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ABSTRACT

SoonerStart is a collaborative interagency effort that provides services to approximately 2,000 developmentally delayed infants and toddlers in Oklahoma. In rural north-central Oklahoma, the early intervention team consists of a regional coordinator, resource coordinator (case manager), child development specialist (lead clinician), nurse, speech pathologist, occupational therapist, and physical therapist. In the past 2 years, this team has conducted 300 assessments, primarily in rural homes. The team uses a four-part organizational and tracking system to ensure timely and quality services. Initial aspects of the assessment phase include: referral; initial home visit by the resource coordinator; assignment of the primary services provider; and clinical intake, information gathering, and initial screening by the primary provider. Prior to assessment, the team meets to review available information and to decide who will act as facilitator and coach during the assessment procedure, what behaviors of the child require specific attention, and the details of the assessment procedure and travel plans. During a team assessment, only the facilitator and the family handle the child. The coach prompts the facilitator, as necessary, and other team members quietly observe and record the child's behaviors. Later, the results are compiled into a report, and team members make recommendations to the primary service provider and the resource coordinator, who are responsible for writing and implementing a service plan with the family. (SV)

TEAM ASSESSMENT OF INFANTS IN THE RURAL SETTING

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Assessment is a very integral part of an early intervention program. A full assessment that addresses the whole child must include information from as many sources as possible. These sources include interviews with parents to gather historical information, observations and the use of screening or testing tools to help establish informed clinical opinion. To get a true picture of the infants present ability and potential, much of the assessment needs to be done in the home (Bailey & Wolery, 1984). This poses particular challenges for early intervention teams working in the rural areas. The plan proposed here to help meet those challenges is one currently being implemented by an early intervention team that is part of the SoonerStart program. Many of the considerations and guidelines suggested throughout this plan were taken from the SoonerStart Policy and Procedures Manual (91) and the Protocol for Child Development And Child Guidance Specialists, SoonerStart Program Services (92).

SoonerStart is Oklahoma's Early Intervention Program, which is a collaborative interagency effort of the State Departments of Education, Health, Human Services and Mental Health. This program provides services to developmentally delayed infants from ages 0-3. The plans for this program began in 1986 as a result of PL 99-457. To qualify for this program, an infant must be delayed in the areas of physical development, cognition, communication, social/emotional and self-help skills. An infant may qualify by displaying a fifty percent delay in one of these areas or a twenty-five percent delay in two or more areas. The theory of this program is driven by the philosophy that being family centered and oriented allows for better opportunities to be successful when providing services to developmentally delayed infants. In an attempt to adhere to this philosophy and provide quality services the SoonerStart program is adapting the transdisciplinary approach (McCollom, Hughes, Woodruff, & McGonigel, 1989). Along with this attitude the SoonerStart program is a proponent of home based services that operates in a Parent-Infant Interaction Model (Affbeck, McGrade, McQueeney, & Allen, 1981).

The SoonerStart program currently serves approximately two thousand children statewide. The state is divided geographically into eleven regions. The team that this plan was derived from functions in north central Oklahoma and currently serves seventy-five children, with approximately fifty of them living the rural areas. This early intervention team consist of a regional coordinator, who is considered a program coordinator, a resource coordinator, who might also be called a case manager, a child development specialist, who also serves as lead clinician, a nurse, a speech pathologist, an occupational therapist, and a physical therapist. In the past two years members of this team have been involved in three hundred assessments. A large majority of them have taken place in rural homes. The families have the option of where and when the assessment takes place and currently ninety percent choose their home. The plan this team uses is a product of these experiences, reevaluating and restructuring, along with information provided through other teams in the state and national sources, with the hope that improvement can be continual.

To ensure timely and quality services, an organizational and tracking plan should be implemented. This team uses a four part plan that allows a child to be tracked anywhere and at any time in this program. The team also knows who is responsible for each phase of the child's individual program. This is very important during the assessment phase

because of the need to gather and share information with the team. The four part plan includes:

a statewide database system containing sixty-five fields covering everything from personal identifying information, to all phases of the program implementation, including projected dates of reevaluations.

a file system used to compile information on each client, including the referral, initial home visit, the service plan and any eligibility information that is necessary.

a tracking sheet that starts with thefile on the day the referral is received and is later moved to a notebook. This sheet has all of the activities of the process and the person responsible for them.

a staffing notebook that contains previous staffing notes for historical references and agendas to keep a record for the future meetings.

All of these activities play a part in ensuring that the team is efficient and expedient in providing appropriate services once a referral is made.

The referral, which may come from a variety of sources, is the first contact that the team has with the family and this starts the assessment process. There are several pieces of information that may come from the referral that may be useful to the team. It may be very important to know who the referral source is and what their relationship is with the child and family. This source may be able to provide specific information about the child's health or development, which could save planning time. It is also important to know why the child was referred or the concerns and if the parents are aware of the referral. Any information that can be acquired through the referral source that will aid in making contact with the family is a necessity, especially when working with rural families. Since the SoonerSart program is totally voluntary, the family is contacted by letter and by phone to set up an appropriate time for someone to do an initial home visit.

The initial home visit process is performed by the resource coordinator. This person is not only responsible for explaining the program to the family, but also for gathering information through a direct interview. This person also serves as a family contact and advocate throughout the families time of involvement with the program. While attempting to be family friendly, this interview focuses mainly on the families concerns about their child and how this program can work with the family for the benefit of the child (Winton & Bailey, 1990). The resource coordinator then brings this information back to present to the program coordinator and the lead clinician and from this meeting a decision can be made on the selection of the appropriate primary service provider (Eagen, 1984). The resource coordinator also presents the information from this interview to the team in a staffing to get their input on the primary service provider assignment and suggestions for the clinical intake process.

The assignment of the primary services provider is made with a lot of care. Every attempt is made to assign a person to this task that will be able to establish and maintain a positive relationship with the family. A part of the transdisciplinary model and a family oriented approach is to limit the number of people that comes into the home and interacts with the family. Therefore the team makes this decision based on the hope that the person will be able to provide the services to the family throughout their time of involvement in the program. This person then begins the clinical intake process. If time and distance are extenuating problems, the initial home visit and the clinical intake can be done simultaneously. The referral information should be very extensive for this to be

appropriate.

The clinical intake is done by direct interview and involves the gathering of extensive information concerning the child's prenatal history, health issues, developmental milestones and any medical information that might be pertinent to the child's development. Through this process the primary service provider initiates a potential list of other professionals that the child or family has been involved with that might be able to share information to the team. Then signed releases of information can be obtained to send to as many of these people as is appropriate to expedite the information gathering process. Also during this meeting the primary service provider observes the child and the interaction with the parents. If the primary service provider decides it is appropriate, then a developmental screening is done. The information gathered from the clinical intake, observation and screening are compiled to help direct the decisions on eligibility and evaluation process. At the close of this meeting the primary service provider explains the process of multidisciplinary staffing and the assessment to the parents. Their attendance and/or input concerning the assessment is encouraged.

The results of the clinical intake, observation, screening and other information gathered concerning the child are shared with the team at a multidisciplinary staffing in which all of the team members are involved. In the transdisiplinary approach, an arena assessment is used as the main component of the evaluation. The following guidelines and considerations for arena or team assessments were taken from the state of Georgia program guidelines and from Wolery and Dyk (1984). The primary service provider uses a pre-assessment protocol to ensure that each component of the assessment has been addressed. These components would include:

Who will act as facilitator during the arena assessment? The facilitator is often a parent or other caregiver, or a member of the professional team from a discipline likely to be needed by the child. The facilitator is the only one who handles or interacts with the child, and attempts to elicit pre-determined behaviors. The parent is generally considered the best person for this role and is encouraged to do so. If the parent does not feel comfortable serving as facilitator, the primary service provider is the next likely candidate, because of their previously established rapport with the child.

Who will act as the coach? The primary service provider will unless they are the facilitator, then the interventionists that could best address any known concerns about the child. The coach helps the facilitator to remember the sequence and pre-determined activities of the assessment.

Behaviors of the child that require specific attention. Based upon the available information, team members decide what further evaluation/assessment information they need.

Assessment/evaluation tools to be used. It is often useful to decide upon one comprehensive developmental test and have each section scored by a member of the discipline most involved with that domain. Although using a transdisciplinary approach requires professionals to cross-train and share techniques to allow them to assess domains that might have been previously considered inappropriate for them. Evaluation tools and assessment procedures that are selected for each child will depend on several factors, the foremost being the purpose of the assessment. The assessment tools can be divided into seven categories: (a) screening tests, which may tap one or several developmental areas; (b) developmental inventories, which assess several areas; (c) cognitive assessment; (d) communication assessment

instruments; (e) motor assessment; (f) social/emotional assessment; and (g) adaptive/self-help assessment. Another factor to be considered is the testing environment. When teams are doing home-based assessments in the rural setting they need to take into consideration whether procedures are appropriate to the home environment.

The order in which the various activities will take place. With young children it is especially important to organize the time to optimize the amount of information that can be obtained before the child becomes tired, hungry, or satiated. For this reason, activities to elicit the most necessary information should usually be done near the beginning of the session.

The toys, food, clothing, and other equipment needed to elicit specific behaviors. The necessary items should be listed and a team member made responsible for having them available at the time of the evaluation/assessment. This information is also helpful for program design when discussing resources available in the home.

Other evaluations or further information that is needed. It may be determined that some needed information is not possible to obtain during an arena assessment. This may include results of standardized cognitive tests, audiological evaluation, or laboratory procedures.

When and where will the arena assessment be conducted? The family should have a lot of input into the time and place of the assessment, and the assessment should be scheduled around the child's daily routine to the extent possible.

Finalizing travel plans. Since a team may cover a large rural area, a concerted effort is made to share travel. This is a very opportune time to go over any pertinent information concerning the child. It also allows the team members a chance to finalize the organization, responsibiiities and communication of the assessment procedure.

The transdisciplinary team assessment, is preferably held in a room that is large enough for the team to sit comfortably removed from the child and facilitator. This may be difficult when doing home-based services. The testing environment should be discussed during the pre-assessment meeting along with potential problems that may arise. Limiting the number of professionals that go into the home and are involved with the assessment helps solve some of the space problems. The choice of seating is then made from a strategic observational standpoint and weighed against the intrusiveness of the professional on the child and family. During a team assessment, only the family and the facilitator (if not the family member) handle the child. The coach prompts the facilitator, as necessary, to ensure that all information requested by the team is elicited. The other team members quietly observe and record pertinent interactions and other behaviors of the child, including interactions with the family.

Participating team members should try to be as organized and thorough as possible. They need to have very good observational skills, so the assessment process is concise, but the necessary information is obtained. This is especially true in the rural areas, because distance and time constraints limit the number of visits a professional can make for assessments. Again, to be family oriented the team should strive to complete the assessment in one visit. Some effort should also be made to provide the family with some closure concerning the assessment. A tentative schedule should be set for a time to discuss the results and implement a program for the family.

Immediately following the evaluation, on the ride back is possible. Participating team members can discuss any issues or concerns. It is very important for team members to give

each other feedback about the process, not only for the current assessment, but for future ones (Landerholm, 1990).

The results of the evaluation/assessment are then compiled into a report and the primary service provider presents this to the team at a post-assessment staffing. Although assessment is considered to be ongoing, for program service implementation purposes, this is the last phase of the assessment process. The team then reviews all the available information and makes recommendations to the primary service provider and resource coordinator, who are responsible for writing and implementing a service plan with the family.

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