-needed basis.

6. If the entire team is not in agreement and cannot justify services over 24 hours per 6-month period, the IFSP team should request technical assistance from the SPOE Early Intervention Consultant.

7. At the next IFSP review, a new justification must be written only if services will be increased. If service level stays the same or decreases no justification is needed even if the services remain above 24 hours for a 6 month period. For example:

IFSP Jan 1, services = 28 hours, justification written.
IFSP July 1, services = 31 hours, new justification is written regarding increase of 3 hours.

IFSP Jan 1, services = 26 hours, justification written
IFSP July 1, services= 26 hours, no justification needed

IFSP Jan 1, services = 28 hours, justification written
IFSP March 1, services = 25 hours, no justification needed

(adapted from Service Guidelines for Children with Autism Spectrum Disorders, New Jersey, July 2003)