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ABSTRACT

This final report describes objectives, activities, and outcomes of a project to provide training to infant specialists employed within a total of 16 infant intervention programs in New York State. The project focused on the acquisition of skills necessary to provide services under Public Law 99-457. Training content and procedures were derived from an earlier demonstration project at the University of Connecticut Health Center. The New York project provided training within each regional planning group through an institute format. An institute consisted of approximately 6 to 10 didactic and activity-based sessions on a specific intervention topic. Topics included the Individualized Family Service Plan; infant curricula; transdisciplinary teaming; and programming for infants, toddlers and their families. Five to 10 infant specialists were enrolled in each institute. Competency tasks provided one measure of program effectiveness. Other measures included pre-post questionnaires, self-rating scales, and consumer satisfaction questionnaires. The major portion of the document consists of appendixes, including a list of institute participants, sample evaluation instruments, details on each of the 16 programs served, evaluation results, an inservice training manual, and an article by Mary Beth Bruder and Tina Nikitas titled "Changing the Professional Practice of Early Interventionists: An Inservice Model To Meet the Service Needs of Public Law 99-457." (Contains 22 references.) (DB)

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BIRTH TO THREE INSERVICE OUTREACH TRAINING PROJECT

FINAL REPORT

Grant #H024D10052

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I. ABSTRACT

The training content and procedures of this outreach project have been derived from a three-year model demonstration inservice training project funded at the University of Connecticut Health Center. This outreach project expanded the demonstration by providing training to infant specialists employed within infant intervention programs in New York State. The program focused on the acquisition of skills necessary to provide services under P.L. 99-457. The project reflected state-of-the-art training content for infant specialists and was consistent with New York State's Part H personnel standards. Toward this end, the project was implemented in conjunction with regional planning groups funded by New York's Part H funds. The project provided training within each regional planning group through an institute format. An institute consisted of approximately six to ten didactic and activity-based sessions on a specific intervention topic. Topics which were implemented and validated through the demonstration project included the IFSP, infant curricula, transdisciplinary teaming, and programming for infants, toddlers and their families. Five to ten representatives of infant programs were enrolled in each institute. Competency tasks provided one measure of program effectiveness. Other measures including pre-post questionnaires, self-rating scales, and consumer satisfaction questionnaires were implemented across student impact, program impact, and community impact.

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III. Project Goals and Objectives

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IV. THEORETICAL AND CONCEPTUAL FRAMEWORK

Many studies have shown that early intervention efforts with infants and children with disabilities have been effective in accelerating and maintaining development (Bricker, Bailey, & Bruder, 1984). Research has also shown that the more time a young child is able to spend in pre-school, the more significant the effects on his/her development. Within the past year, it has been documented that infancy period is an intense time of development and learning (Kagan, Dearlsley. & Zelazo, 1978) and services for this population have increased nationwide. These services have not only provided benefits for young children, but they have also provided benefits for families and other caregivers by providing the support, information and education necessary to maintain the family system, while fostering the development of their child with disabilities (Foster, Berger, & McLean, 1981).

In an effort to support early intervention services to children and thier families, Congress has passed legistlation lowering the mandated age for special education services under the Individuals with Disabilities Education Act (formerly Education for the Handicapped Act-P.L. 94-142) to include children three through five (Part B) and have provided incentive monies for states to encourage them to provide early intervention to children with disabilities from birth through three (Part H). This legislation P.L. 99-457 as well as recommended "best practices" advocate that early intervention programs be family-directed, comprehensive and communtiy-based.

P.L. 99-457 presents many challenges to those in the field of early intervention. States, in particular, are charged with designing a multidisciplinary early intervention program that contains 14 key components, all described within the law. Two of these components focus on the personnel who will be implementing the services. These are the implementation of state standards of practice for all personnel providing early intervention services, and a comprehensive system of personnel development (CSPD) to ensure the availability of appropriately trained early intervention personnel (using both preservice and inservice strategies). Both of these service delivery components will have broad effects across all others, as states begin to implement early intervention services as regulated by P.L. 99-457. At this time state and local agencies are working to develop early intervention programs that reflect these characteristics. New York State has recently passed state legislature to implement Part H of Public Law 99-457. In order to do this effectively, personnel within early intervention programs must possess skills that may be different than previously required. For example, the law requires that professionals from multiple disciplines be trained to collaboratively assess infants and toddler with families, develop an Individualized Family Service Plan (IFSP) based on family priorities and concern, assist families to coordinate services, and provide these services in natural environments. The family focus in the process is unique to this age group and demands additional skills beyond the child-focused intervention skills.

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Both professional organizations (e.g., Campbell, Oetter, Hall & Berger, 1989; McCollum, McLean, McCartan & Kaiser, 1989; Wilcox, et al., 1989) and recognized leaders in early intervention personnel preparation (Bailey, 1989; Hanft & Humphrey, 1989; Hanson & Lynch, 1989; Fenichel & Eggbeer, 1990; McCollum & Thorp, 1988; Thorp & McCollum, 1988) have recommended specific competencies for professionals employed within early intervention. Unfortunately, these competencies have not as yet been included in state licensure or certification standards for professionals within the ten disciplines included under P.L. 99-457 (Bruder, Daguio & Klowsowski, 1991). This absence of state standards has resulted in an increased focus on states' development of a CSPD as the vehicle to provide specific early intervention competencies to personnel through both preservice and inservice opportunities.

The need for expansion within preservice training programs for early interventionists has recently received attention (e.g., Bailey, Palsha & Huntington, 1990; Gallagher & Staples, 1990). However, the current shortage of early intervention personnel (Meisels, Harbin, Modigliani, & Olson, 1988) has prompted many in the field to discount preservice as the training method of choice. Many states are, instead, relying on inservice training as the method to provide staff with the skills necessary to implement the service delivery requirements described in P.L. 99-457. As states begin to plan these inservice training activities, it is imperative that they apply "best practice" principles of adult learning to insure that early intervention staff are prepared for the service delivery challenges of P.L. 99-457.

Inservice education has been defined as the process by which practicing professionals are provided experiences designed to improve or change professional practice (Bailey, 1989). Inservice training is an effective tool for professionals to gain access to new information and the latest research in a particular field. Generally, the objectives of inservice training include the changing of attitudes, the acquisition of new knowledge, and the development and enhancement of technical skills (Laird, 1985; Bernstein & Zarnick, 1982). The desired outcome of inservice training is for participants to internalize new knowledge and apply what has been learned to their specific professional needs (Barcus, Everson, & Hall, 1987). Many of the principles used in effective inservice training are based on some universally accepted assumptions about the adult as a learner. Malcolm S. Knowles (1980), a leader in the field of adult learning theory, identified five principles about adults as learners. These principles served as the Birth to Three Outreach Inservice Training Project's philosophy and, as such, guided the project methodology. The principles will be briefly explained.

The need to know. Adults will learn more effectively if they understand why they need to know certain information, or why they must have the ability to perform particular skills. Adult learners must be able to see that the benefit of learning a skill will outweigh the cost of the time and

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effort it takes to learn it. The more adults can see the benefit to learning, the stronger they will feel the "need to know".

The need to be self directed. As people mature into adulthood, they have a deep psychological need to be responsible for their own lives. Cultural conditions will obviously enhance or retard this process, but there comes a time in the psychological development of adults when they "feel like an adult". At this point in time, adults will resent being told what to do and having decisions made for them. Adult learners are more successful if they can take responsibility for their own learning.

The importance of experience. Adults, by virtue of their age and life experiences, bring a vast amount of knowledge and a wide variety of experiences with them to the classroom. This wealth of life experience can result in the following consequences for the training program:

a) Groups of trainees will have wide and varied backgrounds, therefore, the training staff will have to individualize instruction;
b) Adults are a rich source of information for themselves and the other trainees because of their experiences. The training staff should take advantage of these experiences by using techniques such as group discussion and brainstorming;
c) Adults may have some rigid ways of thinking that consequently interfere with learning. The training staff may need to "unfreeze" these ways of thinking through activities such as sensitivity training or values clarification.

The readiness to learn. Adults will learn the things that they perceive will bring them greater satisfaction or success in life. As adults move through various stages of psychological and social development, their readiness to learn is reflected accordingly. For example, adults are interested in learning job specific skills when they acquire a job. As a result, it is important for the training staff to understand that learning opportunities should be offered in a timely fashion on topics of immediate value.

Orientation to learning. Adults see the reason for learning as acquiring competencies that will enable them to cope more effectively with life, perform life tasks and solve real problems. Training staff need to organize training programs around real world issues that confront adults from day to day.

V. MODEL DESCRIPTION

1. Design

This project was designed to provide training to early interventionists who work for early intervention programs that serve children between the ages of birth to three years with disabilities. The training focused on service components of P.L. 99-457. The training consisted of multiple training sessions called institutes. The institutes included small groups of participants who attended four to six didactic and activity-based sessions. The participants applied the training content through the implementation of competency tasks through a follow-up phase of training.

The institutes included a maximum of twelve participants from a variety of early intervention programs. There were approximately six training sessions, each three hours long and consisting of a combination of lectures, discussions, videos, practical activities and feedback. The sessions were held once a week in a location which was central to all of the participants. The content of each of the sessions was predetermined but was modified according to the needs of the group.

Follow-up began when the training sessions ended and consisted of observations and meetings at the participant's program site for the purpose of providing consultation, support and assistance in implementing the training content through the completion of the tasks. Program tasks were competencies that the participants completed within four to six months after the last training session. Additional follow-up was available to participants for up to one year from the start of the training sessions and the goal of the tasks was the implementation of family service plans by all program staff.

2. Target Population

The target population was early interventionists (all disciplines) from New York State.

3. Methods

This outreach inservice was derived from a statewide model demonstration project which provided training to infant interventionists in the State of connecticut. The Birth to Three Inservice Training Project was funded for three years (October 1987 - October 1990) by the Handicapped Children's Early Intervention Program (H.C.E.E.P.). The project was administered by the Department of Pediatrics, Division of Child and Family Studies, University of Connecticut School of Medicine, Farmington, Connecticut. The purpose of the Birth to Three Inservice Training Project was to develop, implement, and evaluate an inservice training model for infant interventionists in the State of Connecticut. Implementation of the training content was offered via workshop and institute formats.

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This project has adapted its training process from both experts in the field of training (Knowles, 1980), and project experiences from the original Inservice Project. In particular, training was organized to address aspects of adult learning theory as it relates to staff development.

When actually implementing training, the process used addressed many of the aspects of adult learning. All of the training followed certain procedures:

FIRST: A climate conducive to learning was established by attending to both the physical and psychological environments. Collaborations were fostered by the design of learning activities which required sharing and helping. Support and mutual trust was reinforced by the acceptance of the participant's input as valuable. Training staff always acted as facilitators, rather than trainers. Active inquiry and openness was encouraged through the implementation of activities which involved the learner as doer, through whatever learning style he/she most favored. Lastly, mutual respect was encouraged throughout training through the use of such strategies as letting the group decide on learning activities, and allowing the group members to serve as teachers to the training staff.

SECOND: All training was mutually planned. All of the training has been planned by consumer audiences. For example, follow-up tasks for each Institute were planned to correspond directly with the goals set by the participant's goals for their program.

THIRD: Individual learning was diagnosed. Through the use of the Program Review, Self-rating scale, and general interview, the methods and environment for the training were specifically designed to meet the needs of the participants in each group. This method not only assessed content needs, but also logistical needs (time and place for training).

FOURTH: Learning objectives were formulated. Each participant completed a training contract which included specific objectives, activities, and evaluation criteria for the training they were to receive.

FIFTH: Training was implemented through a number of techniques. The training was based on a collaborative model. This teaching style is one of the best and most appropriate teaching styles for adults. The trainer's role was to function as a facilitator rather than a "teacher." The primary task of the trainer was to provide an environment that facilitated learning. The trainer set a climate of collaboration, and attempted to have learners help one another. Emphasis was placed on the learner's participation. Activities of training were selected and designed to center around the learner's experience. Adults place a high value on their experience; consequently, time is given during training for people to share or identify ways to practically apply new technique and innovations (Showers, Joyce, & Bennett, 1987). These kinds of activities enable adults to "unfreeze" some of

their rigid ways of thinking. It also enables them to recognize the possible benefits of acquiring the new information. The case study method was one that was used as appropriate throughout the institutes.

SIXTH: The participant's performance was continually evaluated. Most of the time the participants played a major role in evaluation. The evaluation designed included knowledge measures (pre-post/indices), performance measures (practical activities), and products which demonstrated competence within the training area. For example, participants in the I.F.S.P. institute developed and used I.F.S.P.'s in their programs, developed screening procedures and assessment protocols for their programs, and developed case coordination procedures.

SEVENTH: We provided follow-up to all program participants. This was an integral component to the outreach training. Follow-up assisted the implementation of the training content. It also allowed for an additional and most important indicator of the training effectiveness.

4. Procedures

Institutes were offered each year on content areas pertinent to early interventionists serving infants with disabilities nd infants at risk of developing a disability and their families. A sample content area on Individualized Family Service Plans will be illustrated to the reader:

I.F.S.P. INSTITUTE

Purpose. The purpose of the I.F.S.P. institute was to provide training to infant interventionists on how to involve families in the assessment of needs, planning and decision making for their infant with disabilities.

Process. Institutes consisted of approximately six sessions of didactic course work in which the institute content was delineated into training manuals with objectives, readings and evaluation criteria. A unique feature of the institutes was on the follow-up support provided on-site to institute participants. The support was focused on insuring that institute content was implemented: 1) by intervention teams at each participant's site; 2) across different agencies involved in infant programs; and 3) by parents to enable them to participate as active members of the intervention team. The follow-up support consisted of on-site team meetings with each program's intervention team and families in which activities, timelines, and evaluation criteria were delineated.

Participants. Staff from early intervention programs within New York State's service delivery system were eligible for institutes. Follow-up activities included interdisciplinary team members and parents from each institute participant's program. A prerequisite to institute participation was the involvement of the participant's program intervention staff in follow-up activities, as well as a commitment from the institute participants to

conduct three training activities for early interventionists. In this way, the use of the "train the trainers" model was ensured.

5. Outcomes

The outreach training project resulted in the availability of "state of the art" training opportunities for infant interventionists within New York State. Additionally, the project was conducted in tandem with the New York State regional planning group personnel activities under the I.C.C. This ensured that the training occurred in accordance with the state's evolving system of personnel development.

6. Evaluation

The evaluation design utilized a variety of methods to measure the effectiveness of the project. Both internal and external, formative and summative techniques were used. A variety of types of objective, quantifiable data was obtained on a continuing basis throughout the project. Particular attention was placed on the process variables (antecedents and consequences) which contributed to project effectiveness.

The evaluation design reflected questions and procedures focused on the three training activities across the evaluation targets of trainees, programs, families and children. In some cases instruments were available, though they may have been refined through the evaluation process. Whenever possible, psychometrically sound instruments were used and the evaluation instrument were as non-intrusive as possible. We relied on a discrepancy evaluation model, and in some cases where appropriate, comparisons were made across groups.

We utilized an IBM P.C. to store date and SPSS was used to analyze the projects quantifiable impact. We utilized statistical procedures as warranted. Additionally, we provided training to our replication sites on the use of the computer software to store, manage and analyze data.

VI. PROJECT RESULTS

The Birth to Three Inservice Training Outreach Project provided training to Early Intervention teams on a variety of topics. The topics were arranged into Institutes and project staff kept to the proposed schedule of implementing a minimum of four institutes a year. Demographic information has been compiled on the sixteen programs that participated in training over the past three years and is detailed in Appendix A. Table 1 contains information on the six programs which received training during 1990 and 1991. Table 2 contains information on those programs which received training during the 1991-1992 year. Table 3 contains information on those programs which received training during the 1992-1993 year.

OBJECTIVE 1.0: REFINE INSTITUTE CURRICULA

Activity 1.1 Refine curricula. The curricula for the institutes have been reviewed and refined by project staff.

Activity 1.2 Develop institute syllabi. The institute syllabi have been developed.

OBJECTIVE 2.0: IMPLEMENT INSTITUTES

Activity 2.1 Recruit participants. The participants in the trainings conducted over the last 3 years were recruited on an ongoing basis as a result of project staff visiting numerous programs in the Westchester County area in order to become familiar with the programs and to become aware of the training opportunities that were available. In addition, a letter and brochure describing the project were mailed to program directors in the New York metropolitan area.

Activity 2.2/2.3 Hold orientation and conduct on-site visits. All programs who participated in training held meetings with program staff prior to training. Each orientation session lasted approximately 1.5 hours. During the orientation session, participants were given an overview of the training content and expectations for follow-up. In addition the session readings were disseminated and pre-measures were completed. On site visits were typically held at least once prior to training. These visits were made to observe the program in session and to complete the Program Review with the supervisors.

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Activity 2.4 Implement training. Five institutes were conducted during year 1 of the project, four institutes were conducted during year two of the projct, and seven institutes were conducted during the third and final year. Alist of participating agencies has been included in Appendix A. Institutesconducted during the three years of the project included 5 Transdisciplinary eaming Institutes, 3 Infant Curricula Institutes, 7 IFSP Institutes and 1 Programming for Infants, Toddlers and Their Families Institute (see Appendix S for breakdown by program). Each of the institutes was held once per week for four to seven weeks depending upon the institute topic and length of each session. The session lengths varied depending on the goals of the program, ranging from two to five hours per session. A combination of lecture, discussion and group activities was used to teach the information presented. The overall agendas for the sixteen institutes held to date can be found in the respective appendices for each participating agency.

Activity 2.5 Implement follow-up activities. All of the centers that participated in training during 1990-1993 have completed follow-up. Tasks have been completed in a timely fashion and certificates of completion have been provided individually to each group of participants.

YEAR 1

Greenwich ARC. A seven month follow-up with the Greenwich ARC was ended in July. Contact with the training participants averaged one meeting per month during this follow-up. The meetings varied in content from an assessment training to review of written products and classroom observations. All six training participants completed follow-up, however, the level of participation varied depending on staff roles and amount of time they worked in the program. Three of the six participants consult with the Greenwich ARC Infant/Toddler Program on a part time basis and thus were not as active in the follow-up phase of training. These participants included the psychologist, occupational therapist and physician. The final team meeting was held on July 25, 1991. During this meeting post measures were conducted for the third time. Institute training information has been included in Appendix C.

Rainbow School. There was one follow-up meeting held with the infant/toddler staff at the Rainbow School in July of 1991. The program had a change in administration since the institute began last winter and follow was not consistent. The meeting in July 1991 was held to determine what the participants felt they wanted and could accomplish with the consultation of the Birth to Three Inservice Outreach Training staff. In addition to the staff who participated in training, there were five therapy staff in attendance. Results of this meeting indicated that the program was in a

major transition phase and program needs were great. Primarily, the staff reported that developing a clear eligibility criteria and a system to identify eligible children as their main concern. Also, the education staff felt that they needed more support and time to meet as a team since they were frequently out of the office on home visits. It appeared that the program had needs that were not consistent with the parameters of the institute objectives or the objectives of the project thus a decision was made not to continue follow-up with this program. Institute training information has been included in Appendix D.

BOCES II Infant Program. The seven institute participants from this program completed follow-up in May 1991. A wrap up session was conducted on May 29, 1991 during which time the post measures were conducted. Contact during the three months of follow-up averaged a minimum of two contacts per month for each participant. Tasks were adapted to meet the needs of individual team members. Contact made with the participants of this institute included observations of team meetings and assessments, reviewing and giving feedback on written tasks, answering and clarifying details of incomplete tasks. Post measures were administered for the third time at the final meeting in May. Institute training information has been provided in Appendix E.

Westchester UCP. Seven follow-up meetings were held with the Westchester UCP infant/toddler team since their training ended in March 1991. These meetings were for the purposes of observing tasks and providing technical assistance. The tasks that were observed included conducting team assessments and team meetings for the purpose of developing an IEP. After the assessment and team meeting, time was set aside to discuss the activities and give the team verbal feedback. Follow-up with this program was completed in January, 1992. A wrap up session was conducted on January 30, 1992 during which time a discussion with the participants about the overall benefits of the institute was facilitated, and post follow-up evaluation measures were administered at the meeting. Institute training information has been included in Appendix F. Five of the original seven participants completed follow-up and attended this session. The two that did not attend are no longer working at the UCP Program.

Sullivan Diagnostic Treatment Center. One follow-up meeting was conducted in August 1991. The purpose of this meeting was to define and clarify the terms of the tasks that would be completed and the timelines for completing. It was determined that follow-up meetings would be held at least quarterly. Another meeting was scheduled for mid November, 1991. However, the director of the Sullivan Diagnostic Treatment Center Infant/Toddler Program wrote a letter to the Birth to Three Inservice Outreach Training Project Staff and explained that they would not be participating in follow-up due to time constraints of the program staff. Institute training information has been provided in Appendix G.

YEAR 2

East River Child Development Center. Six follow-up visits and ten follow-up phone calls have been made to this program since follow-up began in January, 1992. Follow-up visits have been primarily in the form of meetings with the training participants and administrative staff to clarify their goals for follow-up and to problem solve issues regarding implementing a transdisciplinary teaming model in their program. During training, the program was in the process of changing directors and also added a new therapy director position. With this change in staff there has been an additional emphasis placed on the need to implement a transdisciplinary team. The institute participants have developed and implemented the use of an integrated therapy report as a part of the follow-up to training. A copy of this report format is contained in Appendix H. A half day teaming/activity based workshop was conducted in July for the entire staff at the East River Child Development Center. A copy of the agenda for this workshop is also contained in Appendix H. Another follow-up workshop on goals and objectives was held in October 1992. Institute training information is included in Appendix H.

Children's School for Early Development. Five follow-up visits and five follow-up phone contacts have been made with this program since the training sessions ended in February, 1992. To date the program staff has revised their family interview questionnaire and their IFSP form as a result of their participation in the training institute. A copy of these forms can be found in Appendix I. In addition three of the participants in this IFSP institute conducted two half day IFSP workshops for the rest of their staff who did not participate in the institute. The Birth to Three Inservice Outreach Training Project staff supported them in the development of these workshops by assisting with the outline of the agenda and providing handouts and overheads. Institute training information is included in Appendix I. Follow-up with this program has been completed.

Special Sprouts. Two follow-up visits and four follow-up phone contacts have been made with this program since the training sessions ended in March, 1992. During this time the institute participants have developed a program brochure including their philosophy and have also developed a family interview questionnaire. The program has implemented the use of a family questionnaire and have included family outcomes on their IFSP's. Institute training information is included in Appendix J.

Alcott School. Five follow-up visits have been made to the participants in this program since the institute training sessions ended in May, 1992. During the first contact each of the participants outlined the follow-up activities of their choice. At the second meeting each of the participants met individually with a staff member from the Birth to Three Inservice Outreach Training Project to refine their goals for follow-up and to identify resources and supports they might need to complete the activities. A follow-up meeting was held in September 1992. The follow-up tasks completed at that time were discussed. These included: revising the role of

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the social worker, implementing a home visit component to the program, restructuring of team meetings, and use of an anecdotal binder to improve communication amongst team members. Additional follow-up meetings focused on reviewing child assessments and activity based instruction. Alcott School has now completed their follow-up task commitments. Institute training information is included in Appendix K.

YEAR 3

Sunnyview Rehab.Center: Sunnyview Rehabilitation Center is located in Schenectady, New York. At the request of Sunnnyview, the Transdisciplinary Teaming Institute was held over two full day sessions, rather than shorter weekly sessions. This proved to be very beneficial to the staff. They felt that the intensive two-day training enhanced the quality of the experience. The follow-up phase of the Institute began with an initial follow-up visit on November 23, 1992. The staff at Sunnyview have put together a program philosophy, and have attempted to implement what they have learned into monthly child assessments and subsequent IFSP meetings. They have been successful in establishing an effective system of communication with both the county as well as the state. Institute training information is included in Appendix L.

Putnam ARC (PARC). A total of five staff members participated in an IFSP Institute conducted at Putnam ARC. The program currently serves children from infancy through five. They have been attempting to conduct IFSP's, however, they felt that the process was not being implemented appropriately. Five weekly sessions were completed and the group felt they learned much from the training. The scheduling of follow-up visits with this group was very difficult due to time constraints and extensive case loads on the part of PARC Preschool. The first follow-up meeting was scheduled for December 15, 1992, but due to staff illness a their center, they requested that follow-up be rescheduled to begin in January. The director continued to coordinate the completion of follow-up commitments and forwarded copies of completed tasks. The program developed a more family-centered philosophy and focused a large portion of its follow-up on the development of appropriate arena assessments for young children. Training information is included in Appendix M.

Columbia ARC (COARC). Ten staff members participated in an IFSP Institute held at COARC. COARC has an intensive home-based program as well as center-based, and felt that training in the appropriate implementation of the IFSP process would benefit the staff as well as the families. Five weekly sessions were completed and follow-up began on January 7, 1993. The group decided to organize their follow-up phase into several key areas including Implementation of the IFSP, the Arena Assessment, and Family Assessment. As a whole, the group feels that follow-up has been very beneficial to the program. They have successfully developed an IFSP protocol which has incorporated the Arena Assessment into their family focused system. Institute training information is included in Appendix N.

Williamsburg Developmental School. Ten participants took part in the IFSP Institute held at Williamsburg Developmental School. Williamsburg Developmental School has focused their follow-up on the development of an Arena Assessment model. They have worked diligently at developing and IFSP protocol that would work successfully within their urban setting. Institute training information is included in Appendix O.

Northside Center for Child Development. Seven participants took part in the Infant Curricula Institute held at Northside Center for Child Development. The participants focused their efforts on the development of appropriate curricula and activities for infants and toddlers. They also attempted to incorporate more child-directed, activity based tasks into their daily routines. Institute training information is included in Appendix P.

New Medico Rehabilitation Center: Eleven participants took part in the IFSP Institute held at New Medico Rehabilitation Center (now renamed Hilltop Manor of Niskayuna: The Center for Brain Injury Rehabilitation). The center has focused their efforts on an attempt to coordinate the rehabilitation program of each young child with an appropriate, well-rounded education program including an IFSP with transition planning. A total of five weekly sessions were held and follow-up began on June 7, 1993. One area that received much attention during initial follow-up was that of effectively assessing and evaluating young children within their familiar classroom environment, rather than pulling them out of the room in a more clinical fashion. As a whole, the group believes they have learned much from this training and is enthusiastic about implementing new ideas into their assessment and IFSP protocols. Institute training information is included in Appendix Q.

Dutchess County Department of Health: Twelve staff members participated in the Transdisciplinary Teaming Institute held at Dutchess Co. Department of Health in Poughkeepsie, NY. This group consisted of participants from a variety of backgrounds, employed at a variety of programs throughout Dutchess County. Their goal was to form a transdisciplinary assessment team for Dutchess County. Four weekly sessions were held, and very specific emphasis was placed on Intake protocol, Assessment protocol, and their role within the overall IFSP process. The team looked closely at the Arena Assessment as a possible approach for standard use by the team. Follow-up for this group began on June 16, 1993 and continued until August 1993. Institute training information is included in Appendix R.

OBJECTIVE 3.0: EVALUATE THE TRAINING

Activity 3.1 Evaluate institute. Evaluation information on the five institutes conducted during year 1, two institutes held during year 2, and the 7 institutes held during year 3 of the project are described below. All institute training sessions were evaluated through a variety of measures. These included a demographic questionnaire, motivation

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questionnaire, learning style inventory, pre/post test, self rating scale, program review and a consumer satisfaction questionnaire. Except for the pre/post tests and self rating scale the measures were constant across each institute. Sample evaluation instruments are included in Appendix B. Individual evaluation results are included in the respective appendices for each participating agency.

YEAR 1

Five Institutes were completed during the first year of this project. Data for each participating agency follows.

Greenwich ARC. There were six participants in the Greenwich ARC Infant Curricula Institute. Two were full time employees of the Association for Retarded Citizens; the remaining four were part time consultants. These six participants each represented different disciplines including occupational therapy, speech pathology, nursing, early childhood special education, psychology and medicine. They ranged in years of experience with the birth to three population from a low of two to a high of twelve. The Learning Style Inventory published by McBer & Company was administered to each participant to determine their learning styles. Results indicated that there were three convergers, two divergers, one accommodator and one assimilator. Participant demographic information is included in Appendix C.

A **motivation questionnaire** which consists of sixteen statements indicating reasons the participants may have been motivated to attend the institute was administered. The participants were asked to rate each of the statements on a scale from 1 to 3 with 1 being "not at all important", and 3 being "very important". In addition, they were asked to state the reason(s) that were primary in their decision to attend. Those starred items were given a rating of "4". The reason that five of the six participants indicated was very important or primary was they felt the information would be useful for their jobs (mean 3.1). Other reasons there cited frequently as very important were to become better informed about early intervention in general (mean 2.71), to become better informed about infant curricula (mean 3.0) and for personal enjoyment and enrichment (mean 2.71).

Participants were also asked to rate nine reasons that may have been problematic in arranging attendance to the institute. Lack of child care and home responsibilities were most frequently cited as "very problematic". These reasons were not surprising given the fact that many of the participants are mothers and the training was held after work hours.

A **self rating scale** consisting of sixteen skills related to infant curricula was given to each of the participants were asked to rate themselves on two levels "Where I am Now" and "Where I Want to Be" in relation to each skill. Each level is rated on a 5 point scale: Unfamiliar, Awareness, Knowledge, Application and Mastery and the participants were asked to rate themselves on each skill listed. The self rating scale was administered prior to and just

after the training sessions according to individual participant needs as much as possible and then to compare pre-post changes on these skills as perceived by the participants.

Results were collapsed across all participants and reported in with regard to overall percentage of items that were rated at each point (U, AW, K, AP, M). When asked prior to training where they currently were on the skills rated the participants perceived themselves on the majority of skills (40%) at the knowledge level. This ranged individually by participants from a low of five percent (5%) to a high of fifty-six percent (56%). Only five percent (5%) of the skills were rated at unawareness, twenty-two percent (22%) at awareness, twenty-three percent (23%) at application and ten percent (10%) at mastery. Prior to training the participants did not feel that they were where they wanted to be on a majority of the items rated. Post training scores indicated that overall the participants perceived the majority of the skills rated (52%) at application and twenty-nine (29%) at mastery. None of the skills were rated at the unawareness level, five percent at awareness and fifteen percent at knowledge. This represents an increase in perceived skill level as compared to pre training results when the majority of skills fell at the knowledge level. Results of the self-rating evaluation are included in Appendix C.

A **pre/post test** with thirteen questions totaling twenty-six points was administered to the participants before and after training to determine changes in knowledge. **Pre test scores** ranged from a low of seven percent (7%) to a high of seventy-seven percent (77%) with the mean score being fifty -three percent (53%). **Post test scores** indicated an increase in the knowledge gained by the participants during the training sessions. Overall, there was a mean percentage increase of thirty-six percent age points (36%). Scores range from a low of eighty-one percent (81%) to a high of one hundred percent (100%). These results are included in Appendix C.

The **program review** is based on the Comprehensive Program Review developed by T.A.D.S. It contains yes/no questions about whether specific components are in place within the participants program. The program review was completed just prior to training, after training, and again after follow-up. Results of the program review prior to training indicated that the majority of components (32 out of 38) were in place. Those pieces that the supervisor identified as wanting to change includes updating their program philosophy, incorporating a variety of assessments in the evaluation process and including families in the development of goals. There were no changes in the program review after training.

The **consumer satisfaction** form administered after training contains seventeen statements that participants were asked to rate on a five point likert scale (1 being strongly disagree, 5 being strongly agree). The statements all relate to the training session and are divided into three sections: content, presenter and logistics of presentation. In addition, four open ended questions were asked. The majority of participants (>90%)

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reported that they were very satisfied with the content, presenters and logistics of training. Consumer Satisfaction results have been included in Appendix C.

Rainbow School. Eight staff members from the Rainbow School Infant/Toddler Program participated in the Infant Curricula Institute. A ninth participant started training but could not complete it due to job responsibilities. The eight participants started training but could not complete it due to job responsibilities. The eight participants included the program coordinator, four home-based teachers, one physical therapist, one occupational therapist, and one social worker. Two participants hold bachelor of arts degrees, six hold master's degrees and one has credits beyond a masters. When asked if they had formal training with the birth to three population, two stated that they had. Six of the eight participants reported that on their jobs they served children between the ages of birth to three and their families. The physical therapist reported only serving children (not families) and the social worker reported only serving families. All of the participants who work with children reported that these children have a wide range of disabilities. Two of the participants stated they had received training on the topic of infant curricula in the two years prior to this training. Detailed demographic information is included in Appendix D.

When asked what motivated them to attend the institute the primary reason was to be better informed about infant curricula, followed by, to be better informed about early intervention and because the information would be useful for their jobs.

A **self rating scale** was administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to the institute topic as a result of the training. The scale consists of eighteen skills that were rated on a five point scale from unawareness to mastery. Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be on each of the skills. Scores were collapsed across the eight participants and a percentage of skills rated in each of the five categories was calculated. Prior to training, percentages were as follows on their perceived level of "where you are": unawareness, 15%, awareness, 21%, knowledge, 32%, application, 25%, and mastery, 7%. After training, there was an upward trend in participants' perceived skills. Results were: unawareness, 1%, awareness, 6%, knowledge, 25%, application, 42%, and mastery, 26%. A majority of the skills (68%) were rated at application or mastery after training as compared to 32% prior to training. This indicates that participants perceived their skill level to have increased as a result of the training. However, when asked where they wanted to be, all participants rated 95% of the skills or higher at application or mastery including there was still improvement they wanted to make. Results of the Self-rating evaluation are included in Appendix D.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consisted of eighteen questions (a combination of open ended, true and false, and multiple choice), totaling thirty-three points. **Pre-test** scores ranged from a low of thirty-three percent (33%) to a high of eighty-two percent (82%) averaging fifty-one percent (51%) across the eight participants. **Post test** scores averaged sixty-one percent (61%) across the eight participants with a range from twenty-seven percent (27%) to eighty-five percent (85%). This indicates a mean increase of ten percentage points (10%). Pre/post evaluation results have been included in Appendix D.

The **program review** was completed through an interview format with the program administrator just prior to and again after the training. Those items related to the institute topic were particularly examined for changes. The Rainbow School Infant and Toddler Program has been in existence for two and one half years. They have six full time and twelve part time staff working in the program. Prior to training, results of the program review indicated that there were no written program philosophy or goals. There are program tasks to address each of these identified areas and these tasks will be completed as a component of follow-up. Also identified as areas for change were including families in the development of goals, writing IFSP's rather than IEP's and expanding their use of assessments. Twenty-six of the thirty-eight components were in place prior to training. This remained the same after training. The program review will be administered again after follow-up.

The same **consumer satisfaction** administered in the previous institutes described in this report was given to participants during the last session of this institute. The average of items across participants ranged from a 3.5 to 4.75. Those items with which the participants were less satisfied included: "all objectives were met" (3.5); "the day and time of training was good" (3.75); "the information was relevant to work" and "presenters were prepared" (3.9). All other components average a 4.0 or higher. When asked what they found most helpful about the institute, participants identified the concept of writing IFSP's as opposed to IEP's was most helpful and as a result of the training, they will write more functional goals and objectives for families. Some of the participants felt that pieces of information presented was basic and they would have liked more in-class activities. Consumer Satisfaction results have been included in Appendix D.

BOCES II Infant Program. Seven staff members from the BOCES II Program participated in the Transdisciplinary Teaming Institute. They included the program administrator, teacher of the hearing impaired, speech pathologist, special educator, social worker, speech therapist, and occupational therapist. One of the participants has a bachelors degree, and six have master's degrees; two of the seven participants reported that they have had formal training with the birth to three population. They ranged in years of experience with this population from four to twenty-two with a mean of nine years. All seven participants reported that in their current positions they

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serve children between the ages of birth to three with a wide range of disabilities and their families. None reported having had training on transdisciplinary teaming in the two years prior to this institute. Demographic information has been included in Appendix E.

When asked what motivated them to attend the institute participants stated as their primary reason that they wanted to become better informed about transdisciplinary teaming. The second most motivating reason was they felt it would be useful for their job.

A **self rating scale** was administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to transdisciplinary teaming as a result of the training. The scale consists of eighteen skills that were rated on a five point scale from unawareness to mastery. Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be on each of the skills. Scores were collapsed across the seven participants and a percentage of skills rated in each of the five categories was calculated. Prior to training, percentages were as follows on their perceived level of "where are you": unawareness, 3%, awareness, 20%, knowledge, 31%, application, 30%, and mastery, 16%. After training, there was an increase in perceived level of skills: unawareness, 1%, awareness, 8%, knowledge, 24%, application, 47%, and mastery, 20%. When asked where they want to be, the majority of skills (>85%) were rated at application and mastery, both before and after training. These results are included in Appendix E.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consists of fifteen questions (a combination of open ended, true/false and multiple choice) totaling thirty-three points. **Pre-test** scores ranged from a low of fifty-one percent (51%) to a high of eighty-two percent (82%), averaging sixty-six (66%) percentage points. **Post test** scores averaged eighty-seven percent (87%) across all participants with a range from seventy-nine percent (795) to ninety-four percent (94%). This indicates a mean increase of thirty-one (31%) points. Individual participant scores have been included in Appendix E.

The **program review** was completed through an interview format with program administrator just prior to and again after the training sessions (see Appendix B). The BOCES II Infant/Toddler Program has been in existence for nine years. They have eighteen full time and five part time staff members. There was no change in the program review after training. Thirty-two of the thirty-eight components addressed were in place. Those that were not included: written program goals for services, conducts family assessment, writes IFSP's, child's progress reviewed quarterly, integration opportunities provided and written interagency agreements. None of these components were specifically addressed in the transdisciplinary teaming institute thus it would not be expected that changes would occur as a result

of the training. The program review will be administered again after follow-up.

The **consumer satisfaction** administered in the previous institute was administered to the participants during the last session of this institute. The average score for each of the items across participants ranged from a 3.5 to a high of 4.8. Overall the participants were very satisfied with the content, presenter and logistics of training. Consumer Satisfaction results have been included in Appendix F. Participants reported that they found the overview of transdisciplinary teaming to be most helpful to them. As a result of this training, participants stated they will incorporate more role release, involve parents in program planning and implement various components of the transdisciplinary model. They found some of the readings the least helpful. Consumer Satisfaction evaluation results have been included in Appendix E.

Westchester UCP. Seven staff members from the UCP program participated in the Transdisciplinary Teaming Institute. They included the program director, infant teacher, occupational therapist, social worker, speech pathologist, chief of speech pathology, and teaching assistant. Five held master's degree's, one was working towards a Ph.D. and one was working on a bachelor's degree. Although the program services children from birth through twenty-one, the participants of this institute were those staff members who work with the birth through three population. Because the program is primarily center based only two participants reported that they worked with parents and families. They ranged in years of experience with the birth to three population from a low of 1 to a high of 10 with the mean number of years being 4. They all reported serving children with a wide range of disabilities, but none had any formal training on the topic. Participant demographic information has been included in Appendix F.

When asked what motivated them to attend the institute the majority of participants stated as their primary reason that they thought it would be useful for their job. The other two most commonly cited reasons were to be better informed about transdisciplinary teaming and to be better informed about early intervention in general. There were no reasons cited as very problematic in the participants ability to attend the institute sessions.

The **self rating scale** was administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to transdisciplinary teaming as a result of the training. The scale consisted of eighteen skills that were rated on a five point scale from unawareness to mastery. Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be on each of the skills. Scores were collapsed across the seven participants and a percentage of skills rated in each of the five categories was calculated. Prior to training, the percentages were as follows on current perceived skill levels: unawareness, 11%, awareness, 15%, knowledge, 23%, application, 43%, mastery, 8%. After training, there was a slight

upward trend in regards to where participants perceived their skills. Percentages were: unawareness, 0%, awareness, 6%, knowledge, 34%, application, 52%, mastery, 8%. Most participants felt they were not where they wanted to be on many skills. Results of the self-rating evaluation have been included in Appendix F.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consisted of fifteen questions (a combination of open ended, true and false, and multiple choice), totaling thirty-three points. **Pre-test** scores ranged from a low of twenty-one percent (21%) to a high of seventy percent (70%) averaging fifty percent (50%) across the seven participants. **Post test** scores averaged seventy-nine percent (79%) across the seven participants with a range from fifty eight percent (58%) to ninety-seven percent (97%). This indicates a mean increase of twenty-nine percentage points (29%). Full pre/post evaluation results, including follow-up scores, have been included in Appendix F.

The **program review** was completed through an interview format with the program administrator just prior to, and again after the training. Those items relating to the institute topic (in this case transdisciplinary teaming) were particularly examined for changes. Prior to training, there were two full time staff and five part-time staff involved in the infant/toddler program. This did not change after training. Twenty-nine of the thirty-eight components reviewed were in place prior to training. This also did not change as a result of the training. The components not in place included writing reports as a team, conducting family assessments, serving non-English speaking families, writing IFSP's, including families in the development of goals and objectives, providing opportunities to integrate children, providing supplementary activities for parents and families writing interagency agreements, for identifying staff development and training needs and keeping program evaluation data. The program review was administered again after follow-up, and similar changes were observed.

The same **consumer satisfaction questionnaire** used in other institutes and found in (see Appendix B) was administered during the last training session. The scores for each statement were averaged across all participants. Overall, the participants were very satisfied with the institute (mean scores were 4 and 5). Scores for the consumer satisfaction have been included in Appendix F. When asked what they found most helpful about the institute, participants responded overwhelmingly they have a better understanding of the transdisciplinary teaming approach and how they might incorporate it into their program. As a result of the training participants reported that they will work on incorporating components of transdisciplinary teaming into their program. They would have liked more in-depth discussion on some of the topics addressed during the sessions.

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Sullivan Diagnostic Treatment Center. Six staff members from the Sullivan Diagnostic and Treatment Center participated in the IFSP Institute. They include the director of staff training/infants, speech-language pathologists, infant teacher/coordinator, senior social worker, senior teacher assistant and adaptive physical education teacher. One of the participants has as associate's degree, one has a bachelor's degree and four have master's degrees; four of the six participants reported that they have had formal training with the birth to three population. They ranged in years of experience with this population from two to twenty with a mean of nine years. All six participants reported that in their current positions they serve children between the ages of birth to three with a wide range of disabilities and their families. Three of the six participants reported that they have had some training on individualized family service plans in the two years prior to this institute. Demographic information has been included in Appendix G.

When asked what motivated them to attend the institute, five of the six participants indicated that their primary reasons were to become better informed about IFSP's and because they felt it would be useful for their jobs. The other two reasons that fifty percent (50%) of the participants stated were very important included "becoming very informed about early intervention" and "to learn more about community problems." There were no reasons cited as very problematic in the participants ability to attend the institute.

A **self rating scale** was administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to individualized family service plans as a result of the training. The scale consists of 30 skills that were rated on a five point scale from unawareness to mastery (see Appendix A for a copy of the scale). Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be on each of the skills. Scores were collapsed across the seven participants and a percentage of the skills rated in each of the five categories was calculated. Prior to training, the percentages were as follows on current perceived skill levels: unawareness, 18%, awareness, 30%, knowledge, 36%, application, 20%, and mastery 2%. After training there was a slight upward trend in regards to where participants perceived their skills. These results have been included in Appendix G.

A **pre/post test** measuring the change in participants' knowledge was also administered before and after training. The test consisted of 22 questions (a combination of open-ended questions, true and false, and multiple choice), totaling 41 points. This test may be found in Appendix A. **Pre-test** scores ranged from a low of forty-one percent (41%) to a high of fifty-six percent (56%), averaging fifty percent (50%) across the six participants. **Post test** scores averaged seventy-eight percent (78%) across the six participants, with a low of fifty-nine percent (59%), and a high of ninety percent (90%). These data indicated a mean increase of twenty-eight (28%)

percentage points. Individual participant scores can be found on Appendix G. The post test was administered again upon after follow-up.

The **program review** was completed through an interview format with the program administrator just prior to and again after the training. Those items related to the institute topic (in this case, individualized family service plans) were particularly examined for changes. There were four full time staff and seventeen part time staff working for the infant/toddler program at the time of training. The program reported they did not have written philosophy or goals for the program. They also were not conducting formal family assessments or writing IFSP's. The program was primarily center-based group settings. There was no opportunity for integration among the birth to three population. Also, the case management services provided were only happening during admission of the family and there were no interagency agreements or transition guidelines in place. Results of the program review did not change after training.

The **consumer satisfaction questionnaire** was administered during the last training session. This questionnaire asks participants to rate on a five point scale from "1" (strongly disagree) to "5" (strongly agree) their satisfaction with the content, presenter and the logistics of training. The scores for each statement were averaged across participants. Overall the participants were very satisfied with the institute (mean scores were 4 and 5). Consumer Satisfaction evaluation results have been included in Appendix G.

YEAR 2

Four institutes were completed during year 2 of the project. The data from the training sessions of these institutes are described below.

East River Child Development Center. Six staff from this program participated in the Transdisciplinary Teaming Institute which took place over 5, 2 hour sessions. The training sessions were held at the East River Child Development Center in New York City from October to December 1991. The participants included a physical therapist, social work assistant, early childhood special educator, social worker, classroom assistant, psychologist and occupational therapist. They ranged in years of experience with the birth to three population from a low of one to a high of seven with the mean number of years being three. A detailed breakdown of the demographics is displayed in Appendix H.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. It was revised from the program review used the in year one. This program review contains sixty yes/sometimes/no questions and five open ended questions about whether specific components are in place within the program. It is divided into the following five sections: program structure, assessment, IFSP, service delivery and team process. Results of the program review indicated that the East River Child Development Center serves 110 children between the ages of 2.5 - 5 years. There were 20 full

time and 10 part time staff representing a variety of disciplines including educators, physical, speech and occupational therapists, psychologists, social workers, and teaching assistants. All services are center based in group settings with some opportunities for children to be integrated with normally developing peers. IEP's are written rather than IFSP's primarily due to the fact that the children being served are preschool age. Transportation is provided to all children. Prior to training integrated assessment reports were not being written. However, during the time of training and since the sessions have ended a format for writing integrated reports was put into place and was being piloted. The team model implemented in the program was described as interdisciplinary both before and after the training. Team meetings were being held very irregularly prior to training with an attempt by the various teams to meet at least monthly. Child assessments are conducted individually by discipline and IEP's were written and implemented sometimes jointly by team members. The results of the program review did not change significantly after training.

When asked on the motivation questionnaire (see Appendix B for a copy) what motivated them to attend the institute the most common responses among participants were they believed the information would be useful for their job (mean=3.1), to be better informed about transdisciplinary teaming (mean=2.9) and to work towards a solution of community problems (mean = 2.9).

The **self rating scale** was administered just prior to and immediately after the training sessions. The scale consists of nineteen skills related to the Transdisciplinary Teaming Institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills. The rating scale consists of five levels, unawareness, awareness, knowledge, application and mastery. Results were analyzed item by item across the participants to determine perceived changes in individual skills. For the purpose of measurement, each level was given a weighted scale as follows: U=1, AW=2, K=3, AP=4, and M=5. Mean scores were determined for each item rated and collapsed across the six participants. Self-rating evaluation results have been included in Appendix H.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consists of fifteen questions (a combination of open ended, true/false and multiple choice) totaling thirty-three points. It can be found in Appendix B. **Pre-test** scores ranged from a low of 9 percent to a high of 48 percent, averaging 31 percent. **Post test** scores averaged 73 percent across all participants with a range from a low of 56 percent to a high of 84 percent (S.D.=9.9). This indicates a mean increase of forty two percentage points which is statistically significant ($p<.001$). Individual participant scores can be found in Appendix H.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. This questionnaire asks participants to rate on a five point scale from "1" (strongly disagree) to "5"

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(strongly agree) their satisfaction with the content, presenter and the logistics of training. The scores for each statement were averaged across participants. Scores ranged from a low of 2.2 (time was well organized) to a high of 4.4 (the presenters valued my input). The highest scores overall were in the statements regarding the presenters. Consumer Satisfaction evaluation results have been included in Appendix H.

__**Children's School for Early Development.**__ The IFSP institute was conducted over three, 5-hour sessions with a session conducted once per month over three months. There are eight staff from this program participating in the IFSP Institute. These staff represent the following disciplines: three early childhood special education, social work, physical therapy, nursing, special education administration and speech pathology. They range in years of work with the birth to three population from a low of two to a high of 13 with the mean being six years. Participant demographic information has been included in Appendix I.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. It was revised from the program review used the in year one. This program review contains sixty yes/sometimes/no questions and five open ended questions about whether specific components are in place within the program. Results of the program review indicated that the Children's School for Early Development was serves 27 children (19 home based and 8 center based) between the ages of birth to 5 years. There were 6 full time and 4 part time staff representing a variety of disciplines including educators, physical, speech and occupational therapists, psychologists, social workers, and teaching assistants. IFSP's are written for each child under the age of three and their family with needs identified through a questionnaire. It was reported that the IFSP's did not necessarily reflect the priorities of the family and families were not given the opportunity to participate in the development of goals and objectives for their children. An interdisciplinary model of teaming is reportedly utilized by this program with weekly team meetings conducted. Assessments and IFSP's are conducted jointly by team members. The program provides a number of support services for families participating in the program.

When asked what motivated them to participate in the institute, the reason given as most important overall was because participants believed it would be "useful for their job" (mean=3.38), followed by "to become better informed about IFSP's" (mean = 3.13), and"for personal enrichment and enjoyment" (mean = 3).

The **self rating scale** was administered just prior to and immediately after the training sessions. The scale consists of thirty skills related to the IFSP Institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills. The rating scale consists of five levels, unawareness, awareness, knowledge, application and mastery. Results were analyzed item by item across the participants to

determine perceived changes in individual skills. Mean scores were determined for each item rated and collapsed across the six participants. A t-test was also done to determine those items which changed significantly. Seventeen of the thirty eight items rated changed significantly. They included: understanding P.L. 99-457, understanding family systems theory, stating their program philosophy, choosing appropriate assessment instruments, administering skills in assessment through observation, choosing family assessments for different purposes, interviewing families, writing results of family assessments, good communication skills with families (inquiry, reflection of feeling and reflection of content), planning a team meeting, writing statements of family priorities and resources, writing family goals, knowledge of IFSP components, incorporating goals prioritized by the family in the IFSP and training other staff on IFSP development. All other items were rated higher on the post training administration of the self rating scale. Self-rating evaluation results have been included in Appendix

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consists of 22 questions (a combination of open ended, true/false and multiple choice) totaling 38 points. **Pre-test** scores ranged from a low of 29 percent to a high of 71 percent, averaging 48 percent. **Post test** scores averaged 77 percent across all participants with a range from a low of 39 percent to a high of 95 percent (S.D.=15.6). This indicates a statistically significant mean increase of twenty nine percentage points ($p<.001$). Pre-post evaluation results including follow-up, have been included in Appendix I.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. The scores for each statement were averaged across participants. Overall the participants were very satisfied with the institute (mean scores were 4 and 5). Consumer Satisfaction evaluation results have been included in Appendix I.

<u>**Special Sprouts**</u>. The IFSP institute was conducted over four 4-hour sessions with a session conducted once every other week. There are seven staff from this program participating in the IFSP Institute. These staff represent the following disciplines: special education administration, social work, physical therapy, occupational therapy, psychology and speech pathology (2). They range in years of work with the birth to three population from a low of one to a high of nine with the mean being three years. Participant demographic information has been included in Appendix J.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. There were 5 full time and 4 part time staff representing a variety of disciplines including education, physical, speech and occupational therapy, and psychology. The infant program started in October, 1991, just 3 months prior to the training. There was no written program philosophy when the training began. IEP's were written rather than IFSP's and families were not given the opportunity to participate in the development of goals and

objectives for their children. All services were center based in group settings. Family concerns, priorities and resources were not collected in a systematic fashion prior to or just after the training and sometimes the staff assisted families in meeting needs not directly related to the child's development. Weekly staff meetings were held with all team members represented. Assessments and goal development were never conducted jointly by team members.

When asked what motivated them to participate in the institute, the reason given as most important overall was "to become better informed about IFSP's" (mean = 3.3), "to be better informed about early intervention overall" (mean=2.8), because participants believed it would "be useful for their job" (mean=2.7), followed by "for personal enrichment and enjoyment" (mean=2.5).

The **self rating scale** was administered just prior to and immediately after the training sessions. The scale consists of thirty skills related to the IFSP Institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills. The rating scale consists of five levels, unawareness, awareness, knowledge, application and mastery. Results were analyzed item by item across the participants to determine perceived changes in individual skills. The scale was administered and analyzed just prior to and after training. Mean scores were determined for each item rated and collapsed across the six participants. A t-test was done to determine those items that changed significantly. Twenty of the thirty eight items rated changed significantly. Primarily these items that showed significant changes were related directly to family focused skills and included: understanding family systems theory, naming and choosing family assessments, interviewing families, writing results of family assessments, involving families in goal setting, understanding family empowerment, writing family goals, incorporating family priorities into the IFSP and knowledge of IFSP components. Self-rating evaluation results have been included in Appendix J.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consists of 20 questions (a combination of open ended, true/false and multiple choice) totaling 37 points. It can be found in Appendix B. The following scores represent those of six of the seven institute participants. **Pre-test** scores ranged from a low of 41 percent to a high of 59 percent, averaging 47 percent. **Post test** scores averaged 84 percent across all participants with a range from a low of 76 percent to a high of 95 percent (S.D.=2.6). This indicates a statistically significant mean increase of thirty seven percentage points ($p<.000$). Pre-post evaluation results, including follow-up, have been included in Appendix J.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. The scores for each statement were averaged across participants. Overall the participants were

very satisfied with the institute (mean scores were 4 and 5). Consumer Satisfaction results have been included in Appendix J.

Alcott School. The Alcott School Birth to Three program staff participated in the Programming for infants toddlers and their families institute. This institute was conducted over 7 sessions and held in a conference room at the Alcott School. The first session was 5 hours in length and each of the following sessions were 2.5 hours long. Seven Alcott School Birth to Three staff members participated in this Institute. They included three teaching assistants, two special educators, one administrator and one speech pathologist. They range in years of work with the birth to three population from a low of one to a high of 2 with the mean being 1.7 years. Participant demographic information has been included in Appendix K.

The same motivation questionnaire used in each of the other institutes was given to these seven participants. In addition, they were asked to state the reason(s) that were primary in their decision to attend. Those starred items were given a rating of "4". Results indicated that overall the most important motivating factor for participating in the training was participants believed it would "be useful for their job" (mean=3.00), followed by "to become better informed about early intervention in general", and "for personal enrichment and enjoyment" (means = 2.86) and "to become better informed about programming for infants, toddlers and their families" (mean = 2.71). Participants were also asked to rate nine reasons that may have been problematic in arranging attendance to the institute. There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. Results of the program review prior to training indicated that Alcott School serves 25 children between the ages of birth to two years. There are 3 full time and 11 part time staff representing a variety of disciplines including education, physical, speech and occupational therapy, and social work The infant program has been in operation for 3 years. The program has a written philosophy and program goals. IFSP's are written, however it was reported that families are not given the opportunity to participate in assessments or the development of goals and objectives for their children. Family concerns, priorities and resources are through the use of a questionnaire administered by the staff social worker. All services are center based and provided in group settings. Children do not have an opportunity to interact with nondisabled peers. Sometimes the staff (social worker) assisted families in meeting needs not directly related to the child's development. A communication book is sent home to inform families of what is happening in school. Weekly staff meetings are held with all team members represented. Assessments are typically conducted by team members in isolation and only sometimes write IFSP goals jointly. Results of the program review did not change after the training sessions, but did change after follow-up.

The **self rating scale** was administered just prior to and immediately after the training sessions . The scale consists of twenty five skills related to the Programming for infants, toddlers and their families institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills. The rating scale consists of five levels, unawareness, awareness, knowledge, application and mastery. Results were analyzed item by item across the participants to determine perceived changes in individual skills. Mean scores were determined for each item rated and collapsed across the six participants. A t test was also done to determine those items which changed significantly. All of the items were rated at a higher mean level by the participants as a results of their participation in training. Those skills that changed more significantly included understanding P.L. 99-457, choosing appropriate assessment instruments for young children, choosing family assessments for different purposes, interviewing families, communication assessment results to families, preparing families for team meetings writing statements of family priorities and resources, writing functional child goals and naming functional activities for young children. Self-rating evaluation results have been included in Appendix K.

A **pre/post test** measuring the change in participants knowledge was also administered before and after training. The test consisted of twenty five questions (a combination of open ended, true/false and multiple choice) totaling thirty three points. **Pre-test** scores ranged from a low of 27 percent to a high of 64 percent, averaging 44 percent. **Post test** scores averaged 60 percent across all participants with a range from a low of 38 percent to a high of 78 percent (S.D.=7.2). This indicates a mean increase of sixteen percentage points. These increase was not statistically significant. Pre-post evaluation results, including follow-up have been included in Appendix K.

The **consumer satisfaction questionnaire** was administered during the last training session. The scores for each statement were averaged across participants. Overall the participants were very satisfied with the institute (mean scores were 4 and 5). Appendix K contains the scores for each item on this questionnaire.

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Sunnyview Rehabilitation Center. The Sunnyview Rehabilitation Center qualified to participate in the Transdisciplinary Teaming institute because they now contract with their county to serve as an independent evaluation site to conduct four (4) evaluations per month, as scheduled by the county. When they first requested training, they felt that they had a team that worked well together, but lacked some of the crucial components needed to make the team truly transdisciplinary. This institute was conducted over a period of two full days (one each in two consecutive weeks) and included the 5 staff members who were already assigned to work together in performing assessments. The participants included 2 physical therapists, one speech therapist, one psychologist, and one occupational therapist. They ranged in years of working with the birth to three population from a low of 0 to a high

of 7, with the mean being 2.6 years. Participant demographic information has been included in Appendix L.

The same **motivation questionnaire** used in preceding Transdisciplinary Teaming institutes was used for this group of participants. Results indicated that overall, the most important motivating factor for participating in the training was that the participants believed it would "be useful for their job" (mean = 3.00) followed by "personal enjoyment and enrichment" (mean = 2.75). There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. The program does not have a written philosophy for early intervention services that is current and reflects the values of the program, nor are there any written materials available describing the purposes and scope of the program. The staff members are very involved with other associations, agencies, networks, and committees for formal and informal training purposes. The assessment team expressed an interest in learning how to write integrated reports. Through the follow-up phase of the institute, Sunnyview Rehab. is practicing their skills at writing integrated reports, and also putting together a strong philosophy and mission statement to disseminate throughout the county.

The **self rating scale** was administered just prior to and immediately after the training sessions. The same scale used in previous Transdisciplinary Teaming institutes was used during this institute. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated and then collapsed across the five participants. A t-test was also conducted to determine those items which changed significantly. All of the items were rated at a higher mean level by the participants as a result of their participation in training. Those skills that changed more significantly included understanding the family systems theory, and stating a program philosophy. Self-rating evaluation results have been included in Appendix L.

A **pre-post test** measuring the change in participant's knowledge was administered before and after the training. The test was the same as that previously administered to participants of other Transdisciplinary Teaming institutes. Pre-test scores ranged from a low of 45 percent to a high of 75 percent, with a mean score of 64.0 percent. Post-test scores averaged 94 percent across all participants and ranged from a low of 90 percent to a high of 100 percent. Pre-post evaluation results have been included in Appendix L.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. Overall, the participants were very satisfied with the Transdisciplinary Teaming Institute (mean scores

ranged from 4.00 to 5.00). Consumer Satisfaction results have been included in Appendix L.

Putnam ARC (PARC). The PARC Preschool program staff participated in the IFSP institute. This institute was conducted over six 2 1/2 hour sessions held on site at the preschool. Five PARC staff members participated in this institute. They included a social worker assistant, a psychologist, an occupational therapist, and two early intervention teachers. They ranged in years of work with the birth to three population from a low of 1 to a high of 18 with the mean being 6.4 years. Participant demographic information has been included in Appendix M.

The **motivation questionnaire** used for this institute was the same one used in each of the other IFSP institutes. A copy of this questionnaire was given to each of the five participants. The participants were asked to rate the items on the scale and state the reasons that were primary in their decision to attend. Results indicated that overall the most important motivating factor for participating in the training was that participants believed it would be "useful for their job" (mean = 3.00), followed by "becoming better informed about children with special needs in day care settings" (mean = 2.90). There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. The program currently serves 60 children between the ages birth to five. Approximately 20 of these children are between the ages of birth to three. Staff make up a variety of disciplines including Speech/Language Pathology, Occupational Therapy, Physical Therapy, Psychology, Education, and Counseling. The program has written philosophy goals and a mission statement; however, they are in the process of attempting to revise both of these and organize a new parent handbook. IFSP's are written, but the staff does not feel that they are incorporating families into the process effectively. Parents and family members are welcome to attend class sessions with their child, and communication is open and ongoing between staff and families.

The **self rating scale** was administered just prior to and immediately following the training sessions. The scale consists of thirty skills related to the IFSP process and the institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills.

Mean scores were determined for each item rated, and collapsed across the five participants. A t-test was also done to determine those items which changed significantly. All of the items were rated at a higher mean level by the participants as a result of their participation in the training. Those skills that changed more significantly included understanding P.L. 99-457, sensitivity to family needs and writing statements on family strengths and

weaknesses. Self-rating evaluation results have been included in Appendix M.

A **pre-post test** measuring the change in participant's knowledge was also administered before and after the training. The test consisted of open-ended, true/false and multiple choice questions. Pre-test scores averaged 35.8 percent across all participants with a range from a low of 25 percent to a high of 58 percent. Post-test scores averaged 88.2 percent with a low of 84 percent and a high of 97 percent. This indicates a mean increase of 52.4 percentage points. This increase was statistically significant. Pre-post evaluation results , including follow-up, have been included in Appendix M.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. Overall, the participants were very satisfied with the institute (mean scores ranged from 4.40 to 5.00). Consumer Satisfaction evaluation results have been included in Appendix M.

Columbia ARC (COARC). The Columbia ARC Birth to Three program staff participated in the IFSP Institute. Ten staff members including three special educators, two home-based early childhood teachers, one PT, one OT, one SP, one Administrator, and one family services specialist, took part in the training. The institute was conducted over a four week period consisting of three half-day sessions (3 1/2 hours each) and one full-day session (8 hours). The participants ranged in years of experience from 1 month to 2 years. Only one of the ten participants reported having had formal training with the birth to three population prior to this training. More than half of the participants reported earning a Master's degree. Participant demographic information has been included in Appendix N.

The same **motivation questionnaire** used for previous IFSP institutes was given to these ten participants. Results indicated that overall the most important motivating factor for participating in the training was participants believed it would "be useful for their job" (mean = 3.00), followed by "to become better informed about early intervention in general", and "for personal enrichment and enjoyment" (means = 2.86). Participants were also asked to rate nine reasons that may be been problematic in arranging attendance to the institute. There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. Results of the program review prior to training indicated the following information. The program currently serves approximately forty children between the ages of birth to three and has a staff of 25 full-time and 10 part-time employees. The program has a written philosophy and goals that are included in a parent handbook. However, the staff has indicated that they would like to reword their philosophy to reflect a more family directed/family centered process. The staff is attempting to write IFSP's, but they have not mastered the process as it should be conducted. Services

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are delivered both home based as well as center based. Family concerns are taken seriously and family input is encouraged and valued during intervention. The staff has expressed an interest in developing an assessment protocol to more fully incorporate families into the assessment and IFSP process.

The **self rating scale** was administered just prior to and immediately following the training sessions. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated, and collapsed across the ten participants. A t test was also done to determine those items which changed significantly. All of the items were rated at a higher mean level by the participants as a result of their participation in training. Those skills that changed more significantly included those related directly to the IFSP process and those that reflected staff ability to communicate effectively with families. Self-rating evaluation results have been included in Appendix N.

A **pre/post test** measuring the change in participant knowledge was also administered before and after training. Pre-test scores ranged from 30 to 58 with a mean score of 43.9 percent (SD = 7.6). Post-test scores ranged from 71 to 97 percent with a mean score of 88.0 percent (SD = 7.8). This indicates a mean increase of 44.1 percentage points. This increase was statistically significant. Pre-post evaluation results have been included in Appendix N.

The **consumer satisfaction questionnaire** found in Appendix A was administered during the last training session. Overall, the participants were very satisfied with the institute (mean scores ranged from 3.90 to 5.00. Consumer Satisfaction results have been included in Appendix N.

Williamsburg Developmental School: The Williamsburg Developmental School Birth to Three program participated in the IFSP Institute. This institute was conducted over 6 sessions that lasted 3 hours each. The group of 10 participants included one PT, one OT, one Administrator, three Speech Pathologists, two Social Workers, one Early childhood educator, and one psychologist. They ranged in years of work with the birth to three population from a low of 2 years to a high of 11 years. Four of the ten participants reported having had formal training with the birth to three population. One participant held a BS degree, eight held a Master's degree, and one held a Ph.D. One participant was unable to complete the full training because she terminated her employment with the agency before the training ended. Participant demographic information has been included in Appendix O.

The same motivation questionnaire used in each of the other IFSP institutes was given to these ten participants. Results indicated that, overall, the most important motivating factor for participating in the training was that participants believed it would "be useful for their job (mean = 3.00). "Becoming better informed" and "to better understand and work toward

solutions of community problems" were the second most predominant reasons (mean = 2.80). There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. Results of the program review prior to training indicated the following information. The Williamsburg School serves 112 children from birth to three. There are 30 full-time and 10 part-time staff representing a variety of disciplines including education, physical, speech and occupational therapy, social work and psychology. The program has a written philosophy for early intervention and has written materials available for parents, describing the purposes and scope of the program. Staff members are involved with other associations, agencies, networks for formal and informal training purposes. The program maintains records on the number and types of children being served. The program includes family input in their assessment process and offers home visits as well as center based services.

The **self rating scale** was administered just prior to and immediately following the training sessions. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated, and collapsed across the ten participants. All of the items were rated at a higher mean level by the participants as a result of their participation in the training. Those skills that changed more significantly included those that related to the inclusion of families in their child's assessment, interviewing families, including families in the team process, and training their staff in IFSP development. Self-rating evaluation results are included in Appendix O.

A **pre/post test** measuring the change in participant knowledge was also administered before and after training. Pre-test scores ranged from 16% to 62% with a mean score of 42%. Post-test scores ranged from 62% to 97% with a mean score of 85%. This indicates a mean increase of 43 percentage points. Pre-post evaluation results have been included in Appendix O.

The **consumer satisfaction questionnaire** was administered during the last training session. Overall, the participants were very satisfied with the institute (mean scores ranged from 4.50 to 5.00). Consumer Satisfaction evaluation results have been included in Appendix O.

Northside Center for Child Development: The Northside Center participated in the Infant Curricula Institute. This institute was conducted over a period of 5 sessions that lasted 3 hours each. The group of seven participants included an administrator, an early childhood educator, two psychologists, a speech pathologist, a nurse, and a teacher/librarian. They ranged in years of work with the birth to three population from a low of 1 year to a high of 13 years. Four of the seven participants reported having had previous formal training with the birth to three population. One of the participants held a BS degree, five held a Master's degree, and one held a

Ph.D degree. Participant demographic information has been included in Appendix P.

The same **motivation questionnaire** used in each of the other Infant Curricula institutes was given to these participants. Results indicated that, overall, the most important motivating factor for participating in the training was that participants believed it would "be useful for their job" (mean = 3.00). "Becoming better informed" and "to better understand and work toward solutions of community problems" were the second most predominant reason (mean = 2.90). There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. Results of the program review prior to training indicated the following information. The early intervention program at Northside Center serves approximately 60 children from birth to three. There are 15 full-time staff representing a variety of disciplines including education, physical therapy, speech therapy occupational therapy, social work and psychology. The program has a written philosophy for early intervention and has written materials available for parents describing the purposes and scope of the program.

The **self rating scale** was administered just prior to and immediately following the training sessions. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated, and collapsed across the ten participants. A t-test was also done to determine those items which changed significantly. All of the items were rated at a higher mean level by the participants as a result of their participation in training. Those skills that changed more significantly included those related directly to infant curricula and those that reflected staff ability to develop appropriate activities for young children within the birth to three population. Results of the self-rating evaluation have been included in Appendix P.

A **pre/post test** measuring the change in participant knowledge was also administered before and after training. Pre-test scores ranged from 23% to 77% with a mean score of 54%. Post-test scores ranged from a low of 69% to a high of 100%, with a mean score of 94%. Pre-post evaluation results have been included in Appendix P.

The **consumer satisfaction questionnaire** was completed in the fourth quarter with the rest of the post session data. Overall, participants related that they were satisfied with the training they received. Consumer Satisfaction evaluation results have been included in Appendix P.

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New Medico Rehabilitation Center: New Medico Rehabilitation Center participated in the IFSP Institute. This institute was conducted over six 2 1/2 hour sessions. The group of 11 participants included 1 Physical Therapist, 4 Social Workers, 2 Speech Pathologists, 1 Nurse, 1 Recreation Therapist, 1 Psychologist, and 1 Early Childhood Special Educator. They ranged in years of work with the birth to three population from a low of 1 year to a high of 13 years. Five of the eleven participants reporting having had previous formal training with this age group, and all but four participants held a Masters Degree in their field. Participant demographic information has been included in Appendix Q.

The same **motivation questionnaire** used in each of the other IFSP institutes was given to these eleven participants. Results indicated that, overall, the most important motivating factor for participating in the training was that participants believed it would "be useful for their job" (mean = 3.00). "To better understand and work toward solutions of community problems" was the second most predominant reason (mean = 2.80). There were no outstanding reasons that made it difficult for any of the participants to attend the institute.

The **program review** based on the Comprehensive Program Review developed by T.A.D.S. was completed just prior to and again after training. Results of the program review prior to training indicated that New Medico currently serves 9 children in its birth to three program. There are 30 full-time and zero part-time staff representing a variety of disciplines. The program did not have a written philosophy at the start of training, but did have some written material available for parents to learn basic information about the program. The birth to three program has only been in operation for one year. By the completion of the training, New Medico, among other things, formulated a written philosophy which satisfied all of the staff members with regard to the basic information New Medico wanted to communicate to the community and its families. A copy of their newly developed Philosophy Statement has been included in Appendix Q.

The **self-rating scale** was administered just prior to, immediately following the training sessions, and a third time after follow-up was completed. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated, and collapsed across the ten participants. All of the items were rated at a higher mean level by the participants as a result of their participation in the training. Those skills that changed more significantly included those that related to the actual incorporation of the IFSP process into their current system, as well as the assessment of children in more child directed ways. Self-rating evaluation results have been included in Appendix Q.

A **pre-post test** measuring the change in participant knowledge was also administered before and after training. Pre-test scores ranged from 0% to 51% with a mean score of 32%. Post-test scores ranged from 83% to 95%

with a mean score of 89%. This indicates a mean increase of 57 percentage points. Pre-post evaluation results have been included in Appendix Q.

The **Consumer Satisfaction Questionnaire** was administered following the last training session. Overall, the participants were satisfied with the institute (mean scores ranged from 4.18 to 4.73. Consumer Satisfaction results have been included in Appendix Q.

Dutchess County Department of Health: The Dutchess County Department of Health participated in the Transdisciplinary Teaming Institute. This institute was conducted over four 3-hour sessions. The group of twelve participants included a variety of Social Workers, Nurses, Psychologists, Administrators, Therapists, and Early Child Special Educators. They ranged in years of work with the birth to three population from a low of zero (no experience) to a high of ten years. All but four of the participants reported having had previous formal training with this age group. Approximately half of the participants held a Masters Degree in their field. Participant demographic information has been included in Appendix R. The participants for this training were employed at a variety of agencies throughout the county including St. Francis Hospital, Rehabilitation Programs, Inc., and Children's Express Learning Center. Employees of the County Health Department as well as a parent of a child with a disability also participated.

A **pre-post questionnaire** measuring the change in participant knowledge was also administered before and after training. Pre-test scores ranged from 35% to 75% with a mean score of 52%. Post-test scores ranged from 90% to 100% with a mean score of 88%. Pre-post evaluation results have been included in Appendix R.

The **self-rating scale** was administered just prior to and immediately following the training sessions. Results were analyzed item by item across participants to determine perceived changes in individual skills. Mean scores were determined for each item rated, and collapsed across the participants. All items were rated higher after training than before. Those items showing the most change included those pertaining to the assessment of children and working with families. Self-rating evaluation results have been included in Appendix R.

The **program review** was completed just prior to and immediately after the training. Results of the program review indicated that, as a group, this team had not yet served any children. This group intended to form a transdisciplinary assessment team to screen and evaluate children from all over the county. Their respective agencies were not assessed with the Program Review. Upon completion of the training, the team was getting ready to evaluate their first group of young children. They had written a philosophy and mission statement, devised a protocol for intake, as well as for evaluation.

The **Consumer Satisfaction questionnaire** was completed at the end of the training. Scores ranged from 4.73 to 5.00 indicating that, overall, participants were satisfied with the training.

Activity 3.2 Evaluate Follow-up. To date, all programs have completed follow-up. A list of tasks as well as sample tasks completed have been included in the respective appendices for each participating program.

Greenwich ARC. The Greenwich ARC infant/toddler team completed all seven tasks in July, 1991. All tasks were completed as a team except the instructional delivery/teaching procedures (task #5). The tasks were reviewed and approved by the Birth to Three Inservice Outreach Training Project Staff and measured in terms of the level of assistance that was necessary for the staff to complete them using the outlined criteria. Level of assistance was measured on a scale of "1 to 3" with "1" being no assistance, "2" being a moderate level of assistance and "3" being a high level of assistance. Four of the seven tasks (numbers 2, 4, 6, & 7) were completed independently receiving a score of "1". Tasks numbers 3 and 5 received a score of "2" meaning they required a moderate amount of assistance and task number 1, developing a program philosophy, required a maximal amount of assistance (see Appendix C).

Post follow-up evaluation measures were administered for the third time at the final meeting with the Greenwich ARC infant team. These measures included the post test, self rating scale, program review and consumer satisfaction with follow-up.

Results of the **post test 2** were compiled, analyzed and compared with results of the first and second administration. The test administered consisted of 13 questions. **Pretest** scores ranged from a low of seven percent to a high of 77 percent with a mean score of 53 percent. **Post training test** scores (post test 1) ranged from a low of 81 percent to a high of 100 percent with a mean score of 89 percent. **Post follow-up test** scores (post test 2) ranged from a low of 58 percent to a high of 100 percent with mean score of 89 percent. The mean score for post test 2 remained equal to that of the initial post test mean score indicating that overall knowledge gained as a result of the training sessions was maintained during the follow-up phase of the institute. Of the six participants, five did not change significantly from post test 1 scores. The score of one participant dropped significantly on post test 2. Follow-up evaluation results have been included in Appendices C and S.

A **consumer satisfaction** with follow-up questionnaire was completed by the participants at the final follow-up meeting. This questionnaire consisted of eight statements pertaining to the quality of tasks and follow-up in general. Responses were averaged across the six participants and mean scores for each of the eight statements were assigned. Results indicate that overall participants were satisfied with the institute follow-up. Mean scores ranged

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from a low of 3.8 to a high of 4.8. The follow-up components that participants appeared to be most satisfied with were: the tasks were related to the course content, tasks enabled participants to perform better at their job and that the institute overall was beneficial to them (mean scores = 4.8). Participants also strongly agreed that there was adequate support provided for them to complete their tasks (mean=4.7), criteria for the tasks were well defined and easy to understand (mean=4.3) and the tasks were relevant to their present job situation (mean=4.2). When asked to rate the statements the tasks were individualized to meet their needs and the tasks were easy to accomplish, mean scores were both 3.8 suggesting that they were in agreement but less so than with the other components of follow-up. Responses to the open ended questions suggested that overall, the Greenwich ARC Program found the team process and time to review program philosophy and framework the most helpful component of the institute. They reported that as a result of their participation in the institute they would write child goals and objectives more functionally, give more thought to family needs, provide more integrated therapy and use a new IFSP form that they recently developed. When asked what they found least helpful about the institute responses included some of the readings and some of the information was too basic.

The **self rating scale** administered just prior to, and immediately following the training sessions was given for the third time after follow-up. The scale consists of sixteen skills related to the Infant Curricula Institute objectives. Participants were asked to rate the level of expertise they perceived themselves as having for each of the skills. The rating scale consisted of five levels, unawareness, awareness, knowledge, application and mastery. Results were analyzed item by item across the participants to determine perceived changes in individual skills. The scale was administered and analyzed at three different times; just prior to and after training and again after follow-up. Mean scores were determined for each item rated and collapsed across the six participants. Results indicated that there were perceived changes on all of the skills both on the first and second post training administrations. Pre test score means ranged from a 2 to a 3.8 on individual skills. After training post test score means ranged from a 3.6 to a 4.4. After follow-up, mean scores increased even further and ranged from a 4 to a 4.8. When comparing the pre training and post 2 scores, all items changed significantly with the exception of items 10.1, 10.2, 10.3 and 11. These scores indicate that the follow-up phase reinforced and increased the perceived level of expertise of each of the participants. Follow-up Self-rating evaluation results have been included in Appendix C.

The **program review** was completed verbally with the program administrator for the third time at the last follow-up session. Results of the program review indicate that since the Greenwich ARC has been involved in the institute there have been some program changes. These include a new program handbook which was a task completed during follow-up. This handbook includes an updated and revised program philosophy and program goals. Also, the staff has begun using two new infant assessments including

the Carolina for Infants and Toddlers and the Uzgiris and Hunt Ordinal Scales of Psychological Development.

Rainbow Program: Due to staff changes and time constraints, the Rainbow Program was unable to participate in the follow-up portion of the Institute training. For full training evaluation results, please refer to Appendices D and S.

BOCES II Infant Program. The seven institute participants from the BOCES II Infant Program in Rochester, New York completed follow-up as scheduled. A wrap up session was conducted on May 29, 1991 during which time the post measures were conducted. Contact during the three months (February - May 1991) of follow-up averaged a minimum of two contacts per month for each participant. Tasks were adapted to meet the needs of individual team members. Contacts made with the participants of this institute included observations of team meetings and assessments, reviewing and giving feedback on written tasks, answering and clarifying details of incomplete tasks (see Appendix E).

Post-test evaluation measures were administered late in May to all participants. The same post test, self rating scale and programs review that were administered before and after training sessions were completed for the third time. A follow-up consumer satisfaction was also administered.

Results of **post test 2** indicated that the participants overall scored slightly lower (mean = 85%) than they scored in post test 1 (mean = 87%). However, scores were still significantly higher than they were on the pre test (mean = 66%). Follow-up evaluation results have been included in Appendices E and S.

When asked to rate themselves for the third and final time on a series of skills related to transdisciplinary teaming, the BOCES II Infant Program team perceived themselves at a higher level than they were before and just after the training sessions. After follow-up, **self rating scale** results ("Where I am") were collapsed across the seven participants. Forty percent of the skills were rated at mastery, 44% at application, and 16% at knowledge. This compares to post test 1 results when only 20% of the skills were at mastery, 47% at application and the remaining 33% spread between knowledge, awareness, and unawareness. Follow-up Self-rating evaluation results have been included in Appendix E.

The **program review** was administered for the third time to determine if there were any program changes related to transdisciplinary training. Although BOCES II implemented specific organizational changes and incorporated new methods into their program, there were no changes in results on this instrument.

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A follow-up **consumer satisfaction** form was the final measure given to participants. Seven of the eight statements averaged a "4" to "4.3" rating. These included: the tasks were related to course content, were relevant to my present job situation, were individualized to meet my needs, enabled me to perform better at my job, were clearly defined and easy to understand, were accompanied with adequate support to complete them and the institute overall was beneficial to me. Participants were extremely satisfied with the support they received to complete the tasks (mean = 4.8). When asked what they found most helpful about the institute the participants responded with statements such as handouts, materials, discussion about the transdisciplinary teaming approach and the individualization of tasks to meet the needs of the program. They also reported that as a result of the institute they would team more with other professionals for evaluation and goal writing, evaluate their model more closely and plan for more effective team meetings. They found the post measures least beneficial. In future institutes participants would like to see more specific information on the implementation of the transdisciplinary approach to teaming.

Westchester UCP. Five of the original 7 Westchester UCP infant/toddler team completed follow-up for the Transdisciplinary Teaming Institute in January 1992, this past quarter. Two of the original team participants are no longer working for UCP and thus did not complete follow-up for training. Seven competency tasks were outlined for this institute to be completed during follow-up. Five of these tasks were completed. Those that were not accomplished included #1) Program Philosophy and #7) Instructional Programs. The tasks were reviewed and approved by the Birth to Three Inservice Outreach Training Project Staff and measured in terms of the level of assistance that was necessary for the staff to complete them using the outlined criteria.

Post follow-up evaluation measures were administered for the third and final time at the final meeting with the Westchester UCP Infant/Toddler Team. These measures included the post test, self rating scale, program review and consumer satisfaction with follow-up.

The same **self rating scale** administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to transdisciplinary teaming as a result of the training was administered again after follow-up. The scale consisted of eighteen skills that were rated on a five point scale from unawareness to mastery. Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be on each of the skills. Scores were collapsed across the seven participants and a percentage of skills rated in each of the five categories was calculated. Prior to training, the percentages were as follows on current perceived skill levels: unawareness, 11%; awareness, 15%; knowledge, 23%; application, 43%; mastery, 8%. After training, there was a slight upward trend in regards to where participants perceived their skills. Percentages were: unawareness, 0%; awareness, 6%; knowledge, 34%; application, 52%; mastery, 8%. Most

participants felt they were not where they wanted to be on many skills. After follow-up scores reflect the five participants and indicate even higher perception in skill levels as compared with after training. Percentages were: unawareness, 0%; awareness, 0%; knowledge, 18%; application, 42% and mastery, 40%. Follow-up self rating evaluation results have been included in Appendix F.

The same **post-test** measuring the change in participants knowledge which was administered before and after training was administered for a third and final time (post test 2). The test consisted of fifteen questions (a combination of open ended, true and false, and multiple choice), totaling thirty-three points. Scores of this final administration are only based on the 5 participants who completed **follow-up test.** Scores ranged from a low of 24 percent to a high of 70 percent averaging 52 percent across the five participants. **Post test 1** scores averaged 84 percent across the five participants ranging from 73 percent to 97 percent. Results of this final test administration **(post-test 2)** ranged from a low of 64 percent to a high of 88 percent with a mean score of 78 percent. This indicates an overall mean drop of 6 percentage points (not statistically significant) during the 10 months of follow-up. Follow-up pre-post evaluation results have been included in Appendices F and S.

The **program review** was completed through an interview format with the program administrator for the third time after the follow-up. Those items relating to the institute topic (in this case transdisciplinary teaming) were particularly examined for changes. Prior to training, there were two full time staff and five part-time staff involved in the infant/toddler program. This did not change after training. Twenty-nine of the thirty-eight components reviewed were in place prior to training. This also did not change as a result of the training. The components not in place included writing reports as a team, conducting family assessments, serving non-English speaking families, writing IFSP's, including families in the development of goals and objectives, providing opportunities to integrate children, providing supplementary activities for parents and families writing interagency agreements, identifying staff development and training needs and keeping program evaluation data. After follow-up, there were two changes in the program review as reported by the administrator and by the staff. These included a greater effort to include families in the development of goals and objectives and reports were written together as a team more often after follow-up than prior to training. As indicated earlier in this report, there was a discussion with the team regarding what they believed to be the impact of the training on their program and themselves.

A **consumer satisfaction** with follow-up questionnaire was completed by the participants at the final follow-up meeting. Responses were averaged across the six participants and mean scores for each of the eight statements were assigned. Results indicate that overall participants were satisfied with the institute follow-up. Mean scores ranged from a low of 4.4 to a high of 5. The follow-up components that participants appeared to be most satisfied

with were: the tasks were related to the course content, tasks were relevant to their job and that the institute overall was beneficial to them (mean scores=5). Participants also strongly agreed (mean=4.8) that there was adequate support provided for them to complete their tasks, tasks enabled them to perform better at their job and the tasks were individualized to meet their needs. When asked if tasks were easy to accomplish and criteria for the tasks were well defined and easy to understand mean scores were 4.6 and 4.4 respectively.

Sullivan Diagnostic Treatment Center: Due to time and scheduling constraints, the staff at Sullivan Diagnostic Treatment Center was not able to participate in the follow-up portion of the training. They felt that the training was extremely beneficial to them and that it provided them with much new information to incorporate into their program. However, the time commitment for follow-up was not possible, as originally planned. For full training evaluation results, please refer to Appendices G and S.

East River Child Development Center: All of the original participants completed the follow-up portion of the training. Seven competency tasks were outlined for this institute to be completed during follow-up. All of the tasks were completed as scheduled. The tasks were reviewed and approved by the Birth to Three Inservice Outreach Training Project Staff.

Post follow-up evaluation measures were administered for the third and final time at the final meeting with the East River Development Center team. These measures included the post-test, self-rating scale, program review, and consumer satisfaction.

The **follow-up post-test** was administered to all of the participants. Scores ranged from a low of 73% to a high of 88% with a mean score of 73%. This mean was identical to the first post-test mean. Follow-up post-test evaluation results have been included in Appendices H and S.

The same **self-rating scale** administered to participants both before and after the training sessions was administered again after follow-up to determine if there were perceived changes in skills related to transdisciplinary teaming as a result of the training. After follow-up, the scores reflected higher perceptions of skill levels across all participants as compared to the scale completed immediately following training.

The **program review** was completed through an interview format with the program administrator again after follow-up. Those items relating to Teaming were particularly examined closely for changes. The program review indicated changes with respect to the assessment process inasmuch as East River was able to develop an Integrated Report Format. A sample of this format has been included in Appendix H.

A **Consumer Satisfaction Questionnaire** was completed by each participant upon completion of follow-up. This questionnaire consisted of eight questions relating specifically to the follow-up portion of this training. All participants felt that the follow-up was beneficial and helped them to better incorporate changes into their program.

Children's School for Early Development: Due to staff changes during the follow-up portion of training, only four of the original participants completed the follow-up training. Seven competency tasks were outlined for completion during follow-up, and all were completed in a timely fashion. The tasks were reviewed and approved by the project staff.

Post follow-up evaluation measures were administered for a third and final time. These measures are discussed individually.

The same **post-test** was administered after follow-up as after training was originally completed. Scores ranged from 90% to 95% with a mean score of 93%. Follow-up post-test evaluation results have been included in Appendices I and S.

The same **self-rating scale** administered to participants both before and after the training sessions, was administered for a third and final time after follow-up. The scores reflected higher perceptions of skill levels across all participants as compared to immediately after training. The most significant changes in score occurred in the areas pertaining to working with and interviewing families. Self-rating evaluation results have been included in Appendix I.

The **program review** was completed again through interview format with the program administrator after follow-up. The program wrote a more family centered philosophy and developed an IFSP format that would more readily reflect the needs of the children and families they serve.

The **Consumer Satisfaction Questionnaire** was completed by each participant after completion of the follow-up tasks. Scores ranged from a low of 4.00 to a high of 4.89 indicating that the participants felt the follow-up portion of training was beneficial to them.

Special Sprouts: Due to staff changes during the training period, four of the original seven participants were able to complete the follow-up portion of the training. They concentrated on developing a family needs questionnaire and an IFSP format.

Post follow-up evaluation measures were administered for a third and final time at the end of the follow-up sessions. Detailed descriptions follow.

The same **post-test** measuring the change in participant knowledge which was administered before and after training, was administered again after follow-up (post test 2). Follow-up scores ranged from 64% to 100% with a

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mean score of 73%. Follow-up post-test evaluation results have been included in Appendices J and S.

The same **self-rating scale** administered to participants both before and after the training sessions was administered again after follow-up. Overall, participants felt they had gained awareness, and showed improvement in all skill areas. Self-rating evaluation results have been included in Appendix J.

The **program review** was again completed through interview format with the program administrator at the end of the follow-up training. Those items relating directly to working with families and developing child goals showed improvement after training was completed.

A **Consumer Satisfaction Questionnaire** was completed again after the follow-up portion of this training. Overall, participants felt the training was worthwhile and beneficial to the families they will ultimately be serving.

Alcott School: Four of the original participants participated in the follow-up portion of this Programming for Infants, Toddlers and Their Families Institute. Six competency tasks were outlined and completed. Tasks were reviewed and approved by the Project staff.

Post follow-up evaluation measures were administered for the third and final time at the end of follow-up. Detailed results follow.

The same **post-test** measuring the change in participant knowledge which was administered after training was administered for a third and final time after follow-up was completed. Scores ranged from a low of 55% to a high of 78%, with a mean score of 65%. Post-test evaluation results have been included in Appendices K and S.

The same **self-rating scale** administered to participants both before and after the training sessions was administered again after follow-up. The participants showed higher perceptions of their skills after follow-up as compared to both their initial as well as post-training results. Self-rating evaluation results have been included in Appendix K.

The **program review** was again completed through interview format at the end of the follow-up sessions. Those items relating to instruction and curriculum with young children showed the most change. The staff had time during follow-up to incorporate activity based instruction techniques and effective observation techniques into their routines with young children.

The **Consumer Satisfaction Questionnaire** was completed again after the follow-up portion of training, but this time reflected only satisfaction with tasks and their completion. Staff felt that the time spent in follow-up was beneficial to them and that the tasks were appropriately designed to meet their needs and goals.

Sunnyview Rehabilitation Center: All of the original participants participated in the follow-up component of this training institute. They worked diligently at creating a cohesive evaluation team that would contract with the county to perform a minimum of four evaluations per month.

The same **post-test** as was administered before and after training, was administered for a third and final time at the end of the follow-up sessions. Follow-up scores ranged from a low of 85% to a high of 100% with a mean score of 92%. Follow-up post-test evaluation results have been included in Appendices L and S.

The same **self-rating scale** administered to participants both before and after training was administered for a third and final time after completion of the follow-up training. Participant scores reflected higher perceptions of skills levels across all participants as compared to the scale completed immediately after training. Self-rating evaluation results for follow-up have been included in Appendix L.

The **program review** was again completed through an interview format wit the program administrator after follow-up. Those items relating to building a team, interagency collaboration, and effective communication with families showed the most improvement.

A **Consumer Satisfaction Questionnaire** was completed by each participant rating their satisfaction with the follow-up portion of the training. Overall, participants felt the training was beneficial in helping them to establish themselves as an evaluation team.

Putnam ARC: All of the original participants participated in the follow-up component of this training institute. They concentrated on establishing a well-written philosophy statement an appropriate Individualized Family Service Plan. The team as a group had a very difficult time scheduling follow-up sessions that would be convenient for all participants. For this reason, the majority of their follow-up tasks were completed independently, with assistance through telephone contact. Seven competency tasks were outlined for the institute to be completed during follow-up (see Appendix Z). All tasks were completed. Level of assistance was "1" for all tasks because they received only minimal telephone consultation for most tasks.

Post follow-up evaluation measures were administered for the third and final time at the final meeting with Putnam ARC. These measures included the post test, self rating scale, program review and consumer satisfaction questionnaire.

The same **post-test** measuring the change in participant knowledge which was administered before and after training, was administered for a third and final time (post test 2). The difference between pre test and final post test scores was significant. Scores from this final administration ranged from a

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low of 92 to a high of 97, with a mean score of 94%. Post-test evaluation results have been included in Appendices M and S.

The same **self-rating scale** administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to Individualized Family Service Plans as a result of the training was administered again after follow-up. Overall, participants felt they had gained awareness, and in some cases mastery, of skills listed on the scale. Self-rating evaluation results have been included in Appendix M.

The **program review** was completed through an interview format with the program administrator at the end of the follow-up training. Those items relating to the institute topic, IFSP, were examined closely. Although the review did not reflect specific changes with respect to implementation of new skills or procedural changes, the group felt they had gained valuable information that would enable them to make administrative changes that would benefit the children and families they serve.

A **consumer satisfaction** questionnaire was completed after follow-up training. This questionnaire reflected that participants were satisfied with the training, but would have preferred that it be conducted at a different time during the day. Two of the five participants were therapists and found it difficult to reschedule children in order to meet the obligations of the training.

Columbia ARC: All but one of the original participants in the Columbia ARC training completed follow-up. Seven competency tasks were outlined for this institute to be completed during follow-up. All of these tasks were completed. The tasks were reviewed and approved by the Birth to Three Inservice Outreach Training Project Staff. Task #1 required assistance for completion. However, tasks 4 through 7 were completed independently.

Post follow-up evaluation measures were administered for the third and final time at the final meeting with the Columbia ARC team. These measures included the post-test, self-rating scale, program review and consumer satisfaction.

The same **post-test** measuring the change in participant knowledge which was administered before and after training was administered for a third and final time (post test 2). The test consisted of twenty questions (a combination of open ended, true and false, and multiple choice), totaling thirty-nine points. Scores for this final administration are based on the nine participants who completed the follow-up test. Scores ranged from a low of 51 percent to a high of 95 percent averaging 83% percent across the nine participants. Follow-up post-test evaluation results have been included in Appendices N and S.

The same **self-rating scale** administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to transdisciplinary teaming as a result of the training was administered again after follow-up. The scale consisted of skills that were rated on a five point scale from unawareness to mastery. Participants were asked to rate themselves according to where they currently thought they were and where they wanted to be with respect to each of the skills. After follow-up, the scores reflected higher perceptions of skill levels across all participants as compared to the scale completed immediately following training. Self-rating evaluation results have been included in Appendix N.

The **program review** was completed through an interview format with the program administrator again after follow-up. Those items relating to the institute topic (in this case, IFSP), were particularly examined for changes. The program developed a protocol for evaluating children through play-based assessment in an arena style setting. They also developed what they hoped would be adopted by their county as an IFSP format.

A **consumer satisfaction** questionnaire was completed by each participant upon completion of follow-up. This questionnaire consisted of eight statements pertaining to the quality of tasks and follow-up in general. Overall, the staff felt that the follow-up training was beneficial in helping them to incorporate necessary changes into their program routines.
Williamsburg Developmental School: Nine of the original ten participants were able to complete the follow-up portion of this IFSP training institute. The staff at Williamsburg Developmental School worked diligently at developing a well written program philosophy. The also hoped to gain a better understanding of the IFSP process and how to effectively work with families for the best of the children.

Post follow-up evaluation measures were administered for the third and final time at the end of the follow-up training. Detailed evaluation information follows.

The same **post-test** measuring the change in participant knowledge that was administered before and after training was administered again immediately after the completion of follow-up. Scores ranged from a low of 54% to a high of 100%, with a mean score of 81%. Follow-up evaluation results have been included in Appendices O and S.

The same **self-rating scale** administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to the IFSP as a result of the training was administered again after follow-up. The scores reflected higher perceptions of skill levels across all participants as compared to the scale completed after training. Self-rating evaluation results have been included in Appendix O.

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The **program review** was again completed through an interview format with the program administrator after follow-up. Those items relating specifically to IFSP showed marked changes inasmuch as the Williamsburg staff was able to develop an understanding of the IFSP process and how it could be effectively incorporated into their evaluation and intervention process.

The **Consumer Satisfaction Questionnaire** was completed by each participant upon completion of follow-up. Overall, participants felt that the follow-up portion of this training was beneficial to them in learning about the IFSP process and working with families.

Northside Center for Child Development: Five of the original seven participants were able to complete the follow-up portion of this Infant Curricula Institute. Northside concentrated their efforts on developing appropriate curricula and activities for young children in the classroom. They also looked at ways to adapt current curricula to meet the needs of every child in the classroom.

Post follow-up evaluation measures were administered for a third and final time and the end of the follow-up portion of training. These results and detailed as follows.

The same **post-test** measuring the change in participant knowledge was administered again after follow-up. Scores for this final administration of the test ranged from a low of 85% to a high of 100% with a mean score of 96%. Follow-up post-test evaluation results have been included in Appendices P and S.

The same **self-rating scale** as was administered previously, was administered for a third and final time at the end of the follow-up training. The scores reflected a higher perception of skill levels across all participants as compared to the scale completed immediately following training. Self-rating evaluation results have been included in Appendix P.

The **program review** was again completed through interview format with the program administrator after follow-up. The program review reflected notable changes with respect to assessment protocol as well as classroom activities.

The **Consumer Satisfaction Questionnaire** was completed by each participant upon completion of the follow-up training. Overall, participants felt that the tasks were outlined appropriately to assist them in meeting their program goals. They also felt that they were assisted well in completing these tasks.

New Medico Rehabilitation Center: All eleven of the original participants were able to complete the follow-up portion of this IFSP Institute training. Tasks were completed thoroughly and on schedule. A written philosophy was developed, and an assessment protocol was established.

Post follow-up evaluation measures were administered for the third and final time at the end of the follow-up training. Detailed results follow.

The same **post-test** measuring the change in participant knowledge was administered again after completion of follow-up. Scores ranged from a low of 85% to a high of 100% with a mean score of 97%. Follow-up post-test evaluation results have been included in Appendices Q and S.

The same **self-rating scale** administered to participants both before and after the training sessions to determine if there were perceived changes in skills related to IFSP development as a result of the training was administered again after follow-up. These scores reflected higher perceptions of skill levels across all participants as compared to the scale completed immediately following training. Mean scores by item are displayed in Appendix Q.

The **program review** was again completed through an interview format with the program administrator after follow-up. Those items relating directly to IFSP development and communication with families showed the most change.

The **Consumer Satisfaction Questionnaire** was completed by each participant following the completion of follow-up training. Participants felt that the training was very helpful to them in establishing a play-based arena assessment protocol, a well-written philosophy, and a strong understanding of the IFSP process and effectively working with families.

Dutchess County Department of Health: Eleven of the original twelve participants were able to complete the follow-up portion of this Transdisciplinary Teaming Institute training. The parent member of the group was unable to finish follow-up due to unforseen circumstances with her son. Seven tasks were outlined and completed quickly and with enthusiasm. In addition, the staff at Dutchess County Department of Health incorporated additional tasks they felt were necessary, into the follow-up.

Post follow-up evaluation measures were administered for the third and final time at the end of the follow-up training. Detailed results follow.

The same **post-test** measuring the change in participant knowledge was administered again at the end of the follow-up portion of this training. Scores ranged from a low of 95% to a high of 100%. All but one participant scored 100%, making the mean score 99%. Follow-up post-test evaluation results have been included in Appendices R and S.

The same **self-rating scale** administered to participants before and after the training sessions was administered again after follow-up. The scores reflected higher perceptions of skill levels across all participants as compared to the scale completed immediately following training. Self-rating evaluation results have been included in Appendix R.

The **program review** was completed through an interview format with the program administrator again after follow-up. The review reflected significant changes in intake and assessment protocol, evaluation criteria, and general team philosophy and mission statement.

The **Consumer Satisfaction Questionnaire** was completed by each participant upon completion of follow-up. The participants felt that the follow-up portion of the training was helpful. However, this group was so highly motivated, that the bulk of the tasks were completed before the actual follow-up sessions began. Follow-up served as a time to refine what had already been done, and initiate actual scheduling of evaluations.

Activity 3.3 — Develop Manual. During the summer of 1992 an initial draft of the inservice training manual was written by project staff. The Birth to Three Training Manual has been revised and disseminated upon request. It will also be used in future trainings. This manual is been included in Appendix T of this report.

VII. PROJECT IMPACT

1. Contribution to Current Knowledge and Practice

This outreach project expanded the knowledge base on early intervention services in a number of ways. **First,** the project translated findings from a statewide demonstration project into training content and subsequent model replication activities within another state. **Second,** the project offered a variety of training activities consistent with the literature on adult learning, thus increasing the effectiveness of the training. **Third,** the program developed materials for use during training and these are now available for national dissemination. **Last,** the program evaluated the effects of training across participants, programs and consumers (both immediate and long term) thus insuring the systematic refinement of both model components and training activities.

2. Dissemination and Replication

There is an accumulating amount of literature on adapting or implementing educational innovations or service models (Paine, Bellamy & Wilcox, 1984). Inherent in any type of service delivery model is the premise that services should be evaluated ultimately on the basis of their benefits to consumers (in this instance young children and their families). Additionally, it has been suggested that innovations within service deliveries undergo a development process in which the delivery **techniques** are defined as procedures, materials, rules, activities or other environmental changes which change the behavior. Changes across individuals is illustrative of a **demonstration**. The **model** is the prototype for replication of the demonstration across service settings, consumers and administrative arrangements (Paine, Bellamy & Wilcox, 1984). During each of these service applications, the processes for development and dissemination are quite different.

Since this project represented the culmination of one demonstration which was based on training techniques, it has been appropriate to focus the dissemination efforts on the expansion of level 2 and the initiation of level 3 as outlined in Table 1. We presented descriptions of the project at meetings as well as distributed the brochure outlining the services. The brochure has been included in Appendix W. Training materials have been developed and were used with our participants and the families they serve. These materials have also been available to others not directly involved in the training. Last, we wrote up our outreach efforts and results (in accordance with the evaluation design) to reach a national audience. A copy of the article published in the Journal of Early Intervention (1992) has been included in Appendix Y. Table 2 contains an outline of these specific activities. The procedural manual from the Inservice Demonstration was used to guide the replication of the institutes.

Table 1

Relationship between program development criteria and standards, dissemination purposes, and levels of development of innovative practices. (Paine, Bellamy, & Wilcox, 1984).

Level of Development	Criteria and Standards for Development	Dissemination Purpose
1. Techniques	1. Functional relationship between intervention and a behavior	a. Information for adaptation of intervention to fit user's purpose
	2. Operational definition and reliable measurement of the behavior	
	3. Definition and reliable use of the intervention	
2. Demonstrations	4. Consistency and reliable use of the consumers	b. Generation of support for a service objective or method
	5. Social significance of behavior change	
	6. Socially acceptable intervention methods	
3. Model	7. Socially valid relationship between intervention and behavioral result	c. Dissemination for replication or adoption
	8. Consistency of effects across users	
	9. Advantage over alternative service delivery	
	10. Fidelity of implementation	

Table 2
Dissemination Activities

Activity	Audience	Scope
Presentations on Outreach model and outcome data	Early interventionists State agency personnel Families	State Level
Distribution of brochure describing training activities	Early interventionists with RPG State agency personnel Families	State Level
Training manuals for the institute	Institute participants RPG members	State Level
Presentations on Inservice Training Content, Methodology and Outcomes	Early interventionists State and Federal agency personnel Families Personnel Preparation Programs	National Level
Articles on Inservice Training Content, Methodology and Outcomes	Early interventionists State and Federal agency personnel Families Personnel Preparation Programs	National Level

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APPENDIX A

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Table 1
Programs receiving training with the Birth to Three Inservice Training Project during the 1990-1991 year.

PROGRAM/CONTACT PERSON	INSTITUTE TOPIC	START DATE	END DATE	NUMBER OF SESSIONS	LENGTH OF SESSIONS	FOLLOW UP DATES
Greenwich ARC Infant/Toddler Program Greenwich, CT Lolly Ross Program Director	Infant Curricula	11-6-90	12-11-90	5 weekly	2.5 Hours	12-90 to 7-91
Rainbow Program 900 Pelham Parkway Bronx, NY 10462 Marie Sica, Coordinator Early Intervention Program	Infant Curricula	1-16-91	3-6-91	7 weekly	2 Hours	4-91 to 7-91
Boces II Infant Program 3599 Big Ridge Road Spencerport, NY 14559 Jim Kelly Program Director	Transdisciplinary Teaming	1-8-91	2-19-91	5 weekly	2 Hours	2-91 to 6-91
UCP Westchester King Street Rye Brook, NY Steve Hernandes Program Director	Transdisciplinary Teaming	1-23-91	2-12-91	4 weekly	3 Hours	2-91 to 5-91
Sullivan Diagnostic Treatment Center Harris, NY Terri Hamlin Program Director	IFSP	4-10-91	6-3-91	4 weekly	4 Hours	7-91 to 9-91

Table 2 Programs receivng training with the Birth to Three Inservice Training Project during 1991-1992 year.

PROGRAM/CONTACT PERSON	INSTITUE TOPIC	START DATE	END DATE	NUMBER OF SESSIONS	LENGTH OF SESSIONS	FOLLOW UP DATES
East River Child Development Center 577 Grand Street New York, New York 10002 Justine Strickland Program Director	Transdisciplinary Teaming Institute	10-25-91	12-12-91	5	2 Hours	1/92 to 4/93
Children's School for Early Development 36 Saw Mill River Parkway Hawthorne, N.Y. Phyllis Rizzi, Program Coordinator	IFSP Institute	11-18-91	1-29-92	3	5 Hours	1/92 to 3/93
Special Sprouts 339 8th Avenue Brooklyn, N.Y. 11215 Catherine Fay Program Coordinator	IFSP Institute	1-13-91	2-24-92	4	4 Hours	2/92 to 5/93
Alcott School -Infant/Toddler Program Mill Road New Rochelle, New York Joanne Doherty Program Director	Programming for Infants, Toddlers and their Families	3-20-92	5-21-92	7	1, 5 Hour 6, 2.5 Hrs	5/92 to 10/92

Table 3 Programs receiving training with the Birth to Three Inservice Training Project during 1992 - 1993.

PROGRAM/CONTACT PERSON	INSTITUE TOPIC	START DATE	END DATE	NUMBER OF SESSIONS	LENGTH OF SESSIONS	FOLLOW UP DATES
Melissa O'Brien Sunnyview Rehabilitation Center Schenectady NY (518) 382-4550	Transdisciplinary Teaming Institute	10/5/92	10/12/92	2	8 Hours	10/92 to 6/93
Nancy Miringoff Putnam ARC Mahopac NY (914) 628-2280	IFSP Institute	10/20/92	11/24/92	6	2 1/2 Hours	11/92 to 6/93
Abbie Schiff Columbia ARC (COARC) Hudson NY (518) 828-3890	IFSP Institute	11/4/92	11/25/92	5	4@3hrs. 1@6hrs	11/92 to 5/93
Laurie Englander Williamsburg Developmental School Brooklyn NY (718) 599-2100	IFSP Institute	11/24/92	12/22/92	5	3 hours	12/92 to 6/93
Roseanne Harris Northside Center for Child Development NY, NY (212) 860-7734	Infant Curricula	1/15/93	3/12/93	5	2.5	3/93 to 7/93
Beth Urbanczyk New Medico Rehabilitation Center Niscayuna, NY (518) 374-2212	IFSP Institute	3/22/93	5/3/93	7	2.5	6/93 to 8/93
Beverly Allyn Dutchess County Health Department Poughkeepsie, NY	Transdisciplinary Teaming	5/5/93	6/2/93	4	2.5	6/93 to 8/93

APPENDIX B

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The **Demographic Questionnaire** collects information on the participant's professional position, level and focus of formal education, certification, and amount and type of teaching experience. The Demographic Questionnaire was administered prior to the institute (during the orientation meeting or site visit). The purposes were to document the characteristics of the training audience (the educational background and experience of participants) and to correlate characteristics with training results. The number of participants from each discipline was determined as well as the number of participants serving each age level (0 to 18 months, 18 to 36 months, and parents), the number of participants serving children with each category of disabilities, the number of participants with each type of degree, the number of participants with each type of certification or licence, the number of participants with formal training focusing on the birth to three population, the mean number of years that the participants had been serving birth to three year olds, the mean number of years that the participants had been working in the field, the number of participants who had experience with different age-groups and in special or regular education, and the number of participants who had participated in training on the specific institute topic in the last two years.

The **Motivation Questionnaire** consists of two sections. In the first section, the participants were asked to rate various factors that may have influenced their decision to attend the institute on a scale from one to three (a "1" indicating "Not at All Important", a "2" indicating "Somewhat Important", and a "3" indicating "Very Important"). The factors include "To become better informed about early intervention in general", "To learn for the sake of learning", "To help advance in present job", and "Because my supervisor recommended it." (See Appendix N for complete questionnaire.) The participants were asked to star those factors they rated a "3" that were primary in their decision to attend. In the second section, the participants were asked to rate various factors that may have posed difficulties when arranging their attendance to the institute on a scale from one to three (a "1" indicating "Not at All Problematic", a "2" indicating "Somewhat Problematic", and a "3" indicating "Very Problematic"). The factors included "Attending 3-4 hours each session", "Transportation difficulties", and "Getting release time from my job." The Motivation Questionnaire was administered prior to the institute (during the orientation meeting or site visit). The purposes were to determine which motivating factors were indicated most often as being significant in determining participation and to determine which motivators correlated most strongly with positive training results.

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The **Learning-Style Inventory** is published by McBer and Company, 137 Newbury Street, Boston, MA 02116 and is a self-administered measure that "describes the way you learn and how you deal with ideas and day-to-day situations in your life." The inventory itself consists of twelve sentences with four possible completions. The participant was asked to rank the completions as to which was most descriptive of the participant. For example, question one was: "When I learn: ___ I like to deal with my feelings. ___ I like to watch and listen. ___ I like to think about ideas. ___ I like to be doing things." and the participant was to rank the completions with "four" being the most like the participant and "one" being the least like the participant. The results are depicted in two formats. The first depicts the participant's strengths and weaknesses as a learner along the following "learning modes": concrete experience, reflective observation, abstract conceptualization, and active experimentation. The second depicts the participant's learning style as one of the following: accommodator, diverger, assimilator, or converger. A description is given of the characteristics of each learning style. The Learning-Style Inventory was administered prior to the institute. The participant was able to take the inventory home to complete it. The purposes were for the participant to become more aware of his or her best mode of learning, to help project staff to plan for people's learning strengths, and to correlate learning styles with training outcomes. The number of participants exhibiting each of the learning styles was determined, and any correlation between a specific learning style and positive training outcome was determined.

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The **Program Review** is based on the Comprehensive Program Review developed by T.A.D.S. It contains yes/no questions about whether specific components were in place within the participant's program; some items required a listing (e.g., list of assessment tools used during evaluation). Items were added, deleted, and adapted based on the objectives of the institute training. The program review remained the same, however, from institute to institute, so that even though assessment and other components were not directly addressed in all institutes, they were measured for all institutes. Written documentation of some components was collected (e.g., an actual interagency agreement developed by the program). The Program Review was administered prior to the institute, immediately after the sessions were completed, immediately after the tasks were completed, and at three-month intervals until one year from the completion of the sessions. The program review was intended to be administered with the program supervisor present. The purposes were to determine which components were added or changed during or immediately after the training sessions, which components were added or changed during the implementation of the tasks, and which components were added or changed after the completion of the tasks, but within one year of the institute. The hope was to document that participants' programs were positively effected by the training as evidenced by the increase in or improvement of program components.

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The **Self-Rating Scale** was developed specific to each institute topic, and is based on the competencies to be achieved and the specific components of the topic. The participants rated themselves on 16 to 36 components (depending on the institute) according to how skilled they were in each area and according to how skilled they would like to have been. They rated themselves on the following scale: "Unfamiliar: This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?", "Awareness: I have heard about it, but I don't know its full scope such as its principles, components, applications, and modifications. I need information.", "Knowledge: I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.", "Application: I am ready to apply this. For example, I can design, modify, and use it in my program.", "Mastery: I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others." This evaluation form was also administered to the other staff from the participant's program. The Self-Rating Scale was administered prior to the institute (participants and staff were able to take the form home to complete it), immediately after the sessions were completed, immediately after the tasks are completed, and at three-month intervals until one year from the completion of the sessions. One purpose of administering the Self-Rating Scale to the participants was to determine their perceptions of their own skill levels and compare them to their desired performance levels. This assisted the instructors in determining the specific area or areas in which the participants wanted to improve. A second purpose was as a pre/post measurement to determine whether the participants perceived an increase in their skill levels after the sessions and after completing the tasks, and whether their perceived skill level was maintained over the period of one year post-training. The purpose of administering the Self-Rating Scale to the other staff from the participants' programs was to determine whether any information or skills were transferred during the sessions, and to determine whether any information or skills were transferred through completion of the tasks, one of which was to train others in the program.

The **Pre/Post Test** consists of questions designed to measure the participant's knowledge on specific aspects of the institute topic. Each institute's test consists of multiple choice, true/false, and completion questions to total 20 to 49 points. The Pre/Post Test was administered prior to the institute (during the orientation meeting or site visit), immediately after the sessions were completed, immediately after the tasks are completed, and at three-month intervals until one year from the completion of the sessions. The purpose was to determine change in the participant's knowledge from pre-session to post-session and follow-up. Scores are reported as percentage correct. The objective was for each participant to achieve at least 80% correct when the test was administered at the last training session and to maintain that percentage when the test was administered after completing the tasks and during the follow-up evaluations.

The **Consumer Satisfaction Questionnaire** consists of a Likert-type scale (from one, "strongly disagree", to five, "strongly agree") for the participants to rate the institute within three sections. There are seven statements to rate in the "Content" section, five statements in the "Presenter" section, and five statements to rate in the "Logistics of Presentation" section. For example, one of the statements in the "Content" section is, "All topics on the agenda were addressed." There are also four open-ended questions for the participants to answer regarding what was most helpful and least helpful about the institutes, what they would like to see included in the future, and what they would do differently as a result of the institute. The consumer satisfaction questionnaire administered after completion of the tasks also contains eight statements on the tasks. The Consumer Satisfaction Questionnaire was administered during the last session of the institute, after completion of the tasks, and one year after completion of the institute sessions. The purposes were to determine whether specific aspects of the training met with the participants' satisfaction and to determine which aspects were most and least beneficial. Scores were reported in terms of the percentage of participants responding at each rating level for each statement.

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The **Program Task Evaluation Forms** were designed specifically to evaluate the important aspects of the individual tasks. For example, the IFSP Implementation - Home Visit form attached was designed to evaluate the IFSP task "IFSP Implementation" Every task did not necessarily have an evaluation form, only those that address multiple skills or otherwise lend themselves to needing a form. The Program Task Evaluation Forms were administered during or immediately after completion of the tasks they were designed to evaluate. The purpose was to document participants' performance in an organized and consistent manner from instructor to instructor and from participant to participant

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The **Task Evaluation Checklist** lists all the tasks for a particular institute, with spaces to enter the completion date, instructor's initials, and level of assistance needed to complete the task. The level of assistance consists of a three-point scale, with a "1" indicating that the participant completed the task independently, a "2" indicating that the participant required some assistance to complete the task, and a "3" indicating that the participant required much assistance to complete the task. The Task Evaluation Checklist was administered throughout the follow-up period until all tasks were completed. The purpose was to document completion of tasks, how long it took participants to complete the tasks and how much assistance was needed to complete the tasks. The level of assistance needed to complete each task was determined for each participant and is averaged across participants. The mean level of assistance needed by each participant was also determined. The Task Completion Checklist that the participants received in their course binders was the same as the Task Evaluation Checklist except that it did not have the column to rate the level of assistance. Its purpose was to assist the participants in keeping track of their progress.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
PARTCIPANT INFORMATION

NAME: ____________________

AGENCY: ____________________

DATE: ____________ INSTITUTE: ____________

Have you been to a Birth to Three Inservice training before? ________
If yes, when? ____________

What is your current position?

____ Early Childhood Special Educator
____ Occupational Therapist
____ Physical Therapist
____ Speech Pathologist
____ Nurse
____ Administrator/Supervisor/Coordinator of Special Education
____ Administrator/Supervisor/Coordinator of Early Intervention
____ Administrator/Supervisor/Coordinator of Day Care
____ Nursery School/Day Care Teacher
____ Consultant
____ Guidance Counselor
____ Learning Disabilities Teacher
____ Psychologist
____ Social Worker
____ Other ____________

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Who do you serve?

_______ 0-18 month old children

_______ 18 months-3 year old children

_______ parents and families

What are the types of disabilities of children you serve?

_______ mild/moderate MR

_______ severe/profound MR

_______ multihandicapped

_______ physical handicaps

_______ blind

_______ deaf/blind

_______ hearing impaired

_______ learning disabled

_______ developmental delays

_______ emotionally disturbed

_______ medically involved

_______ behavior disordered

_______ speech and language delayed

_______ other _______________

What is your current degree?

_______ BA _______ BS _______ MA

_______ MS _______ M.Ed. _______ 6th year cert.

_______ MSW _______ Ed. D. _______ Post Masters

_______ Ph.D _______ RN _______ C.C.C.-SLP

_______ Other ______________________________

What is the area of your Certification/License?

______	Early Childhood Ed.	______	Early Childhood Special Ed.
______	PT	______	OT
______	Special Education	______	Psychology
______	Blind/Visually Impaired	______	Administration
______	Elementary Ed.	______	Reading
______	Learning Disabilities	______	Speech Pathology
______	Counseling	______	Social Work
______	Nursing	______	Hearing Impaired

Have you had any formal training focusing on the birth to three population? ____ yes ____ no

How long have you been serving 0-3 olds? ____________

How long have you been teaching or working in your field? ____________

What types of previous experience have you had?

______ 3-5 year olds - Early Intervention
______ Primary Special Ed.
______ Adolescents/Adults - Special Ed.
______ 0-5 typical children
______ Elementary Regular Ed.
______ Secondary Regular Ed.
______ Other Education
______ Other (Please List) ____________________

Have you had any training during the past two years on this institutes' topic? ____________

BIRTH TO THREE INSERVICE TRAINING PROJECT
MOTIVATION QUESTIONNAIRE

Name: ______________________________ Date: _______________

1. Please rate each of the following reasons for attendance on a scale of 1 to 3 according to its importance in your decision to attend the Birth To Three Inservice Training Project.

   Circle 1 if the statement was not a consideration.

   Circle 2 if the statement was somewhat important in your decision to attend.

   Circle 3 if the statement was very important in your decision to attend.

   In addition, please star the reason or reasons that were primary in your decision to attend (choose from those you rated a 3).

Reason	Not at All Important	Somewhat Important	Very Important
To become better informed about early intervention in general.	1	2	3
To become better informed about infant curricula.	1	2	3
For personal enjoyment and enrichment.	1	2	3
To learn for the sake of learning.	1	2	3
Because CEUs were available.	1	2	3
To help get a new job.	1	2	3
To help to advance in present job.	1	2	3

Reason	Not at All Important	Somewhat Important	Very Important
To better understand and work toward solution of community problems.	1	2	3
To meet new people.	1	2	3
Because the location was convenient.	1	2	3
Because it was free of charge.	1	2	3
To keep my job.	1	2	3
Because my supervisor recommended it.	1	2	3
Because my supervisor required it.	1	2	3
Because I expect the information to be useful for my job.	1	2	3
To get away from job requirements and get "recharged."	1	2	3

Other (Please specify.) ______________________

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2. Please rate each of the following issues that may have been problematic in arranging your attendance on a scale of 1 to 3.

Circle 1 if the statement was not a consideration.

Circle 2 if the statement was somewhat problematic.

Circle 3 if the statement was very problematic in arranging your attendance.

Issue	Not at All Problematic	Somewhat Problematic	<u>Very</u> Problematic
Attending once a week for four to six weeks.	1	2	3
Attending 3-4 hours each session.	1	2	3
Continuing involvement for one year.	1	2	3
Lack of child care.	1	2	3
Transportation difficulties	1	2	3
Friends or family attitudes.	1	2	3
Home responsibilities.	1	2	3
Job responsibilities.	1	2	3
Getting release time from my job.	1	2	3

Other (Please specify.) ______________________________

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BIRTH TO THREE INSERVICE TRAINING PROJECT
PROGRAM REVIEW

PROGRAM NAME ______________________ DATE: ____________

1.	Does the program have a written philosophy for early intervention services that is current and reflects the values of the program?	Yes	No	
2.	Are written materials available describing the purposes and scope of the program?	Yes	No	
3.	Does the program have written goals and objectives for services that reflect current practices?	Yes	No	
4.	Does the program have an established written eligibility criteria for entry into the program?	Yes	No	
5.	Does the program have an established method of referring children who are not eligible for the program?	Yes	No	
6.	Does the program provide on-going feedback to the referral sources (and to other appropriate sources) with regard to child's progress?	Yes	Sometimes	No
7.	Does the program utilize written interagency service agreements with at least one other community agency?	Yes	No	

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8. Does the program have a process for identifying staff development and training needs? Yes Sometimes No

9. Are resources (human, material, and financial) available for training? Yes Sometimes No

10. Are staff members involved with other associations, agencies, networks, committees for formal and informal training purposes? (Please List.) Yes Sometimes N

11. Does the program maintain records on the number and types of children being served? Yes Sometimes No

12. Does the program maintain records on the type of services actually received by each child and family? Yes Sometimes No

13. Does the program have identified personnel gaps/needs? (Please List.) Yes Sometimes No

14. Are public awareness of the needs of this population and screening activities conducted in the community/LEA? Yes Sometimes No

15. How many staff are currently involved in program service delivery? Full Time ____________ Part Time ____________

16. How many children are currently being served in the program? ____________

17. How long has the program been in operation? ____________

18. What is the cost per pupil? ______________

Assessment

	Question			
1.	Does the program utilize staff from different disciplines when assessing each child age birth to three years?	Yes	Sometimes	No
2.	Does the program utilize valid and reliable assessments in the evaluation process? (Please list assessment tools used.)	Yes	Sometimes	No
3a.	Does the program staff write assessment reports?	Yes	Sometimes	No
3b.	If yes, do team members write an integrated report?	Yes	Sometimes	No
4.	Does the program encourage families to participate in the assessment process by: a. preparing families regarding their role in the process?	Yes	Sometimes	No
	b. allowing parents to administer test items and/or provide suggestions on how to get child's best performance and provide information about their child at home?	Yes	Sometimes	No
	c. giving families assessment results in a manner that is understood and meaningful to the family?	Yes	Sometimes	No

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II. Individualized Family Service Plan

1.	Does the program orient parents about their rights and the law (PL 99-457)?	Yes	Sometimes	No
2.	Does the program identify families' concerns, priorities and resources (ie: through interview, assessment)? (Please explain.)	Yes	Sometimes	No
3.	Does the program service non-english speaking families in a culturally-sensitive manner? (Please explain)	Yes	Sometimes	No
4.	Does the program develop Individual Family Service Plans for each family which contain the 7 components specified in PL 99-457?	Yes	Sometimes	No
5.	Does the program develop IFSP's which reflect the priorities of the family?	Yes	Sometimes	No
6.	Are IFSP's reviewed every six months and rewritten every 12 months?	Yes	Sometimes	No
7.	Does each child have written goals and objectives for service delivery which are functional?	Yes	Sometimes	No

8.	Are families given the opportunity to participate in the development of goals and objectives for their child?	Yes	Sometimes	No
9.	Is the child's progress reviewed quarterly?	Yes	Sometimes	No
10.	Does the program have written transition guidelines?	Yes	Sometimes	No

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III. Service Delivery

1.	Does the program offer home visits to families?	Yes	Sometimes	No
2.	Does the program provide services for children within a group setting?	Yes	Sometimes	No
3.	Are opportunities provided for the child to be mainstreamed/integrated with normally developing peers?	Yes	Sometimes	No
4.	Are center-based services provided in a child-centered environment which facilitates learning?	Yes	Sometimes	No
5.	Does the program provide transportation for the children and families they serve?	Yes	Sometimes	No
6a.	Are IFSP goals implemented across activities during the child's daily routines at home and/or at school?	Yes	Sometimes	No
6b.	If yes, is there a systematic, documented procedure for implementing these goals?	Yes	Sometimes	No
7.	Are case management services provided for each child and family in the program?	Yes	Sometimes	No
8.	Do program staff coordinate services by meeting with other community agencies providing services to children in their program?	Yes	Sometimes	No

10.	Does the program keep evaluation data on:			
	a. the program?	Yes	Sometimes	No
	b. child progress?	Yes	Sometimes	No
	c. parent satisfaction?	Yes	Sometimes	No
11.	Are families encouraged to make decisions about their children's intervention programs (what to do and how to do it)?	Yes	Sometimes	No
12.	Is the ongoing scheduling of home or clinic visits flexible to meet the changing demands of the family?	Yes	Sometimes	No
13.	Does the staff attend to and assist parents in meeting family needs or concerns that are not directly related to the development of their children with special needs?	Yes	Sometimes	No
14.	Does the staff spend time talking to parents on home visits about issues not directly related to their children's intervention issues?	Yes	Sometimes	No
15.	Does the staff provide opportunities for parents to actively participate in classroom activities (if they want to)?	Yes	Sometimes	No
16.	Does the staff provide parents with daily information regarding what their children did in the classroom?	Yes	Sometimes	No
17.	Does the staff provide support services for families in the program? (Please describe.)	Yes	Sometimes	No

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IV. Teaming

1.	What model of teaming does the early intervention program follow?	Multi-disciplinary	Inter-disciplinary	Trans-discipl
2.	What types and how many of each discipline are represented on the early intervention team?			
3.	Are families encouraged to actively participate on the team (ie: attend team meetings, participate in assessment)? (Please describe.)	Yes	Sometimes	No
4.	Does the staff hold regularly scheduled team meetings at least monthly. If yes, how often?	Yes	Sometimes	No
5.	Do team members conduct child assessments jointly?	Yes	Sometimes	No
6.	Do team members write assessment results jointly?	Yes	Sometimes	No
7.	Do team members jointly develop the child's IFSP?	Yes	Sometimes	No
8.	Are IFSP goals implemented across discipline boundaries?	Yes	Sometimes	No

VI. Cultural Considerations

		Yes	Sometimes	No
1.	Are materials/information provided to families in preferred language?	Yes	Sometimes	No
2.	Are extended family members included in planning (when appropriate) and intervention?	Yes	Sometimes	No
3.	Is staff knowledgeable (i.e. know names and services provided) about a variety of resources for different cultures in their community? Have staff used any of these resources in the past?	Yes	Sometimes	No
4.	Are cultural customs such as : religion, food and clothing respected and taken into consideration when assessing and providing services for children and families?	Yes	Sometimes	No

LSI

Learning-Style Inventory

Name ______________________

Date ______________________

McBer and Company

Self-scoring Inventory and Interpretation Booklet

McBer and Company
137 Newbury Street
Boston, Massachusetts 02116
(617) 437-7080

ERIC

Learning-Style Inventory

The Learning-Style Inventory describes the way you learn and how you deal with ideas and day-to-day situations in your life. e all have a sense that people learn in different ways, but this inventory will help you understand what learning style can mean to you. It will help you understand better:

- how you make career choices
- how you solve problems
- how you set goals
- how you manage others
- how you deal with new situations

Instructions

On the next page you will be asked to complete 12 sentences. Each has four endings. Rank the endings for each sentence according to how well you think each one fits with how *you* would go about learning something. Try to recall some recent situations where you had to learn something new, perhaps in your job. Then, using the spaces provided, rank a "4" for the sentence ending that describes how you learn *best*, down to a "1" for the sentence ending that seems *least* like the way you would learn. Be sure to rank all the endings for each sentence unit. Please do not make ties.

Example of completed sentence set:

0. When I learn: __4__ I am happy. __1__ I am fast. __2__ I am logical. __3__ I am careful.

REMEMBER: 4 = *most* like you
3 = *second most* like you
2 = *third most* like you
1 = *least* like you

AND: You are ranking across, not down.

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Learning-Style Inventory

1. When I learn:	____ I like to deal with my feelings.	____ I like to watch and listen.	____ I like to think about ideas.	____ I like to be doing things.
2. I learn best when:	____ I trust my hunches and feelings.	____ I listen and watch carefully.	____ I rely on logical thinking.	____ I work hard to get things done.
3. When I am learning:	____ I have strong feelings and reactions.	____ I am quiet and reserved.	____ I tend to reason things out.	____ I am responsible about things.
4. I learn by:	____ feeling.	____ watching.	____ thinking.	____ doing.
5. When I learn:	____ I am open to new experiences.	____ I look at all sides of issues.	____ I like to analyze things, break them down into their parts.	____ I like to try things out.
6. When I am learning:	____ I am an intuitive person.	____ I am an observing person.	____ I am a logical person.	____ I am an active person.
I learn best from:	____ personal relationships.	____ observation.	____ rational theories.	____ a chance to try out and practice.
8. When I learn:	____ I feel personally involved in things.	____ I take my time before acting.	____ I like ideas and theories.	____ I like to see results from my work.
9. I learn best when:	____ I rely on my feelings.	____ I rely on my observations.	____ I rely on my ideas.	____ I can try things out for myself.
10. When I am learning:	____ I am an accepting person.	____ I am a reserved person.	____ I am a rational person.	____ I am a responsible person.
11. When I learn:	____ I get involved.	____ I like to observe.	____ I evaluate things.	____ I like to be active.
12. I learn best when:	____ I am receptive and open-minded.	____ I am careful.	____ I analyze ideas.	____ I am practical.

TOTAL the scores from each column:	☐ Column 1	☐ Column 2	☐ Column 3	☐ Column 4

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CONCRETE EXPERIENCE (CE)

This stage of the learning cycle emphasizes personal involvement with people in everyday situations. In this stage, you would tend to rely more on your feelings than on a systematic approach to problems and situations. In a learning situation, you would rely more on your ability to be open-minded and adaptable to change.

Learning from feeling

- Learning from specific experiences
- Relating to people
- Sensitivity to feelings and people

REFLECTIVE OBSERVATION (RO)

In this stage of the learning cycle, people understand ideas and situations from different points of view. In a learning situation you would rely on patience, objectivity, and careful judgment but would not necessarily take any action. You would rely on your own thoughts and feelings to form opinions.

Learning by watching and listening

- Careful observation before making a judgment
- Viewing things from different perspectives
- Looking for the meaning of things

ABSTRACT CONCEPTUALIZATION (AC)

In this stage, learning involves using logic and ideas, rather than feelings, to understand problems or situations. Typically, you would rely on systematic planning and develop theories and ideas to solve problems.

Learning by thinking

- Logical analysis of ideas
- Systematic planning
- Acting on an intellectual understanding of a situation

ACTIVE EXPERIMENTATION (AE)

Learning in this stage takes an active form — experimenting with influencing or changing situations. You would have a practical approach and a concern with what really works, as opposed to watching a situation. You value getting things done and seeing the results of your influence and ingenuity.

Learning by doing

- Ability to get things done
- Risk taking
- Influencing people and events through action

REMEMBER:

1. The LSI gives you a general idea of how *you* view yourself as a learner.
2. Because learning is a cycle, the four stages occur time after time. Often in a learning experience you may have to go through the cycle several times.
3. The LSI does not measure your learning skills with 100% accuracy. You can find out more about how you learn by gathering information from other sources — your friends, instructors, and co-workers.

Learning Style

From the preceding descriptions of Concrete Experience, Reflective Observation, Abstract Conceptualization, and Active Experimentation, you may have discovered that no single mode entirely describes your learning style. This is because each person's learning style is a *combination* of the four basic learning modes. Because of this, we are often pulled in several directions in a learning situation. By combining your scores, you can see which of four *learning-style types* best describes you. They are named as follows:

- Accommodator
- Diverger
- Converger
- Assimilator

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...erstanding your learning-style type — its strengths and weaknesses — is a major step toward increasing your learning ...er and getting the most from your learning experiences.

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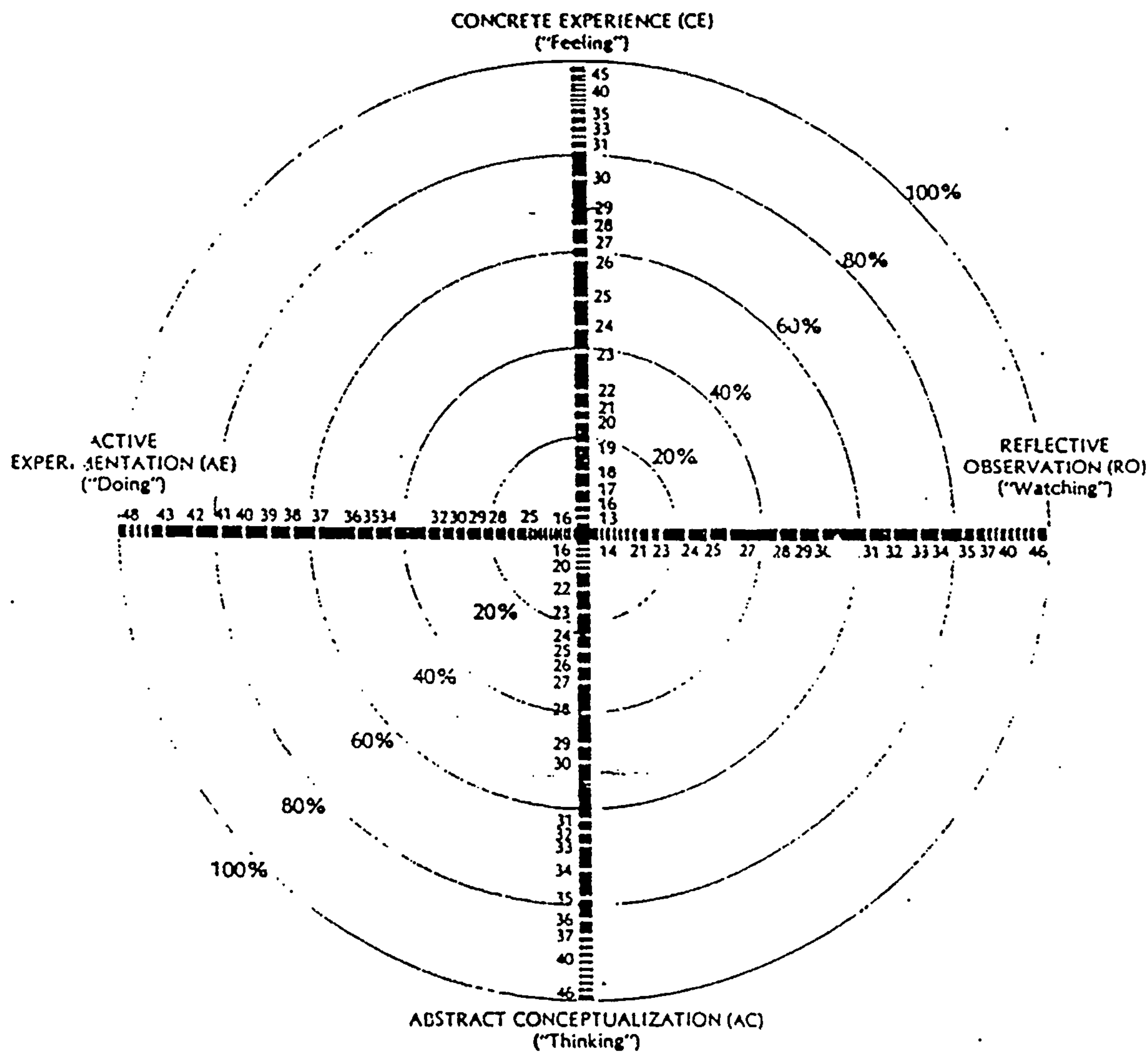
The Cycle of Learning

The four columns that you have just totaled relate to the four stages in the Cycle of Learning from Experience. In this cycle are four *learning modes:* Concrete Experience (CE), Reflective Observation (RO), Abstract Conceptualization (AC), and Active Experimentation (AE). Enter your total scores from each column:

Column 1 (CE): ☐ Column 2 (RO): ☐ Column 3 (AC): ☐ Column 4 (AE): ☐

In the diagram below, put a dot on each of the lines to correspond with your CE, RO, AC, and AE scores. Then connect the dots with a line so that you get a "kitelike" shape. The shape and placement of this kite will show you which learning modes you prefer most and which you prefer least.



The Learning-Style Inventory is a simple test that helps you understand your strengths and weaknesses as a learner. It measures how much you rely on four different learning modes that are part of a *four-stage cycle of learning.* Different learners start at different places in this cycle. Effective learning uses each stage. You can see by the shape of your profile (*above*) which of the four learning modes you tend to prefer in a learning situation.[1]

On the next page are explanations of the different learning modes.

[1] One way to understand the meaning of your LSI scores better is to compare them with the scores of others. The profile above gives norms on the four basic scales (CE, RO, AC, AE) for 1,446 adults ranging from 18 to 60 years of age. The sample group contained slightly more women than men, with an average of two years beyond high school in formal education. A wide range of occupations and educational backgrounds is represented. The raw scores for each of the four basic scales are listed on the crossed lines of the target. The concentric circles on the target represent percentile scores for the normative group. In comparison to the normative group, the shape of your profile indicates which of the four basic modes you tend to emphasize and which you emphasize less.

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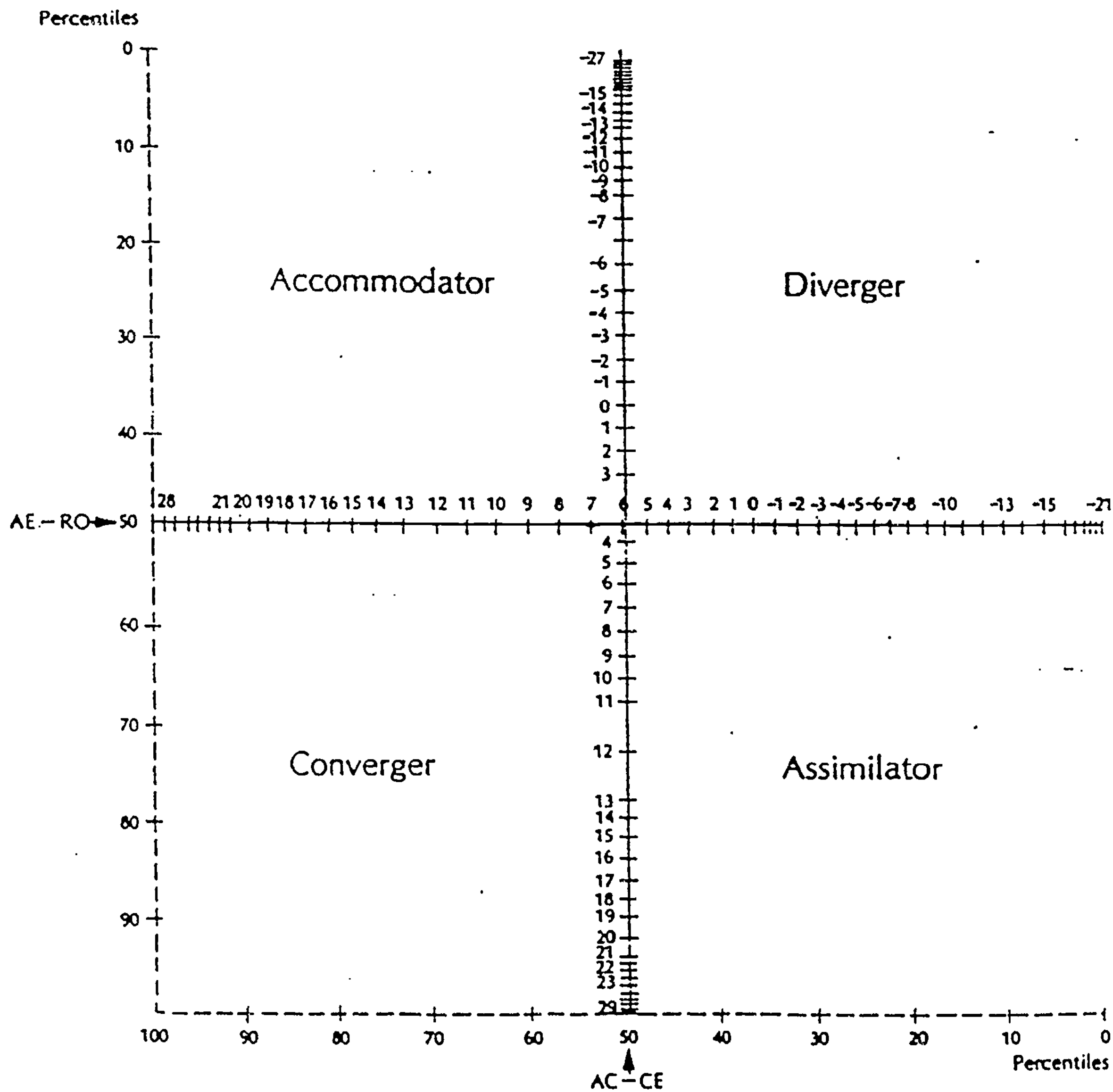
Learning-Style Type Grid

Take your scores for the four learning modes, AC, CE, AE, and RO, listed on page 4, and subtract as follows to get your two *combination scores:*

AC	−	CE	=	AC − CE		AE	−	RO	=	AE − RO
☐	−	☐	=	☐		☐	−	☐	=	☐

A positive score on the AC − CE scale indicates that your score is more abstract. A negative score on the AC − CE scale indicates that your score is more concrete. Likewise, a positive or negative score on the AE − RO scale indicates that your scores are either more active or more reflective.

By marking your two combination scores, AC − CE and AE − RO, on the two lines of the following grid and plotting their point of interception, or *data point,* you can find which of the four learning styles you fall into. These four quadrants, labeled Accommodator, Diverger, Converger, and Assimilator, represent the four dominant learning styles.



The quadrant of the Learning-Style Type Grid into which your data point falls shows your preferred learning style. For example: If your AC − CE score was − 8 and your AE − RO score was + 15, your style would fall into the Accommodator quadrant. An AC−CE score of + 7 and an AE − RO score of + 10 would fall into the Converger quadrant. The closer the data point is to the center of the grid, the more balanced is your learning style. If the data point falls near any of the far corners of the grid, [illegible] tend to rely heavily on one particular learning style.

ERIC

The ability to learn is the most important skill you can acquire. We are often confronted with new experiences or learning situations in life, in our careers, or on the job. In order to be an effective learner you have to *shift* — from getting involved (CE), to listening (RO), to creating an idea (AC), to making decisions (AE). As an adult, you have probably become better at some of these learning skills than others. You tend to rely on some skills and steps in the learning process more than others. As a result you have developed a learning style.

Understanding your learning style helps you become aware of your strengths in some steps of the learning cycle. One way you can improve your learning effectiveness is to use those strengths when you are called upon to learn. More important, you can increase your effectiveness as a learner by improving your use of the steps you underuse.

Another way of understanding your learning style is to see how closely related it is to:

- choosing careers
- problem solving
- managing people
- working as part of a team

On the following pages, you will:

- see how problem solving relates to learning styles
- learn how to strategize to improve your learning skills
- find out which careers are closely related to certain learning styles

Using the Learning Cycle to Help Solve Problems

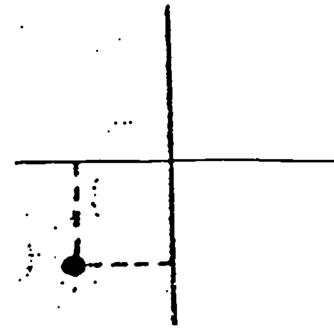
Understanding your learning style can make you an effective problem solver. Nearly every problem that you encounter on the job or in your life involves the following skills:

- identifying the problem
- selecting the problem to solve
- seeing different solutions
- evaluating possible results
- implementing the solution

Different pieces of the problem must be approached in different ways. Look back at your strengths and weaknesses in the four learning modes. Compare them with the problem-solving model illustrated below. If you rely heavily on Concrete Experience, you may find that you can easily identify problems that need to be worked on or solved. However, you may need to increase your ability to evaluate possible solutions, as in Abstract Conceptualization. Or you may find that your strong points rest with carrying out or implementing solutions, as in Active Experimentation. If this is so, you may need to work on carefully selecting the problem, as in Reflective Observation.

CONVERGER

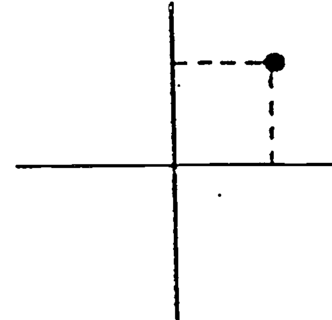
Combines learning steps of
ABSTRACT CONCEPTUALIZATION and ACTIVE EXPERIMENTATION



People with this learning style are best at finding practical uses for ideas and theories. If this is your preferred learning style, you have the ability to solve problems and make decisions based on finding solutions to questions or problems. You would rather deal with technical tasks and problems than with social and interpersonal issues. These learning skills are important to be effective in specialist and technology careers.

DIVERGER

Combines learning steps of
CONCRETE EXPERIENCE and REFLECTIVE OBSERVATION



People with this learning style are best at viewing concrete situations from many different points of view. Their approach to situations is to observe rather than take action. If this is your style, you may enjoy situations that call for generating a wide range of ideas, as in a brainstorming session. You probably have broad cultural interests and like to gather information. This imaginative ability and sensitivity to feelings is needed for effectiveness in the arts, entertainment, and service careers.

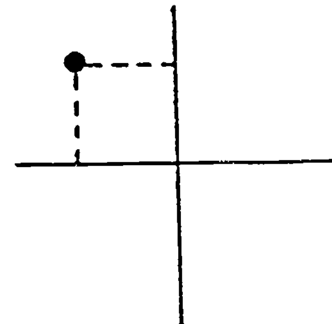
ASSIMILATOR

Combines learning steps of
ABSTRACT CONCEPTUALIZATION and REFLECTIVE OBSERVATION

People with this learning style are best at understanding a wide range of information and putting it into concise, logical form. If this is your learning style, you probably are less focused on people and more interested in abstract ideas and concepts. Generally, people with this learning style find it more important that a theory have logical soundness than practical value. This learning style is important for effectiveness in information and science careers.

ACCOMMODATOR

Combines learning steps of
CONCRETE EXPERIENCE and ACTIVE EXPERIMENTATION



People with this learning style have the ability to learn primarily from "hands-on" experience. If this is your style, you probably enjoy carrying out plans and involving yourself in new and challenging experiences. Your tendency may be to act on "gut" feelings rather than on logical analysis. In solving problems, you may rely more heavily on people for information than on your own technical analysis. This learning style is important for effectiveness in action-oriented careers such as marketing or sales.

[2] The Learning-Style Inventory is based on several tested theories of thinking and creativity. This is reflected in its terminology *Assimilation* and *accommodation* originate in Jean Piaget's definition of intelligence as the balance between the process of adapting concepts to fit the external world (accommodation) and the process of fitting observations of the world into existing concepts (assimilation). *Convergence* and *divergence* are the two essential creative processes identified by J. P. Guilford's structure-of-intellect model

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Review the Career Map below. See how well your learning style matches your job.

Concrete Experience

ACCOMMODATOR

CAREERS IN ORGANIZATIONS

Fields: Management
Public Administration
Educational Administration
Banking

Jobs: Accountant
Manager/Supervisor
Administrator

CAREERS IN BUSINESS AND PROMOTION

Fields: Marketing
Government
Business
Retail

Jobs: Salesperson/Retailer
Politician
Public Relations Specialist
General Manager

DIVERGER

CAREERS IN ARTS AND ENTERTAINMENT

Fields: Literature
Theater
Television
Journalism

Jobs: Actor/Actress
Athlete
Artist
Musician
Designer

CAREERS IN SERVICE ORGANIZATIONS

Fields: Social Work
Psychology
Police
Nursing

Jobs: Counselor/Therapist
Social Worker
Personnel Manager
Planner
Management Consultant

Active Experimentation

Reflective Observation

CONVERGER

CAREERS AS SPECIALISTS

Fields: Mining
Farming
Forestry
Economics

Jobs: Civil Engineer
Chemical Engineer
Production Supervisor

CAREERS IN TECHNOLOGY

Fields: Engineering
Medicine
Computer Science
Physical Science

Jobs: Physician
Engineer
Computer Programmer
Medical Technician
Applied Scientist
Industrial Salesperson
Manager

ASSIMILATOR

INFORMATION CAREERS

Fields: Education
Ministry
Sociology
Law

Jobs: Teacher
Writer
Librarian
Minister
College Professor

CAREERS IN SCIENCE

Fields: Mathematics
Physical Science
Biology

Jobs: Planner
R & D Scientist
Academic Physician
Researcher
Financier

Abstract Conceptualization

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You can improve your ability to learn and solve problems in three ways

1. Develop learning and work relationships with people whose learning strengths and weaknesses are opposite to yours.
2. Improve the fit between your learning-style strengths and the kinds of learning and problem-solving experiences you face.
3. Practice and develop learning skills in your areas of weakness.

FIRST STRATEGY

Develop supportive relationships. This is the easiest way to improve your learning skills. Recognize your own learning-style strengths and build on them. At the same time, value other people's *different* learning styles. Also, don't assume that you have to solve problems alone. Learning power is increased by working with others. Although you may be drawn to people who have similar learning skills, you'll learn better and experience the learning cycle more fully with friends and co-workers of opposite learning skills.

How? If you have an abstract learning style, like a Converger, you can learn to communicate ideas better by associating with people who are more concrete and people-oriented — like Divergers. A person with a more reflective style can benefit from observing the risk taking and active experimentation of someone more active — like an Accommodator.

SECOND STRATEGY

Improve the match or fit between your learning style and your life situation. This is a more difficult way to achieve better learning performance and life satisfaction.

How? There are a number of ways to do this. For some people, this may mean a change of career or job, or a move to a new ' where they feel more at home with the values and skills required of them. Most others can improve the match between their learning style and task by reorganizing their priorities and activities. They can concentrate on those tasks and activities that lie in their areas of learning strength and rely on other people in their areas of learning weakness.

THIRD STRATEGY

Become a flexible learner. You can do this by developing your learning weaknesses. This strategy is the most challenging, but it can be the most rewarding. By becoming flexible, you will be able to cope with problems of all kinds. And, you will be more adaptable in changing situations. Because this is harder, it involves more time and tolerance for your own mistakes and failure.

How?

1. Develop a long-term plan. Look for improvements and payoffs over months and years, rather than right away.
2. Look for safe situations to practice. Find situations that test your new skills but will not punish you for failure.
3. Reward yourself — it's hard work.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UConn Health Center -- Division of Child and Family Studies

CONSUMER SATISFACTION SHEET

Name: ________ __________ Date: ______________________
Agency: __________________ Institute: _________________

Please rate the following statements on a scale of 1 through 5:
- 1 indicating that you strongly disagree with the statement,
- 2 indicating that you mildly disagree with the statement,
- 3 indicating neutral,
- 4 indicating that you mildly agree with the statement,
- 5 indicating that you strongly agree with the statement.

	Strongly Disagree		Neutral		Strongly Agree
I. CONTENT					
1. Objectives of the training were met.	1	2	3	4	5
2. All topics on the agenda were addressed.	1	2	3	4	5
3. The materials (e.g., readings, overheads) were relevant to the training content.	1	2	3	4	5
4. Adequate illustrations and examples were used during presentations.	1	2	3	4	5
5. Time was well organized.	1	2	3	4	5
6. The information is relevant and can be applied to my work situation.	1	2	3	4	5
7. I feel I now have a better understanding of the subject presented.	1	2	3	4	5

II. PRESENTER

1. The presenters were well prepared and organized.	1	2	3	4	5
2. The presenters were knowledgeable in the subject.	1	2	3	4	5
3. The presenters used a variety of activities that corresponded with the content.	1	2	3	4	5
4. The presenters were easy to listen to.	1	2	3	4	5
5. The presenters valued our input.	1	2	3	4	5

III. LOGISTICS OF PRESENTATION

1. I found the environment to be comfortable.	1	2	3	4	5
2. There was adequate time for breaks during the training sessions.	1	2	3	4	5
3. The size of the group was appropriate for the sessions.	1	2	3	4	5
4. The location of the training was convenient for me.	1	2	3	4	5
5. The day and time of the training was convenient for me.	1	2	3	4	5

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IV. QUESTIONS

1. What did you find most helpful about the institute?

2. What did you find least helpful about the institute?

3. What additional information would you like to see included in future Infant Curricula institutes?

4. What will you do differently as a result of this institute?

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PEDIATRIC RESEARCH AND TRAINING CENTER
UCONN HEALTH CENTER - DIVISION OF CHILD AND FAMILY STUDIES
BIRTH TO THREE INSERVICE TRAINING PROJECT

CONSUMER SATISFACTION SHEET
INSTITUTE FOLLOW UP

Name: ________________ Date: ____________________
Agency: ________________ Institute: ________________

Please rate the following statements on a scale of 1 through 5:
1 indicating that you strongly disagree with the statement,
2 indicating that you mildly disagree with the statement,
3 indicating neutral,
4 indicating that you mildly agree with the statement,
5 indicating that you strongly agree with the statement.

	Strongly Disagree		Neutral		Strongly Agree
TASKS					
1. The tasks were related to the course content. Please list any which were not related.	1	2	3	4	5
2. The tasks were relevant to my present job situation.	1	2	3	4	5
3. The tasks were individualized to meet my needs.	1	2	3	4	5
4. There was adequate support provided to complete the tasks.	1	2	3	4	5
5. The tasks were easy to accomplish.	1	2	3	4	5
6. The tasks enabled me to perform better at my job.	1	2	3	4	5

	1	2	3	4	5
7. The criteria for the tasks were well defined and easy to understand.	1	2	3	4	5
8. Overall, the institute was beneficial to me.	1	2	3	4	5

QUESTIONS

1. What did you find most helpful about the institute?

2. What did you find least helpful about the institute?

3. What additional information would you like to see included in future Transdisciplinary Teaming institutes?

4. What will you do differently as a result of this institute?

APPENDIX C

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Table 1 Participant Demographics for the Greenwich ARC Infant Curricula Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field	Learning Style
1	Occupational Therapist	BA	Occupational Therapy	No	6	9	Converger
2	Speech Pathologist	MS	Speech Pathology	No	10	10	Accommodator
3	Nurse	RN	Nursing	Yes	2	2	Diverger
4	Educator/ Administrator	6th year	Early Childhood Special Ed.	Yes	12	12	Converger
5	Psychologist	Ph.D.	Psychology	Yes	2	5	Diverger
6	Physician	M.D.	Medicine	No	7	10	Assimilator

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Table 2

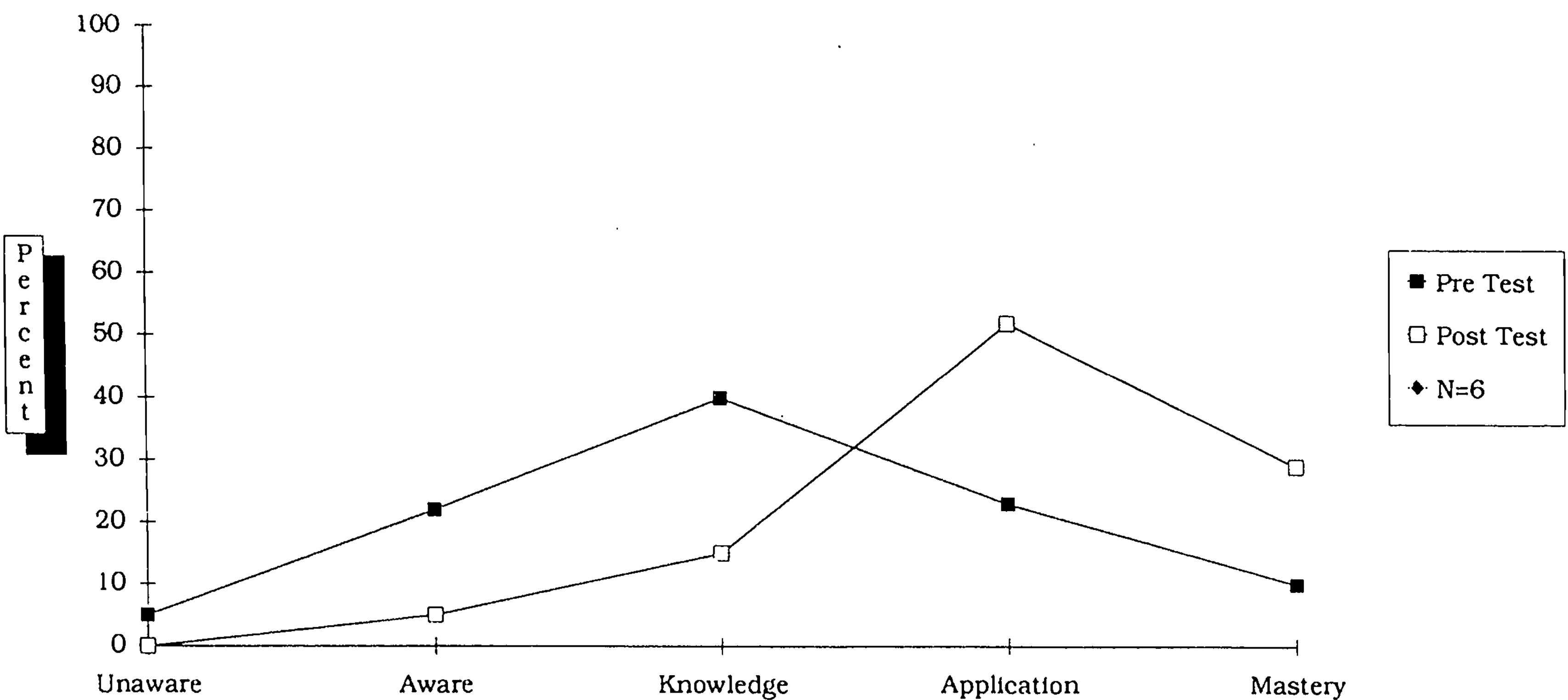

Table 1

Participant #	Pre Test	Post Test 1	Post Test 2
1	62%	92%	83%
2	46%	92%	100%
3	7%	100%	100%
4	73%	85%	100%
5	54%	81%	58%
6	77%	81%	92%
Overall Means	53%	89%	89%

Mean pre, post 1 and post 2 test scores for individual participants from the Greenwich ARC Infant Curricula Institute.

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Table 2

Item #	Item Description	Pre	Post 1	Post 2
1	State program philosophy	3	4	4.66
2	State program goals	3	4.2	4.5
3	Name four infant assessments	2	3.6	4.17
4	Choose appropriate assessments for specific purposes	2.3	3.8	4.5
5.1	Demonstrate skills in assessing infants/toddlers through: observation	3.3	3.6	4.5
5.2	structuring environment	3.3	3.6	4.5
5.3	direct test	3	3.6	4.5
6	Communicate assessment results to families	3.8	3.8	4.8
7	Collaborate with families to develop goals	3.3	4	4.66
8	Develop functional child goals	3	4.2	4.5
9	Write functional child objectives	3.16	4.2	4.5
10.1	Use a variety of teaching techniques with children including: incidental teaching	3.3	4.2	4.5
10.2	utilizing natural cues	3.3	4.2	4.5
10.3	arranging environment	3.16	4.2	4.3
11	Respond to child cues	3.5	4.4	4.5
12	Incorporate multiple objectives into one activity	3.16	4.2	4.3
13	Address goals and objectives through functional activities	3.3	4.2	4.5
14	Name activities in a typical day of infants/toddlers	3.16	4.2	4.66
15	Instruction with small groups	2.5	3.8	4

Mean pre, post 1 and post 2 self rating scale scores collapsed across the six Greenwich ARC Infant Curricula Institute participants.

BIRTH TO THREE INSERVICE TRAINING PROJECT

UCONN Health Center--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

Pre/Post test

Name: ______________________ Date: ______________

1. A program philosophy is important because the program's ______________ should share the same philosophical basis.

   a. assessments

   b. curricula

   c. staff

   d. all of the above.

   e. a & b

2. Name two standardized assessments (where results are expressed in standard scores) that are used with the birth to three year old population.

   ____

   ____

3. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a ______________ assessment.

   a. standardized

   b. criterion-referenced

   c. norm-referenced

   d. a & c

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4. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

   Screening (list one instrument):

   ____

   Determining Eligibility (list two instruments):

   ______________________ ______________________

   Program Planning (list two instruments):

   ______________________ ______________________

   Program Evaluation (list one instrument):

   ____

5. When assessing a young child, birth to three years, a standardized, norm-referenced test will give the most accurate picture of what the child can do.

   True   False

6. The best way to determine child goals is to address the items the child missed on the assessment.

   True   False

7. List three characteristics of a functional skill.

   ____

   ____

   ____

8. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True　　　　　　　　　　False

9. What are two principles of activity based teaching?

____

____

10. Give three examples of typical activities that occur either in the home or in the classroom and briefly describe how you could address an object permanence objective within each activity. (Continue on back, if necessary.)

____

____

____

____

11. When organizing children for group instruction, they should always be grouped according to developmental levels (i.e., children at same developmental levels together) otherwise it will be impossible to address their individual instructional goals.

True　　　　　　　　　　False

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12. Develop and describe below, one art activity in which the following IFSP objectives could be incorporated:

a. Jay will rotate either wrist to turn an object (eg. scooping with a spoon, turning a knob on the radio, wind up toy or doorknob)
b. Given a social situation, Jay will initiate turn-taking, 90% of the time.
c. In a given activity, Jay will initiate requests for assistance and/or materials, 90% of the time.

____
____
____
____
____
____
____
____
____
____
____

13. State one way in which the environment may affect a young child's performance/behavior?

____
____

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Birth to Three Inservice Training Project

Name________________ Program________________ Date________

INFANT CURRICULA: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Infant Curricula institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in
my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. State overall program goals.										
3. Name a minimum of four assessment instruments and their uses with the birth to three year old population.										
4. Choose appropriate assessment instruments for various purposes.										
5. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
6. Communicate assessment results to families and/or other professionals in understandable terms.										
7. Collaborate with families in the development of goals for their children.										
8. Develop functional child goals and objectives from assessment information.										
9. Demonstrate skills in writing functional short term behavioral objectives for children.										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
11. Demonstrate skills in utilizing a variety of teaching techniques with young children including:										
least prompts										
graduated guidance										
incidental teaching										
utilizing naturalistic cues										
arranging the environment to facilitate skill acquisiton										
12. Demonstrate skills in responding to child cues.										
13. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.										
14. Utilize functional activities to address goals and objectives.										
15. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.										
16. Demonstrate skills in providing instruction to groups of children from one to three years of age.										
17. Develop or modify teaching materials to facilitate skill acquisition in children with sensory or physical impairments.										
18. Name two curricular guides for use with children birth to three years of age.										
19. Additional skills desired:										

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UZGIRIS AND HUNT
INFANT SCALES OF PSYCHOLOGICAL DEVELOPMENT

GREENWICH ARC
1-22-91

Time	Topic
15 min.	Review Tasks
20 min.	Piaget's Sensorimotor Skills
20 min.	Sensorimotor Stages 1-6
10 min.	Break
35 min.	Overview of Uzgiris Hunt Scales
20 min.	Group Activity

SAMPLE TASKS

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PROGRAM TASKS
INFANT CURRICULA INSTITUTE

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, the current program philosophy will be reviewed and updated as determined necessary by the program director and staff.	Must address family involvement, delivery of services and team functioning and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review three (3) developmental assessments including one standardized, for use with the 0-3 population b) choose one assessment (new to student) to administer to two children (one developmentally delayed child and one normally developing child that are of the same chrononlogical age).	a) Reviews will be completed on a form provided by the instructor and submitted to the instructor for review b) Written score sheets, summaries of the results, and implications for programming must be submitted to the instructor for review.
3) Goal Setting	In collaboration with the family and other members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	The child goals will reflect the needs of the child as identified by the family and the team asessment process. Goals must be reviewed by the instructor.
4) Behavioral Objectives	Based on parent input and results of the child assessment, the student will write two (2) short-term behavioral objectives in each curricular domain (gross motor, fine motor, cognition, communication, self-help, social). The objectives will include the following components: a) critical behaviors that are specified in operational terms b) criteria for achievement c) functional activities in which they will occur	Written objectives will be reviewed by, discussed with, and approved by the instructor.

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Teaching Procedures/ Instructional Delivery	Given individual, small group, and large group instructional responsibilities, the student will demonstrate effective instructional delivery and teaching procedures. Delivery should: a) adhere to the infant's schedule b) utilize task presentation delineated in instructional program adjusting for unforeseen circumstances (task presentation includes arrangement of the environment to promote skill acquisition) c) utilize appropriate pacing of activity responding to child cues d) systematically incorporate multiple domains into a single activity e) choose appropriate activities for group instruction f) utilize appropriate techniques to manage behavior instruction g) include a written program, data collection and current data summary Teaching procedures should: a) sample a variety of stimulus presentation formats (imitation, match to sample, errorless learning) b) utilize a variety of assistance and reinforcement techniques.	The instructor will evaluate the appropriateness of instructional delivery and teaching procedures through observation. A minimum of two (2) observations will be made. Written feedback will be provided.

DESCRIPTION	PROGRAM TASK	CRITERIA
6) Activities Matrix	The student will: a) Choose five (5) routines that occur during an infant's typical day (either home or classroom). Examples include: arrival, departure, mealtime, art, circle, diapering/toileting. b) For each of the five routines, develop and describe one (1) activity that will enhance development and that can naturally be implemented as part of the routine. c) Address how example goals from each domain (gross motor, fine motor, cognition, self-help, social) can be incorporated into the activities.	The matrix will be submitted to and approved by the instructor.
7) Environmental Designs	The staff either individually or in small groups will identify at least one environmental change in the classroom that can be made to enhance the learning of the children in the classroom.	Rationale for the environmental change(s) must be written and discussed with the supervisor. Observation will be made of the completed design while children are in the room.

ERIC

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

SESSION 1 - READINGS

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Philosophy and conceptual framework In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 5-10). Washington, DC: ACCH.

REFERENCES

Smith, B. J., & Strain, P. S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

Gallagher, J.J., Trohanis, P.T., & Clifford, R. M. (Eds.). (1989). Policy implementation & P.L. 99-457: Planning for young children with special needs. Baltimore, MD: Paul Brooks Publishing Company.

ERIC

APPENDIX D

ERIC

Table 1 Participant Demographics for the Rainbow School Infant Curricula Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field	Learning Style
1	Early Childhood Special Education	M.Ed.	Special Education	No	1	2	Converger
2	Occupational Therapist	M.A.	Occupational Therapy	Yes	2.5	12	
3	Early Childhood Special Education	M.S.	Early Childhood Special Education	No	1.5	10	Converger
4	Early Childhood Special Education	B.S.	Special Education	No	3	20	
5	Early Childhood Special Education	M.A.	Special Education	No	.5	3	
6	Social Worker	MSW	Social Work	No	15	20	
7	Supervisor of Early Intervention	BS	Occupational Therapy	Yes	10	10	Diverger
8	Physical Therapist	MS	Physical Therapy	No	5	7	Accommodator

Table 2

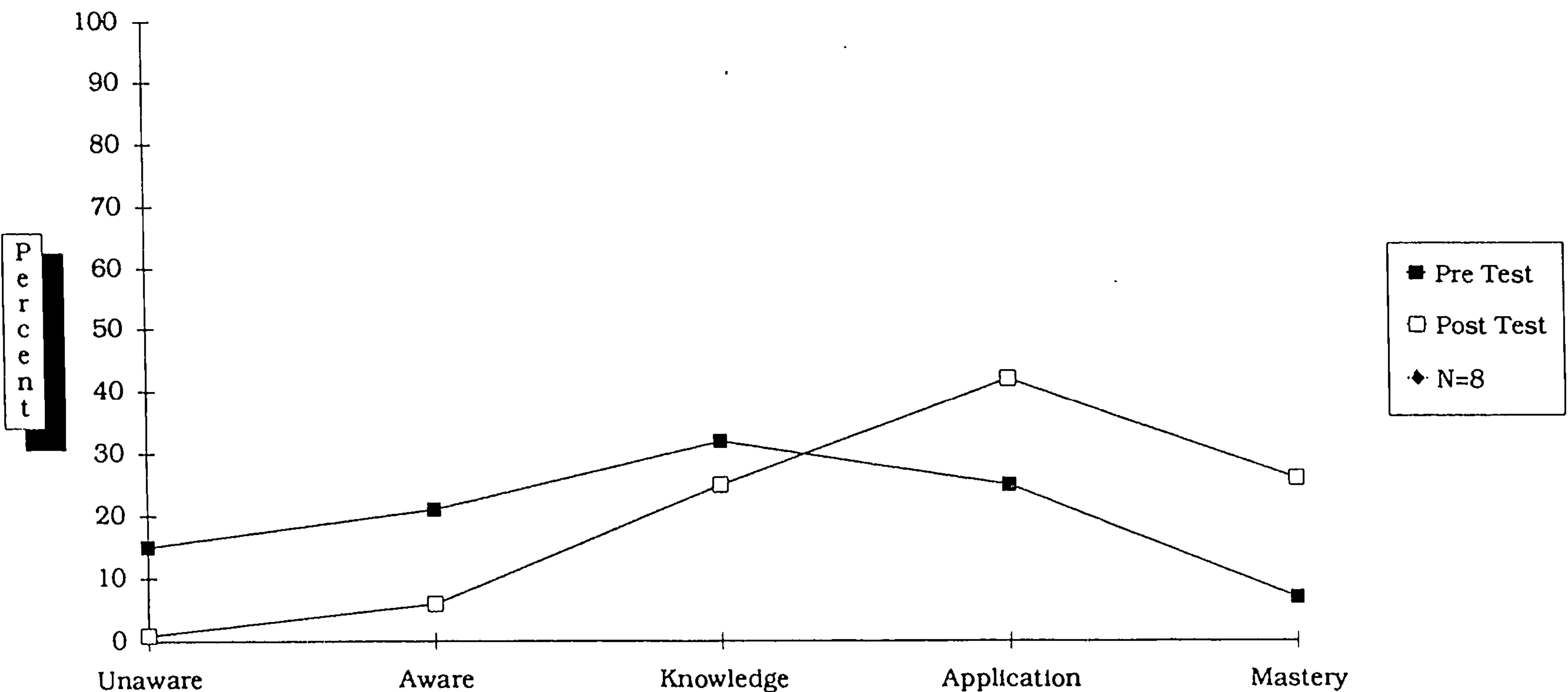

Table 3

BIRTH TO THREE INSERVICE TRAINING PROJECT

UCONN Health Center - Division of Child and Family Studies

Institute Name: Infant Curricula
Program Name: Rainbow Program
Trainer:

ID#	Pre Test	Post Test 1	Post Test 2
1	82%	85%	
2	58%	55%	
3	48%	58%	
4	52%	48%	
5	39%	70%	
6	33%	27%	
7	48%	67%	
8	48%	79%	
Mean Scores	51%	61%	

ERIC

Table 4

Consumer Satisfaction - Rainbow School

I.	CONTENT	
	1.	3.5
	2.	4.25
	3.	4.0
	4.	4.25
	5.	3.9
	6.	3.75
	7.	3.9
II.	PRESENTER	
	1.	4.5
	2.	4.63
	3.	4.38
	4.	4.5
	5.	4.75
III.	LOGISTICS	
	1.	4.63
	2.	4.25
	3.	4.5
	4.	4.38
	5.	3.75

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

Pre/Post test

Name: ______________________________ Date: _______________

1. A program philosophy is important because the program's _________________ should share the same philosophical basis.

   a. assessments

   b. curricula

   c. staff

   d. all of the above

   e. a & b

2. Name two standardized assessments (where results are expressed in standard scores) that are used with the birth to three year old population.

   ____

   ____

3. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a ________________ assessment.

   a. standardized

   b. criterion-referenced

   c. norm-referenced

   d. a & c

4. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

   Screening (list one instrument):

   ____

   Determining Eligibility (list two instruments):

   ______________________________ ______________________________

   Program Planning (list two instruments):

   ______________________________ ______________________________

   Program Evaluation (list one instrument):

   ____

5. When assessing a young child, birth to three years, a standardized, norm-referenced test will give the most accurate picture of what the child can do.

   True   False

6. When writing a report which summarizes the results of a child's assessment, one should include:

   a. the child's age level of functioning in each domain

   b. the scores the child obtained

   c. examples of the skills the child was able to perform

   d. a & b

   e. all of the above

7. The best way to determine child goals is to address the items the child missed on the assessment.

True False

8. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

9. Presenting a child with a task, letting him attempt it independently, then giving more and more assistance until he is successful, is an assistance technique called:

a. graduated guidance

b. least prompts

c. time delay

d. gestural cuing

10. Give three examples of typical activities that occur either in the home or in the classroom and briefly describe how you could address an object permanence objective within each activity. (Continue on back, if necessary.)

____

____

____

____

11. During a weekly home visit, data has to be taken on all IFSP goals.

True False

12. State three criteria that would determine whether a goal is functional when developing a plan for an infant or toddler.

____

____

____

13. List two principles of activity based teaching.

____

____

14. Circle all of the following items that represent best practice intervention strategies for infants/toddlers:

a. scheduling determines when a child has completed an activity.

b. follow the child's cues

c. use direct, one to one teaching

d. use chronologically age appropriate materials

e. structure the environment to promote independence

f. all of the above

ERIC

15. When organizing children for group instruction, they should always be grouped according to developmental levels (i.e., children at same developmental levels together) otherwise it will be impossible to address their individual instructional goals.

True False

16. State one way in which the environment may affect a young child's performance/behavior?

____

____

17. List two published curricula available for use with the birth to three population.

____

____

18. Give four reasons for why a child might not be making progress on an instructional program.

____

____

____

____

Birth to Three Inservice Training Project

Name________________________ Program________________________ Date__________

INFANT CURRICULA: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Infant Curricula institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in
my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. State overall program goals.										
3. Name a minimum of four assessment instruments and their uses with the birth to three year old population.										
4. Choose appropriate assessment instruments for various purposes.										
5. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
6. Communicate assessment results to families and/or other professionals in understandable terms.										
7. Collaborate with families in the development of goals for their children.										
8. Develop functional child goals and objectives from assessment information.										
9. Demonstrate skills in writing functional short term behavioral objectives for children.										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
11. Demonstrate skills in utilizing a variety of teaching techniques with young children including:										
least prompts										
graduated guidance										
incidental teaching										
utilizing naturalistic cues										
arranging the environment to facilitate skill acquisiton										
12. Demonstrate skills in responding to child cues.										
13. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.										
14. Utilize functional activities to address goals and objectives.										
15. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.										
16. Demonstrate skills in providing instruction to groups of children from one to three years of age.										
17. Develop or modify teaching materials to facilitate skill acquisition in children with sensory or physical impairments.										
18. Name two curricular guides for use with children birth to three years of age.										
19. Additional skills desired:										

SAMPLE TASKS

ERIC

PROGRAM TASKS
INFANT CURRICULA INSTITUTE

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, the current program philosophy will be reviewed and updated as determined necessary by the program director and staff.	Must address family involvement, delivery of services and team functioning and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review three (3) developmental assessments including one standardized, for use with the 0-3 population b) choose one assessment (new to student) to administer to two children (one developmentally delayed child and one normally developing child that are of the same chrononlogical age).	 a) Reviews will be completed on a form provided by the instructor and submitted to the instructor for review b) Written score sheets, summaries of the results, and implications for programming must be submitted to the instructor for review.
3) Goal Setting	In collaboration with the family and other members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	The child goals will reflect the needs of the child as identified by the family and the team asessment process. Goals must be reviewed by the instructor.
4) Behavioral Objectives	Based on parent input and results of the child assessment, the student will write two (2) short-term behavioral objectives in each curricular domain (gross motor, fine motor, cognition, communication, self-help, social). The objectives will include the following components: a) critical behaviors that are specified in operational terms b) criteria for achievement c) functional activities in which they will occur	Written objectives will be reviewed by, discussed with, and approved by the instructor.

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Teaching Procedures/ Instructional Delivery	Given individual, small group, and large group instructional responsibilities, the student will demonstrate effective instructional delivery and teaching procedures. Delivery should: a) adhere to the infant's schedule b) utilize task presentation delineated in instructional program adjusting for unforeseen circumstances (task presentation includes arrangement of the environment to promote skill acquisition) c) utilize appropriate pacing of activity responding to child cues d) systematically incorporate multiple domains into a single activity e) choose appropriate activities for group instruction f) utilize appropriate techniques to manage behavior instruction g) include a written program, data collection and current data summary Teaching procedures should: a) sample a variety of stimulus presentation formats (imitation, match to sample, errorless learning) b) utilize a variety of assistance and reinforcement techniques.	The instructor will evaluate the appropriateness of instructional delivery and teaching procedures through observation. A minimum of two (2) observations will be made. Written feedback will be provided.

ERIC

DESCRIPTION	PROGRAM TASK	CRITERIA
6) Activities Matrix	The student will: a) Choose five (5) routines that occur during an infant's typical day (either home or classroom). Examples include: arrival, departure, mealtime, art, circle, diapering/toileting. b) For each of the five routines, develop and describe one (1) activity that will enhance development and that can naturally be implemented as part of the routine. c) Address how example goals from each domain (gross motor, fine motor, cognition, self-help, social) can be incorporated into the activities.	The matrix will be submitted to and approved by the instructor.
7) Environmental Designs	The staff either individually or in small groups will identify at least one environmental change in the classroom that can be made to enhance the learning of the children in the classroom.	Rationale for the environmental change(s) must be written and discussed with the supervisor. Observation will be made of the completed design while children are in the room.

APPENDIX E

ERIC

Table . / Participant Demographics for the BOCES II Transdisciplinary Teaming Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field	Learning Style
1	Speech Pathology	M.S., CCC, SLP	Speech Pathology	No	4	12	
2	Occupational Therapy	B.S.	Occupational Therapy	Yes	10	12	
3	Speech Pathologist	M.S.	Speech Pathology	No.	5	8	
4	Early Childhood Special Educator	M.S.	Early Childhood Education Hearing Impaired	Yes	22	22	
5	Social Worker	MSW	Social Work	No	5	5.5	
6	Early Childhood Special Educator	MS	Special Education	No	5	13	
7	Administrator of Special Education	M.Ed.	Special Education/ Administration	No	6	6	

Table 2

Boces II Transdisciplinary Teaming Institute - Participant responses to "where I am" on self rating scale skills

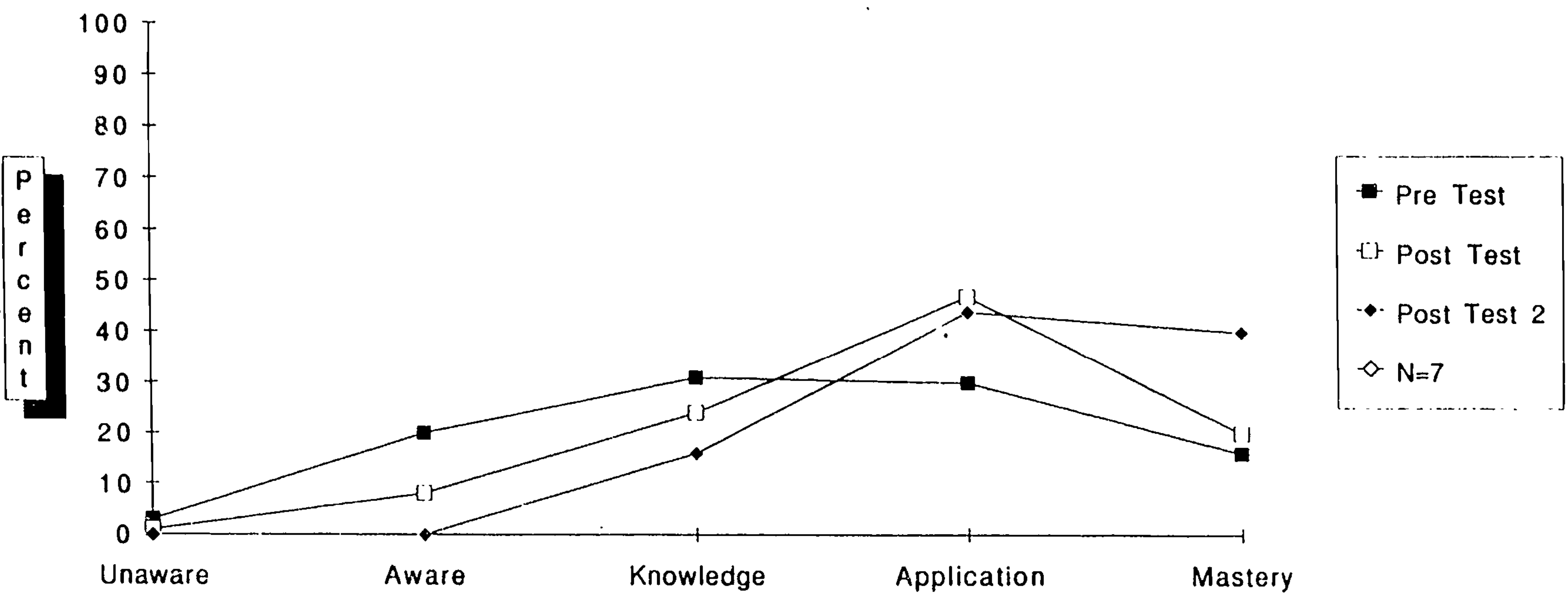

Table 5

Pre,post test 1 and post test 2 scores for individual participants from the BOCES II Infant Program Transdisciplinary Teaming Institute

Participant #	Pre Test	Post Test 1	Post Test 2
1	73%	88%	82%
2	70%	94%	85%
3	57%	79%	91%
4	51%	91%	91%
5	67%	82%	78%
6	61%	82%	82%
7	82%	91%	88%
Mean Scores	66%	87%	85%

ERIC

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

TRANSDISCIPLINARY TEAMING

SESSION 1 - AGENDA

TIME	TOPIC	FORMAT
10 mins.	Logistics	
20 mins.	Program Philosophy	Lecture/Discussion
20 mins.	Overview of Teams	Lecture/Discussion
30 mins.	Team Models	Lecture/Discussion
10 mins.	Break	
30 mins.	UCP Team Model	Group Activity

ERIC

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

TRANSDISCIPLINARY TEAMING

SESSION 1 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify the importance of having a program philosophy.
2. understand the differences between the three most common team models used in early intervention programs.
3. have described their program's current team model.
4. be able to identify the major features of the transdisciplinary team model.

ERIC

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center--Division of Child and Family Studies

TRANSDISCIPLINARY TEAMING

SESSION 1 - READINGS

Holm, M. D., & McCartin, R. (1978). Team functioning and staff development. In M. D. Holm & R. McCartin (Eds.), Early intervention: A team approach (pp. 102-103). Baltimore: University Park Press.

Lyon, S., & Lyon, G. (1980). Team functioning and staff development: A role release approach to providing integrated educational services for severely handicapped students. Journal of the Association for Persons with Severe Handicaps, 5(3), 250-263.

REFERENCES

United Cerebral Palsy, National Organized Collaborative Project to Provide Comprehensive Services for Atypical Infants & Their Families. (1976). Staff development handbook: A resource for the transdisciplinary process. New York: United Cerebal Palsy Association.

McGonigel, M. J., & Garland, C. W. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. Infants and Young Children, 1(1), 10-21.

SAMPLE TASKS

ERIC

PROGRAM TASKS

Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Philosophy statement must be submitted to and discussed with the instructor and must be adopted by the student's program.
2) Current Team Model	The student will identify his or her current team model and will describe: a) members of the team (i.e., background and training, percentage of time spent with program) b) roles and responsibilities of team members (include how instruction and therapy are provided) c) frequency and length of team meetings d) purposes of team meetings e) structure of assessments f) development of instructional goals g) barriers to transdisciplinary teaming	The description of the team model must address the components delineated in the program task and must be submitted to and discussed with the instructor.
3) Policies and Procedures	The student, in collaboration with the members of his or her team, will develop policies and procedures for the implementation of a transdisciplinary model. The following issues should be addressed: a) team members b) system of communication c) meetings d) assessment e) writing plans/goals f) training others g) implementation of programming	The policies and procedures must address the issues delineated in the program task, be approved by the instructor, and be adopted by the student's program.

PROGRAM TASKS
Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
4) Assessment	a) The student will observe a minimum of two physical therapy assessments, two occupational therapy assessments, two speech therapy assessments, and two educational assessments administered to children under the age of three years. (The student does not have to observe the assessments in his or her own discipline.)	a) The observations will be documented and discussed with the instructor.
	b) The student, in collaboration with at least one other member of his or her team, will conduct joint assessments on a least two (2) children utilizing assessments that address all areas of development.	b) Written results of the assessment must be submitted in report form with the following components included: - history/background of child - behavioral observations - results of assessment in all developmental areas - recommendations for programming Report must be approved by the instructor.
5) Team Meetings	The student will coordinate four (4) regularly scheduled team meetings following the program's policies and procedures. Responsibilities include: a) notifying all team members b) ensuring there is a written agenda c) ensuring there is a meeting facilitator d) ensuring there is a meeting recorder e) ensuring the minutes are distributed to all who attended the meeting as well as those who were absent At least two (2) of the team meetings must be for the purpose of determining goals for the children assessed in Task #4.	All responsibilities delineated in the program task must be successfully completed. The instructor will attend a minimum of two (2) team meetings that are coordinated by the student and outcomes will be discussed.

PROGRAM TASKS
Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) Goal Development	The goals developed through the team meeting must: a) include goals across disciplines b) address the child and family needs c) specify behavior in operational terms d) include criteria for achievement e) specify conditions under which the behavior will occur f) address generalization and maintenance of skills.	The goals must address the components delineated in program tasks, be approved by members of the team and submitted to and approved by the instructor.
7) Instructional Programs	The student will write at least two (2) instructional programs for each of the two children from the previous tasks. The programs must include the following components: a) a statement of the instructional objective that includes: - behaviors specified in operational terms and that incorporate skills from more than one discipline - criteria for achievement - conditions under which the behaviors will occur b) task analysis of instructional sequence delineating components.	The written documentation of the instructional programs must include the components delineated in the program task and, in addition, the student must submit progress data which will be discussed with the instructor.

APPENDIX F

ERIC Full Text Provided by ERIC

Table 1 Participant Demographics for the UCP Westchester Transdisciplinary Teaming Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field	Learning Style
1	Chief, Speech Pathology	M.S., CCC, SLP	Speech Pathology	No	1	11	Diverger
2	Early Childhood Special Education	M.S.	Special Education	Yes	1	8	Accommodator
3	Social Worker	M.S.	Social Work	No	10	23	Diverger
4	Occupational Therapist	M.S.	Occupational Therapy	Yes	10	18	Accomodator
5	Speech Pathologist	M.A. CCC, SLP	Speech Pathology	No	2.5	2.5	Converger
6	Teaching Assistant	Associate		No	1	2	Assimilator
7	Special Education Administrator	Post Masters	Administrative Counseling	Yes	1	10	

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Table 2

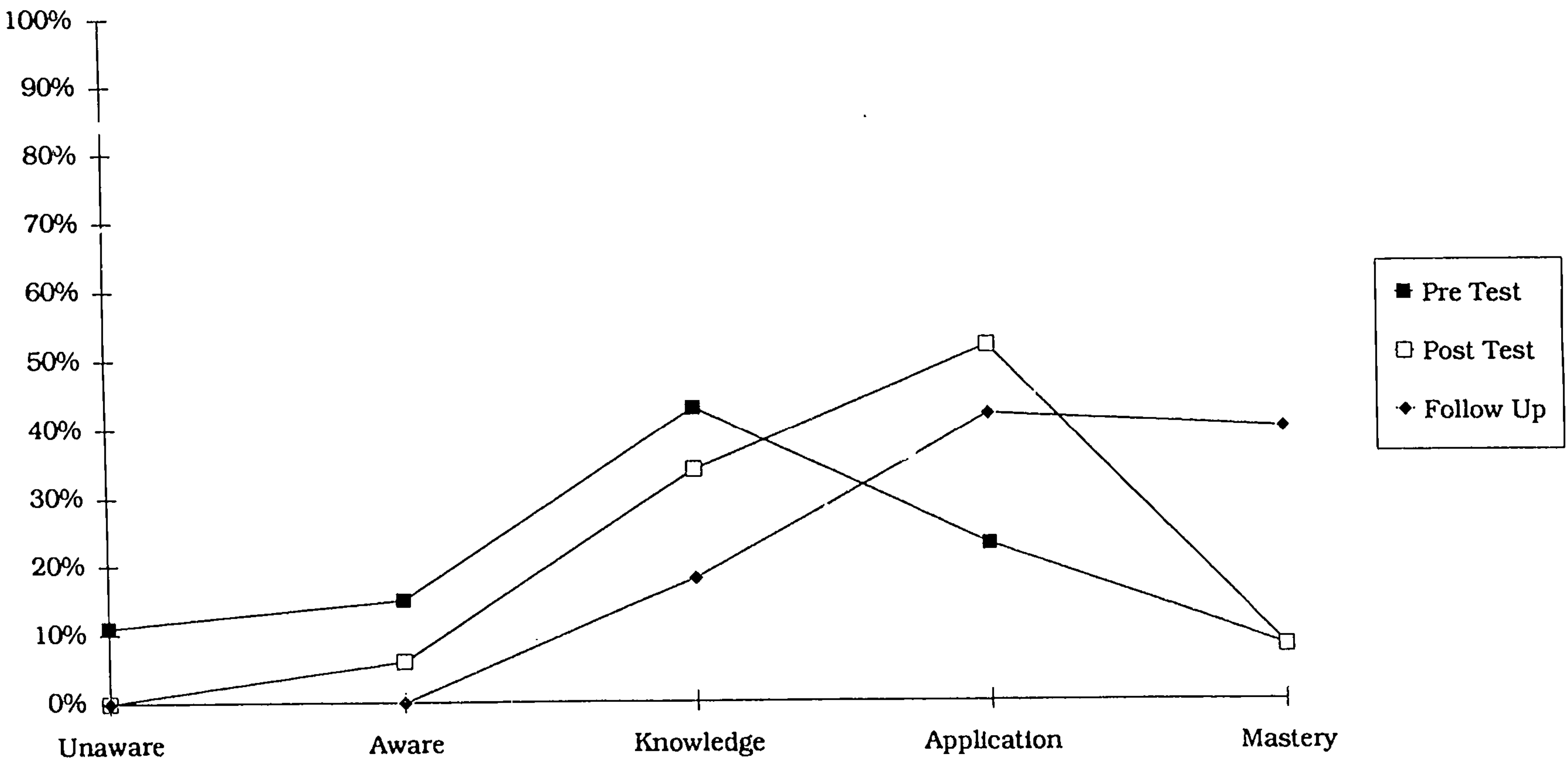

Table 3

Pre, post 1 and post 2 test scores for individual participants from the Westchester UCP Transdisciplinary Teaming Institute.

Participant #	Pre Test	Post Test 1	Post Test 2
1	52%	97%	82%
2	24%	73%	64%
3			
4	64%	85%	88%
5	58%	88%	79%
6			
7	67%	76%	79%
Mean Scores	52%	84%	78%

Table 4

Consumer Satisfaction - UCP Westchester

I.	CONTENT	
	1.	4.86
	2.	4.71
	3.	5.0
	4.	5.0
	5.	4.3
	6.	5.0
	7.	5.0
II.	PRESENTER	
	1.	5.0
	2.	4.86
	3.	4.71
	4.	4.86
	5.	4.86
III.	LOGISTICS	
	1.	4.57
	2.	4.86
	3.	5.0
	4.	5.0
	5.	4.86

ERIC

UCONN HEALTH CENTER- DIVISION OF CHILD AND FAMILY STUDIES
BIRTH TO THREE INSERVICE TRAINING PROGRAM

TRANSDISCIPLINARY TEAMING PRE/POST TEST

Name: ______________________________ Date: ____________

1. Name the three most commonly utilized team models with a brief definition of each.

____
____
____
____
____
____
____
____
____
____
____
____

2. In the transdisciplinary team model, each team member separately conducts their own assessments and then share their program plans with one another.

True False

ERIC

3. A philosophy that guides the transdisciplinary team model is:

   a. Team members recognize the importance of contributions from other disciplines.

   b. Team members teach, learn, and work together across discipline boundaries to implement unified service plans.

   c. Team members are willing and able to develop, share and be responsible for providing services that are part of the total service plan.

   d. None of the above

4. It is possible to implement the transdisciplinary team model in one part of an early intervention program (e.g. in the intervention process) but not implement it in other parts of an early intervention program (e.g. in the assessment process).

   True False

5. Direct therapy for children is not part of the transdisciplinary model.

   True False

6. List three factors that influence team effectiveness:

   ____

   ____

   ____

7. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

   True False

ERIC

8. List four purposes for assessing young children.

____
____
____
____

9. The best way to determine child goals is to address the items the child missed on the assessment.

True False

10. What are the four components of a behavioral objective?

____
____
____
____

11. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

12. Presenting a child with a task, letting him attempt it independently, then giving more and more assistance until he is successful, is an assistance technique called:

a. graduated guidance

b. least prompts

c. time delay

d. gestural cuing

13. Describe one barrier to transdisciplinary teaming in each of the three categories listed below:

1. Professional Barrier ______________________________
____

2. Interpersonal Barrier ______________________________
____

3. Administrative Barrier ______________________________
____

14. Describe how you would functionally address the following 3 objectives for a two year old child who is developmentally delayed, during snack.
    1. Child will voluntarily release small objects into a containter.
    2. Child will communicate his want for an object by looking at or reaching for one when given a choice of two or more objects.
    3. Child will use 3 simple objects functionally.

____
____
____
____
____
____
____
____
____
____
____
____
____

15. Name two ingredients that contribute to an effective team meeting.

____
____

ERIC

Birth to Three Inservice Training Project

Name____________________ Program____________________ Date__________

TRANSDISCIPLINARY TEAMING: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Transdisciplinary Teaming institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it, but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. Demonstrate understanding of the characteristics of multidisciplinary, interdisciplinary, and transdisciplinary teams.										
3. Describe own team structure.										
4. Describe program's policies and procedures relating to team functioning (e.g., team members, system of communication,meetings, assessment, writing plans/ goals, training others, program implementation).										
5. Conduct transdisciplinary assessments.										
6. Demonstrate skills in administering assessments to young children: through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing results of assessments										
8. Plan a team meeting, including: formulating an agenda										
contacting participants										
preparing families										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
8. Facilitate a team meeting, including:										
following the agenda										
ensuring opportunity for participation of all members										
ensuring minutes are taken and distributed										
9. Demonstrate good communication skills with families and professionals including:										
effective listening (eye contact, silence, paraphrase)										
effective inquiry (open-ended questions, silence)										
effective reflection of feeling ("I hear you saying...")										
effective reflection of content (paraphrase)										
10. Communicate assessment results to families and/or other professionals in understandable terms.										
11. Prepare families for their role in team meetings.										
12. Develop child and family goals as a team.										
13. Demonstrate skills in writing functional behavioral objectives for children across disciplines.										
14. Write instructional programs that incorporate skills from more than one discipline.										
15. Conduct instructional programs within naturally occuring activities that incorporate skills from more than one discipline.										
16. Share knowledge and skills of own discipline with other team members.										
17. Learn knowledge and skills from other team members.										
18. Demonstrate skills in training staff on various aspects of transdisciplinary teaming.										
19. Additional skills desired: (please write in any skills you would like to improve.) ____ ____ ____										

PEDIATRIC RESEARCH AND TRAINING CENTER
UCONN HEALTH CENTER - DIVISION OF CHILD AND FAMILY STUDIES
BIRTH TO THREE INSERVICE TRAINING PROJECT

CONSUMER SATISFACTION SHEET
INSTITUTE FOLLOW UP

Name: ________________ Date: ____________________
Agency: _______________ Institute: _______________

Please rate the following statements on a scale of 1 through 5:

1 indicating that you strongly disagree with the statement,
2 indicating that you mildly disagree with the statement,
3 indicating neutral,
4 indicating that you mildiy agree with the statement,
5 indicating that you strongly agree with the statement.

	Strongly Disagree		Neutral		Strongly Agree
TASKS					
1. The tasks were related to the course content. Please list any which were not related.	1	2	3	4	5
2. The tasks were relevant to my present job situation.	1	2	3	4	5
3. The tasks were individualized to meet my needs.	1	2	3	4	5
4. There was adequate support provided to complete the tasks.	1	2	3	4	5
5. The tasks were easy to accomplish.	1	2	3	4	5
6. The tasks enabled me to perform better at my job.	1	2	3	4	5

UConn Health Center - Division of Child and Family Studies

Birth to Three Inservice Training Project

TRANSDISCIPLINARY TEAMING INSTITUTE

	Content	Format
Session 1:	Introductions	
	Program Philosophy	Lecture/Discussion
	Team Models	Lecture
	Overview of Participants' Team Models	Discussion
	Transdisciplinary Model	Lecture
Session 2:	Review Session 1	
	Dynamics of Teams	Lecture/Discussion
	Applications of Trans. Model	Lecture/Discussion
	Team Meetings	Lecture/Discussion
Session 3:	Review Session 2	
	Overview of Assessments	Lecture/Discussion
	Transdsiciplinary Team Assess.	Lecture/Discussion
	Sharing Assessment Results	Lecture/Discussion
	Mechanics of Writing Goals & Objectives	Lecture/Discussion
	Practice Writing Goals/Obj.	Group Activity
Session 4:	Review Session 3	
	Instructional Programs	Lecture/Discussion
	Case Study: Writing Instructional Programs	Group Activity
	Barriers to Implementing Transdisciplinary Model	Discussion
	Strategies to Overcome Barriers	Discussion

APPENDIX G

ERIC

Table 1

Participant Demographics for the Sullivan Diagnostic Treatment Center IFSP Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field	Learning Style
1	Speech Pathologist	MA, CCC-SLP	Speech Pathology	No	9	9	Assimilator
2	Early Childhood/ Special Education	BS	Early Childhood/ Elementary Ed.	Yes	4	10	Diverger
3	Social Worker	MSW	Social Work	No	15	25	Diverger
4	Senior Teacher Assistant	AAS	Early Childhood	Yes	20	20	Diverger
5	Director of Staff Training/ Infants	Post Masters	Special Education	Yes	6	8	Diverger
6	Adaptive Physical Education Teacher	MS	Elementary Education	Yes	2	6	Diverger

ERIC Full Text Provided by ERIC

Table 2

Sullivan Diagnostic Treatment Center - IFSP Institute - Participant responses to "where I am" on self rating scale skills

Table 3

Pre-post test scores for individual participants from the Sullivan Diagnostic Treatment Center IFSP Institute

Participant #	Pre Test	Post Test
1	63%	88%
2	54%	90%
3	46%	83%
4	41%	59%
5	56%	76%
6	41%	73%
Mean Scores	50%	78%

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UConn Health Center -- Division of Child and Family Studies

INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	"Family Centered Care"	Film
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
	Why We Assess Families	Lecture/Discussion
	Types & Methods of Family Assessment	Lecture/Discussion
Session 2:	Overview of Communication & Interview Skills	Lecture/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Group Activity
	Overview of Child Assessments	Lecture
Session 3:	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Mock Situation	Group Activity
	Review Components of IFSP	Group Participation
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
Session 4:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

APPENDIX H

ERIC

Table 1
Participant demographics from the East River Child Development Center Transdisciplinary Teaming Institute

Participant Number	Position	Highest Degree	Area of Certification	Any Formal B - 3	Years 0 - 3	Years Teaching	Type of Previous Experience
1	Physical Therapy	MA	Physical Therapy	No	4	25	3-5 ei
2	Social Work Assistant	none		No	2	2	3-5 ei
3	Early Childhood Special Education	BA	Early Childhood Special Education	No	2	5	Mix of Special Ed & Regular Education
4	Social Worker	BA	Social Work	No	1	2	3-5 ei
5	Classroom Assistant	none		No	1	1	
6	Psychologist	PHD	Psychology	Yes	3	40	Mix of Special Ed & Regular Education
7	Occupational Therapy	MA	Occupational Therapy	Yes	7	10	Mix of Special Ed & Regular Education

Table 2
Pre-post test scores for individual participants from the EAST RIVER CHILD DEVELOPMENT CENTER TRANSDISCIPLINARY TEAMING INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
1	48%	81%	82%
2	45%	75%	73%
3	30%	84%	88%
4	9%	56%	48%
5	24%	67%	73%
Mean	**31%**	**73%**	**73%**

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Table 3

Mean scores across participants from the East River Child Development Center Transdisciplinary Teaming Institute for each item on the consumer satisfaction survey .

ITEM	Mean Scores
Objectives Met	3.2
Topics Covered	3
Relevant Material	3.8
Adequate Illustration	3.4
Time Organized	2.2
Information Relevant to Work	3.8
Better Understanding of Subject	4
Presenter Prepared	3.8
Presenter Knowledgeable	4.2
Presenter Used Activities	3.8
Presenter Easy to Listen to	4.2
Presenter Valued Input	4.4
Environment Comfort	4.2
Adequate Breaks	3.4
Good Group Size	3.6
Good Location	4.2
Good Day and Time	3.8

*Participants rated on a Liekart Scale (1=Strongly Disagree - 5=StronglyAgree) their satisfaction with the institute.

East River Child Development Center

July 29, 1992
9:00AM-12:00PM

TEAMING WORKSHOP

AGENDA

9-9:15 I. Introductions

-10:00 II. What is a Team? Discussion/Activity

Started by doing a scavenger hunt. Broke participants into groups of 5 people. Each group was given a list of 10 items and asked to go find them. They had to bring each thing on the list back within 10 minutes. When they returned we had a great discussion about the process and then tied it into their day to day work.

-10:15 III. Types of Teams Lecture

-10:30 BREAK

-11:15 IV. Team Development Lecture/Discussion

Did much on activity base instruction here as that was what they really needed to know. In future sessions spend time talking more about specific examples related to Trans Teaming and this approach. Break down routines and activities and give examples of how each routine can be used to teach across disciplines.

-12:50 V. Reflecting on your Team Activity

Yardstick for team growth form was dissmentinated and they filled it out on their own. Based on the results, we discussed future need of the teams.

-12:00 VI. Wrap Up

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EAST RIVER CHILD DEVELOPMENT CENTER

WORKSHOP

7-29-92

At the end of the training session participants reviewed and completed the yardstick of team growth tool that was disseminated in their packets. Using this tool and the morning's discussions we brainstormed a list of areas that they felt they would like to have some follow up in. These areas included:

Goal Clarity
Team Meetings
how to keep agenda, minutes, what to focus on in meetings.
Time Management
Including families
Communication
Activity Based Instruction and Goal Writing

One participant suggested that maybe they could focus as a large group on some of the broader issues of team functioning first such as goal clarity, and then each individual team as they become more effective can identify specific skills they would like polishing up on.
This seemed to be agreeable and I will talk to Glen in September after they have had vacation and time to discuss the next step.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

TRANSDISCIPLINARY TEAMING INSTITUTE

	Content	Format
Session 1:	Introductions	
	Program Philosophy	Lecture/Discussion
	Team Models	Lecture
	Overview of Participants' Team Models	Discussion
	Transdisciplinary Model	Lecture
Session 2:	Dynamics of Teams	Lecture/Discussion
	Applications of Trans. Model	Lecture/Discussion
	Team Meetings	Lecture/Discussion
Session 3:	Overview of Assessments	Lecture/Discussion
	Transdsiciplinary Team Assess.	Lecture/Discussion
	Sharing Assessment Results	Lecture/Discussion
	Mechanics of Writing Goals & Objectives	Lecture/Discussion
	Practice Writing Goals & Objectives	Group Activity
Session 4:	Instructional Programs	Lecture/Discussion
	Case Study: Writing Instructional Programs	Group Activity
	Barriers to Implementing Transdisciplinary Model	Discussion
	Strategies to Overcome Barriers	Discussion

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

Transdisciplinary Teaming Institute

The objectives of the Transdisciplinary Teaming Institute are based on the knowledge and skills needed to develop and implement the transdisciplinary team model. Through the course of the institute, the participants apply the knowledge and skills in their home program by completing competencies. These competencies relate directly to the objectives of the institute. The general goals of the institute are as follows:

Each participant will:

1) ensure that the program has a written philosophy that includes a statement on teaming;
2) identify their program's current team model;
3) develop policies and procedure for the implementation of a trandisciplinary team model in regards to: team members, system of communication, meetings, assessment, development of goals and objectives, training others and the implementation of goals and objectives;
4) observe professionals from other disciplines assessing infants and toddlers and demonstrate the ability to conduct a joint assessment with at least one other team member;
5) facilitate team meetings, including formulating agendas, delineating roles and responsibilities and preparing families for their role in the meeting;
6) work collaboratively with team members to determine child goals and objectives that include all encessary components and reflect the needs ofthe child;
7) develop instructional programs that incorporate skills from more than one area of development;
8) implement goals and objectives delineated in the instructional programs through functional activities carried out in the home or center-based program.

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PROGRAM TASKS
Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Philosophy statement must be submitted to and discussed with the instructor and must be adopted by the student's program.
2) Current Team Model	The student will identify his or her current team model and will describe: a) members of the team (i.e., background and training, percentage of time spent with program) b) roles and responsibilities of team members (include how instruction and therapy are provided) c) frequency and length of team meetings d) purposes of team meetings e) structure of assessments f) development of instructional goals g) barriers to transdisciplinary teaming	The description of the team model must address the components delineated in the program task and must be submitted to and discussed with the instructor.
3) Policies and Procedures	The student, in collaboration with the members of his or her team, will develop policies and procedures for the implementation of a transdisciplinary model. The following issues should be addressed: a) team members b) system of communication c) meetings d) assessment e) writing plans/goals f) training others g) implementation of programming	The policies and procedures must address the issues delineated in the program task, be approved by the instructor, and be adopted by the student's program.

PROGRAM TASKS
Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
4) Assessment	a) The student will observe a minimum of two physical therapy assessments, two occupational therapy assessments, two speech therapy assessments, and two educational assessments administered to children under the age of three years. (The student does not have to observe the assessments in his or her own discipline.)	a) The observations will be documented and discussed with the instructor.
	b) The student, in collaboration with at least one other member of his or her team, will conduct joint assessments on a least two (2) children utilizing assessments that address all areas of development.	b) Written results of the assessment must be submitted in report form with the following components included: - history/background of child - behavioral observations - results of assessment in all developmental areas - recommendations for programming Report must be approved by the instructor.
5) Team Meetings	The student will coordinate four (4) regularly scheduled team meetings following the program's policies and procedures. Responsibilities include: a) notifying all team members b) ensuring there is a written agenda c) ensuring there is a meeting facilitator d) ensuring there is a meeting recorder e) ensuring the minutes are distributed to all who attended the meeting as well as those who were absent At least two (2) of the team meetings must be for the purpose of determining goals for the children assessed in Task #4.	All responsibilities delineated in the program task must be successfully completed. The instructor will attend a minimum of two (2) team meetings that are coordinated by the student and outcomes will be discussed.

PROGRAM TASKS

Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) Goal Development	The goals developed through the team meeting must: a) include goals across disciplines b) address the child and family needs c) specify behavior in operational terms d) include criteria for achievement e) specify conditions under which the behavior will occur f) address generalization and maintenance of skills.	The goals must address the components delineated in program tasks, be approved by members of the team and submitted to and approved by the instructor.
7) Instructional Programs	The student will write at least two (2) instructional programs for each of the two children from the previous tasks. The programs must include the following components: a) a statement of the instructional objective that includes: - behaviors specified in operational terms and that incorporate skills from more than one discipline - criteria for achievement - conditions under which the behaviors will occur b) task analysis of instructional sequence delineating components.	The written documentation of the instructional programs must include the components delineated in the program task and, in addition, the student must submit progress data which will be discussed with the instructor.

Westchester Institute for Human Development
Family Support/Early Intervention

Birth to Three Inservice Training Project

TRANSDISCIPLINARY TEAMING INSTITUTE

	Content	Format
Session 1:	Team Models - Overview	Lecture/Discussion
	Program Philosophy	Lecture/Discussion
	"Family Centered Care"	Video
Session 2:	Team Dynamics - Overview	Lectures/Discussion
	Intake Protocol - Development	Group Activity
	"Joining Forces"	Video
Session 3:	Assessment - Overview	Lecture/Discussion
	Arena Evaluation	Lecture/Discussion
	"Arena Assessment"	Video/Activity
	Integrated Reports	Discussion
	Assessment Protocol - Development	Group Activity
Session 4:	Play-Based Assessment - Overview	Lecture/Discussion
	"Melissa" - Sample Battelle Assessment	Video
	Assessment Protocol - Development	Group Activity
Session 5:	Summary	Lecture/Discussion
	Follow - Up Scheduling	Discussion
	Post Data	

Birth to Three Inservice Training Project

Name:________________________ Program:________________________ Date:________

Teaming: Self Rating Scale

Below are the basic competencies that you will have the opportunity to gain through participation in this institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to achieve for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

AW = Awareness. I have heard about, but don't know it's full scope such as it's principles, components, applications and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	A	M	U	AW	K	A	M
1. State program philosophy.										
2. Demonstrate understanding of the characteristics of multidisciplinary, interdisciplinary, and transdisciplinary teams.										
3. Describe own team structure.										
4. Describe program's policies and procedures relating to team functioning (e.g., team members, system of communication, meetings, assessment, writing plans/goals, training others, program implementation).										
5. Conduct transdisciplinary assessments.										
6. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing an integrated assessment report										
8. Plan a team meeting, including:										
formulating an agenda										
contacting participants										
preparing families										

Participant will:	Where I Am					Where I Want To Be				
	U	Aw	K	A	M	U	Aw	K	A	M
9. Facilitate a team meeting, including:										
following the agenda ______										
ensuring opportunity for participating of all members______										
ensuring minutes are taken and distributed______										
10. Communicate assessment results to families and/or other professionals in understandable terms.										
11. Including families in team meetings.										
12. Develop child and family goals as a team, with families										
13. Demonstrate skills in writing functional behavioral objectives for children across disciplines.										
14. Demonstrate sills in determining family concerns, priorities and resources.										
15. Share knowledge and skills of own discipline with other team members.										
16. Learn knowledge and skills from other team members.										
17. Additional skills desired: (please write in any skills you would like to improve). ______ ______ ______										

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FAMILY SUPPORT/EARLY INTERVENTION
WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
NEW YORK MEDICAL COLLEGE

BIRTH TO THREE INSERVICE TRAINING PROGRAM

TEAMING PRE/POST QUESTIONNAIRE

Name: ______________________________ Date: ____________

1. Name the three most commonly utilized team models with a brief definition of each.

____
____
____
____
____
____
____
____
____
____
____
____

2. In the transdisciplinary team model, each team member separately conducts their own assessments and then shares their program plans with one another.

True False

3. A philosophy that guides the transdisciplinary team model is:

a. Team members recognize the importance of contributions from other disciplines.

b. Team members teach, learn, and work together across discipline boundaries to implement unified service plans.

c. Team members are willing and able to develop, share and be responsible for providing services that are part of the total service plan.

d. None of the above

4. It is possible to implement the transdisciplinary team model in one part of an early intervention program (e.g. in the intervention process) but not implement it in other parts of an early intervention program (e.g. in the assessment process).

True False

5. Direct therapy for children is not part of the transdisciplinary model.

True False

6. List three factors that influence team effectiveness:

____

____

____

7 When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

True False

8. The best way to determine child goals is to address the items the child missed on the assessment.

True False

9. The following is a good example of how *functional* goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

10. Name two ingredients that contribute to an effective team meeting.

____

____

11. Which of the following statements are rationales for collaborative goal setting with families?

a.) Families will cooperate more readily when professionals determine goals and then share them.

b.) Relationships, trust and respect will be improved.

c.) Ownership of goals is an important factor in accomplishing them.

1.) a,c
2.) b,c
3.) a,b
4.) all of the above

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12. Goals that address needs prioritized by the family should always be included in the IFSP.

True False

13. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a day care for Peter."

True False

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BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
MRI/INSTITUTE FOR HUMAN DEVELOPMENT
NEW YORK MEDICAL COLLEGE

REGISTRATION FORM

Name: ______________________________
(Print name as you wish it to appear on certificate)

Address: ______________________________
Street

____
City State Zip Code

Phone: ____________________

Work Address: ______________________________
Street

____
City State Zip Code

Phone: ____________________

Position: ______________________________

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BIRTH TO THREE INSERVICE TRAINING PROJECT

PARTCIPANT INFORMATION

NAME: ______________________________

AGENCY: ______________________________

DATE: ______________ INSTITUTE: ______________

Have you been to a Birth to Three Inservice training before? __________
If yes, when? ______________

What is your current position?

______ Early Childhood Special Educator
______ Occupational Therapist
______ Physical Therapist
______ Speech Pathologist
______ Nurse
______ Administrator/Supervisor/Coordinator of Special Education
______ Administrator/Supervisor/Coordinator of Early Intervention
______ Administrator/Supervisor/Coordinator of Day Care
______ Nursery School/Day Care Teacher
______ Consultant
______ Guidance Counselor
______ Learning Disabilities Teacher
______ Psychologist
______ Social Worker
______ Other ______________________

Who do you serve?

_______ 0-18 month old children

_______ 18 months-3 year old children

_______ parents and families

What are the types of disabilities of children you serve?

_______	mild/moderate MR	_______	severe/profound MR
_______	multihandicapped	_______	physical handicaps
_______	blind	_______	deaf/blind
_______	hearing impaired	_______	learning disabled
_______	developmental delays	_______	emotionally disturbed
_______	medically involved	_______	behavior disordered
_______	speech and language delayed	_______	other _______

What is your current degree?

_______	BA	_______	BS	_______	MA
_______	MS	_______	M.Ed.	_______	6th year cert.
_______	MSW	_______	Ed. D.	_______	Post Masters
_______	Ph.D	_______	RN	_______	C.C.C.-SLP

_______ Other _______________________

ERIC

What is the area of your Certification/License?

_______	Early Childhood Ed.	_______	Early Childhood Special Ed.
_______	PT	_______	OT
_______	Special Education	_______	Psychology
_______	Blind/Visually Impaired	_______	Administration
_______	Elementary Ed.	_______	Reading
_______	Learning Disabilities	_______	Speech Pathology
_______	Counseling	_______	Social Work
_______	Nursing	_______	Hearing Impaired

Have you had any formal training focusing on the birth to three population? ____ yes ____ no

How long have you been serving 0-3 olds? ________________

How long have you been teaching or working in your field? ________________

What types of previous experience have you had?

_______ 3-5 year olds - Early Intervention
_______ Primary Special Ed.
_______ Adolescents/Adults - Special Ed.
_______ 0-5 typical children
_______ Elementary Regular Ed.
_______ Secondary Regular Ed.
_______ Other Education
_______ Other (Please List) ____________________________

Have you had any training during the past two years on this institutes' topic? ______________

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
MOTIVATION QUESTIONNAIRE

Name: ______________________ Date: ______________

1. Please rate each of the following reasons for attendance on a scale of 1 to 3 according to its importance in your decision to attend the Birth To Three Inservice Training Project.

   Circle 1 if the statement was not a consideration.

   Circle 2 if the statement was somewhat important in your decision to attend.

   Circle 3 if the statement was very important in your decision to attend.

   In addition, please star the reason or reasons that were primary in your decision to attend (choose from those you rated a 3).

Reason	Not at All Important	Somewhat Important	Very Important
To become better informed about early intervention in general.	1	2	3
To become better informed about transdisciplinary teaming.	1	2	3
For personal enjoyment and enrichment.	1	2	3
To learn for the sake of learning.	1	2	3
Because CEUs were available.	1	2	3
To help get a new job.	1	2	3
To help to advance in present job.	1	2	3

Reason	Not at All Important	Somewhat Important	Very Important
To better understand and work toward solution of community problems.	1	2	3
To meet new people.	1	2	3
Because the location was convenient.	1	2	3
Because it was free of charge.	1	2	3
To keep my job.	1	2	3
Because my supervisor recommended it.	1	2	3
Because my supervisor required it.	1	2	3
Because I expect the information to be useful for my job.	1	2	3
To get away from job requirements and get "recharged."	1	2	3

Other (Please specify.) ____________________

2. Please rate each of the following issues that may have been problematic in arranging your attendance on a scale of 1 to 3.

Circle 1 if the statement was not a consideration.

Circle 2 if the statement was somewhat problematic.

Circle 3 if the statement was very problematic in arranging your attendance.

Issue	Not at All Problematic	Somewhat Problematic	Very Problematic
Attending once a week for four to six weeks.	1	2	3
Attending 3-4 hours each session.	1	2	3
Continuing involvement for one year.	1	2	3
Lack of child care.	1	2	3
Transportation difficulties	1	2	3
Friends or family attitudes.	1	2	3
Home responsibilities.	1	2	3
Job responsibilities.	1	2	3
Getting release time from my job.	1	2	3

Other (Please specify.) ________________________________

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IV. QUESTIONS

1. What did you find most helpful about the institute?

2. What did you find least helpful about the institute?

3. What additional information would you like to see included in future Transdisciplinary Teaming institutes?

4. What will you do differently as a result of this institute?

SAMPLE TASKS

ERIC

PROGRAM TASKS

Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Philosophy statement must be submitted to and discussed with the instructor and must be adopted by the student's program.
2) Current Team Model	The student will identify his or her current team model and will describe: a) members of the team (i.e., background and training, percentage of time spent with program) b) roles and responsibilities of team members (include how instruction and therapy are provided) c) frequency and length of team meetings d) purposes of team meetings e) structure of assessments f) development of instructional goals g) barriers to transdisciplinary teaming	The description of the team model must address the components delineated in the program task and must be submitted to and discussed with the instructor.
3) Policies and Procedures	The student, in collaboration with the members of his or her team, will develop policies and procedures for the implementation of a transdisciplinary model. The following issues should be addressed: a) team members b) system of communication c) meetings d) assessment e) writing plans/goals f) training others g) implementation of programming	The policies and procedures must address the issues delineated in the program task, be approved by the instructor, and be adopted by the student's program.

PROGRAM TASK
Transdisciplinary Teaming .istitute

DESCRIPTION	PROGRAM TASK	CRITERIA
4) Assessment	a) The student will observe a minimum of two physical therapy assessments, two occupational therapy assessments, two speech therapy assessments, and two educational assessments administered to children under the age of three years. (The student does not have to observe the assessments in his or her own discipline.) b) The student, in collaboration with at least one other member of his or her team, will conduct joint assessments on a least two (2) children utilizing assessments that address all areas of development.	a) The observations will be documented and discussed with the instructor. b) Written results of the assessment must be submitted in report form with the following components included: - history/background of child - behavioral observations - results of assessment in all developmental areas - recommendations for programming Report must be approved by the instructor.
5) Team Meetings	The student will coordinate four (4) regularly scheduled team meetings following the program's policies and procedures. Responsibilities include: a) notifying all team members b) ensuring there is a written agenda c) ensuring there is a meeting facilitator d) ensuring there is a meeting recorder e) ensuring the minutes are distributed to all who attended the meeting as well as those who were absent At least two (2) of the team meetings must be for the purpose of determining goals for the children assessed in Task #4.	All responsibilities delineated in the program task must be successfully completed. The instructor will attend a minimum of two (2) team meetings that are coordinated by the student and outcomes will be discussed.

PROGRAM TASKS
Transdisciplinary Teaming Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) Goal Development	The goals developed through the team meeting must: a) include goals across disciplines b) address the child and family needs c) specify behavior in operational terms d) include criteria for achievement e) specify conditions under which the behavior will occur f) address generalization and maintenance of skills.	The goals must address the components delineated in program tasks, be approved by members of the team and submitted to and approved by the instructor.
7) Instructional Programs	The student will write at least two (2) instructional programs for each of the two children from the previous tasks. The programs must include the following components: a) a statement of the instructional objective that includes: - behaviors specified in operational terms and that <u>incorporate skills from more than one discipline</u> - criteria for achievement - conditions under which the behaviors will occur b) task analysis of instructional sequence delineating components.	The written documentation of the instructional programs must include the components delineated in the program task and, in addition, the student must submit progress data which will be discussed with the instructor.

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EAST RIVER CHILD DEVELOPMENT CENTER

Integrated Report Format

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TEAM REPORT PART 1

LAST NAME: FIRST:

CLASSROOM TEAM

SOCIAL HISTORY

BEST COPY AVAILABLE

STRENGTH AND NEEDS IN DEVELOPMENTAL DOMAINS

BEST COPY AVAILABLE

COGNITIVE
CURRENT FUNCTIONAL RANGE

BEST COPY AVAILABLE

FINE MOTOR
CURRENT FUNCTIONAL RANGE

BEST COPY AVAILABLE

GROSS MOTOR
CURRENT FUNCTIONAL RANGE

BEST COPY AVAILABLE

TEAM REPORT PART 2

LAST NAME:
FIRST:

SOCIAL/EMOTIONAL
CURRENT FUNCTIONAL RANGE

BEST COPY AVAILABLE

LEARNING STYLES

NAME and [illegible]

MEDICAL

MEDICAL STATUS:
[illegible]

BEST COPY AVAILABLE

APPENDIX I

ERIC Full Text Provided by ERIC

Table 1
Participant demographics for the Children's School for Early Development IFSP Institute

Participant Number	Position	Highest Degree	Area of Certification	Any Formal B - 3	Years 0 - 3	Years Teaching	Type of Previous Experience
1	Early Childhood Special Education	M.Ed.	Special Education	Yes	3	16	Mix of Special Ed & Regular Education
2	Social Work Assistant	MSW		Yes	3	12	3-5 ei
3	Physical Therapy	BS	Physical Therapy	Yes	13	14	3-5 ei
4	Nurse	RN	Nursing	Yes	2	15	Mix of Special Education
5	Early Childhood Special Education	M.Ed.	Special Education	No	10	15	Mix of Special Ed & Regular Education
6	Early Childhood Special Education	M.Ed.	Special Education	No	10	14	Mix of Special Ed & Regular Education
7	Administration Special Education	Post Masters	Special Education	Yes	5	14	Mix of Special Ed & Regular Education
8	Speech Pathologist	Masters CCC-SLP	Speech Pathology	Yes	4	12	Mix of Special Education

Table 2

Self Rating Scale Results for CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	2.6	3.9	4.2
2. Understand family systems theory.	2.6	3.9	4.1
3. State program philosophy.	3.3	4.3	4.9
4. Name variety of assessment instruments for B-3 years.	3.0	3.8	3.8
5. Choose appropriate assessment instruments.	2.9	3.9	3.9
6. Demonstrate skills in administering assessments to young children:			
through observation	2.9	4.0	4.0
structuring the environment to elicit skills	3.1	4.0	4.0
through direct testing	3.0	4.0	4.0
7. Demonstrate skill in writing results assessments.	3.0	3.7	4.0
8. Name family assessments.	3.3	3.8	4.0
9. Choose appropriate family assessments.	2.3	3.7	4.0
10. Demonstrate skills in interviewing families.	2.1	4.0	4.0
11. Skills in writing results of family assessments.	2.5	3.8	4.0
12. Communication skills with families including:			
effective listening (eye contact, silence, paraphrase)	3.5	4.4	4.8
effective inquiry (open-ended questions, silence)	3.4	4.4	4.6
effective reflection of feeling ("I hear you saying...")	3.4	4.4	4.6
effective reflection of content (paraphrase)	3.4	4.4	4.6
13. Sensitivity to family needs.	4.1	4.6	4.6
14. Plan a team meeting, including:			
formulating an agenda	3.0	4.3	4.6
contacting participants	3.0	4.1	4.5
preparing families	2.9	4.1	4.5

Table 2 (CONT'D.)
Self Rating Scale Results for CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda	3.1	4.1	4.7
ensuring opportunity for participation of all members	3.1	4.1	4.7
16. Communicate assessment results to families.	3.6	4.2	4.5
17. Prepare families for role in team meetings.	3.1	4.0	4.5
18. Involve families in goal setting.	3.4	4.1	4.5
19. Understanding of family empowerment.	3.9	4.3	4.8
20. Skills in writing functional behavioral objectives.	3.5	3.8	4.8
21. Writing statements on family strengths and weaknesses.	2.5	3.9	4.8
22. Writing family goals.	2.4	4.0	4.8
23. Knowledge of components of an IFSP.	2.9	4.1	4.6
24. Incorporate family priorities into the IFSP.	2.8	4.0	4.5
25. Incorporate child goals into functional activities.	3.8	4.3	4.5
26. Review and update goals.	3.9	4.3	4.5
27. Write and follow a flexible agenda for home visits.	3.6	4.0	4.5
28. Evaluate home visits/classroom activities.	3.5	3.8	4.9
29. Collaborate with other community agencies.	3.5	4.0	4.5
30. Training staff on IFSP development.	2.4	3.4	4.6

Table 3
Pre-post test scores for individual participants from the CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT IFSP INSTITUTE

Participant #	Pre Test	Post Test 1	Post Test2
1	58%	82%	90%
2	55%	79%	
3	58%	84%	90%
4	29%	74%	95%
5	42%	74%	
6	42%	39%	
7	71%	79%	95%
8	45%	81%	
9	50%	95%	
10	50%	95	50%
Mean Scores	**47%**	**76%**	**93%**

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Table 4
Mean scores across participants from the CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT IFSP INSTITUTE for each item on the consumer satisfaction survey.

ITEM	Mean Scores
Objectives Met	4.11
Topics Covered	4.00
Relevant Material	4.56
Adequate Illustration	4.44
Time Organized	4.11
Information Relevant to Work	4.44
Better Understanding of Subject	4.56
Presenter Prepared	4.67
Presenter Knowledgeable	4.89
Presenter Used Activities	4.67
Presenter Easy to Listen to	4.67
Presenter Valued Input	4.78
Environment Comfort	4.67
Adequate Breaks	4.78
Good Group Size	4.78
Good Location	4.78
Good Day and Time	4.78

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

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SAMPLE TASKS

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Must include the three areas delineated in program task and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review a minimum of three (3) developmental assessments including at least one standardized assessment for the 0-3 population. b) choose two (2) of the assessments to administer to three children (two who are developmentally delayed and one who is developing normally). One developmentally delayed child and one normal child must be of the same chronological age. When assessing the two developmentally delayed children, a second staff member or project staff member, who is familiar with the instrument, must accompany the student and score the child separately to determine reliability.	Written reviews of the assessments must include: - Name of assessment, author, publisher and address - Cost - Validity, reliability and norming sample data - Population recommended for - Domains assessed - Materials needed - Training needed - Type of scores obtained - Type of test (standardized, criterion referenced, etc.) - Ease of administration - Judgment as to usefulness - Strengths and weaknesses Written summaries of the results must include: - scores obtained - skills exhibited - child's strengths and weaknesses - implications for programming Handwritten summaries of results and implications for programming must be submitted to, discussed with and approved by the instructor.

DESCRIPTION	PROGRAM TASK	CRITERIA
3) Family Assessment	The student will: a) review a minimum of two (2) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare: - an agenda - open-ended questions During the interview, the student will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments must include information on: - Rationale - Norming sample - Areas tested - Types of scores obtained - Judgments as to usefulness - Strengths and limitations Reviews must be submitted to and approved by the instructor. The instructor will observe the family interview and provide written feedback. Written summaries of results and implications for services must include: - family strengths and needs - implications for programming Summaries will be submitted to the instructor. The instructuor will provide written feedback.
4) Team Meeting	The student will participate in two (2) team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the student will: a) develop a written agenda b) delineate roles and responsibilities of participants c) prepare families for their role in the meeting	The instructor will observe the team meetings and provide written feedback. The student will submit a written summary of the results of the meetings and discuss them with the instructor.

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DESCRIPTION	PROGRAM TASK	CRITERIA
5) IFSP	In collaboration with each family and team members the student will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expected duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will be submitted to, discussed with, and approved by the program supervisor, team, and instructor. The goals delineated in the IFSP must correspond to the goals prioritized by the staff and family during meetings and interviews.

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DESCRIPTION	PROGRAM TASK	CRITERIA
6)Implementation of IFSP	The student will implement each of the IFSP's through contacts with the child and family, either in the home or through a center-based program. At least one of these contacts must be a home visit. Implementation of the IFSP will include: a) following written flexible agenda for a home/center visit which includes child and family IFSP objectives to be addressed during the home/ center visits, and activities to address the IFSP objectives b) data collection procedures c) other evaluation procedures	The instructor will review the agenda, objectives, activities and data for the first three (3) visits, and will accompany student on at least one (1) home/center visit. Outcome of the visits will be discussed with the instructor. The instructor will also review evaluation procedures.
7) Family-Centered Practices	The participant will select two (2) parameters from Brass Tacks 2: Individual Interactions with Families to incorporate into current case management practices. The selected parameters may be utilized to enhance already existing practices or to inroduce new practices into case management services.	Written rationale to support selected parameters must include: -a description of case management practice prior to implementation of changes -actions taken to enhance or introduce practices -outcomes resulting from changes in case management practices Rationales will be submitted to the instructor. The instructor will provide written feedback.

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THE CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT

FAMILY INFORMATION SHEET

NAME: ______________________ DATE: ______________

____
Relationship to child

We would like information about how we, as an Intervention Program can be of help to your family and child. All questions are optional and you can leave any out you wish. Please read each statement and circle the number that applies to your family.

	This is something I feel we have a good handle on	Not Sure	I would like help with this
NEEDS FOR INFORMATION			
1. I would like more information about my child's disability.	1	2	3
I would like more information about child development, especially motor development.	1	2	3
3. I would like information on child development from the perspective of language and communication.	1	2	3
4. I would like information regarding developmentally appropriate toys and activities for my child.	1	2	3
5. I would like information on services that are presently available f r my child.			
6. I would like information on the services my child : receive in the future.	1	2	3

chart2 (#10)

NEEDS FOR INFORMATION

1. I would like opportunity to talk with another parent or a couple who have a child with similar disability.	1	2	3
2. I would like to participate in a parent support group of parents whose children are in this program.	1	2	3
3. I would like a referral to, or discuss seeing, a counselor or therapist for myself and/or my spouse or my family.	1	2	3
4. I would like help from professional for my family to work on such things as: support each other during difficult times, discussing problems and reaching solutions, spending more time together, reducing conflict over chores, child care, etc.	1	2	3
5. I would like information on respite services (agencies who provide baby sitter for special children to give parents some free time).	1	2	3

EXPLAINING TO OTHERS

1. I Would like input on how to explain my child's condition to his/her siblings.	1	2	3
2. I would like suggestions in explaining my child's condition to my friends & family.	1	2	3

COMMUNITY SERVICES

1. I would like assistance locating a doctor who understands me and my child's needs.	1	2	3
2. I would like assistance locating a pediatric dentist.	1	2	3

chart2 (#10)

ERIC

INANCIAL NEEDS

1. I would like information regarding county resources available: oods, housing, medical care, clothing, transportation and other services for my child's special needs.	1	2	3
2. I would like information on how to get special equipment for my child.	1	2	3

1. What are some of your family strengths at this time?

2. What are some concerns you have for your family?

3. Are there other areas that you would like to work on together?

chart2 (#10)

APPENDIX J

ERIC

Table 1 Participant Demographics for the Special Sprouts IFSP Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
1	Speech Pathologist	MA, CCC, SLP	Speech Pathology	Yes	3 years	18 years
2	Speech Pathologist	MA, CCC, SLP	Speech Pathology	Yes	9 years	17 years
3	Education Director	MS	Special Ed/ Elementary Ed	No	1 year	21 years
4	Physical Therapist	BA	Physical Therapy	No	2 years	2 years
5	Psychologist	MA	Psychology	No	3 years	13 years
6	Occupational Therapist	BA	Occupational Therapy	Yes	2 years	11 years
7	Social Worker	MSW	Social Work	No	1 year	15 years

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Table 3
Pre-post test scores for individual participants from the SPECIAL SPROUTS IFSP INSTITUTE

Participant #	Pre Test	Post Test 1	Post Test 2
1	59%	95%	100%
2	41%	76%	59%
3	47%	81%	67%
4	49%	89%	
5			
6	41%	81%	
7	43%	81%	64%
Mean Scores	**47%**	**84%**	**73%**

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Table 2
Self Rating Scale Results for SPECIAL SPROUTS IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	3.3	3.9	4.0
2. Understand family systems theory.	2.3	2.4	4.0
3. State program philosophy.	2.7	2.6	4.0
4. Name variety of assessment instruments for B-3 years.	3.2	3.3	3.9
5. Choose appropriate assessment instruments.	3.0	3.6	3.9
6. Demonstrate skills in administering assessments to young children:			
through observation	3.8	4.0	4.6
structuring the environment to elicit skills	3.5	3.9	4.6
through direct testing	3.7	4.0	4.5
7. Demonstrate skill in writing results assessments.	3.7	4.1	4.5
8. Name family assessments.	2.2	3.3	4.5
9. Choose appropriate family assessments.	2.2	3.4	4.0
10. Demonstrate skills in interviewing families.	2.8	4.0	4.0
11. Skills in writing results of family assessments.	2.7	3.7	4.0
12. Communication skills with families including:			
effective listening (eye contact, silence, paraphrase)	3.8	4.3	4.8
effective inquiry (open-ended questions, silence)	3.5	4.3	4.8
effective reflection of feeling ("I hear you saying...")	3.7	4.1	4.8
effective reflection of content (paraphrase)	3.7	4.3	4.5
13. Sensitivity to family needs.	4.2	4.4	4.5
14. Plan a team meeting, including:			
formulating an agenda	3.5	4.0	4.5
contacting participants	3.5	4.1	4.5
preparing families	3.3	3.9	4.5

Table 2 (Cont'd)
Self Rating Scale Results for SPECIAL SPROUTS IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	3.7 3.7	4.3 4.1	4.6 4.5
16. Communicate assessment results to families.	3.7	4.1	4.5
17. Prepare families for role in team meetings.	3.0	3.7	.4.0
18. Involve families in goal setting.	2.8	3.7	4.0
19. Understanding of family empowerment.	2.8	3.9	4.0
20. Skills in writing functional behavioral objectives.	3.6	3.9	4.0
21. Writing statements on family strengths and weaknesses.	2.8	4.0	4.0
22. Writing family goals.	2.5	3.9	4.0
23. Knowledge of components of an IFSP.	2.3	3.7	4.0
24. Incorporate family priorities into the IFSP.	2.2	3.7	3.7
25. Incorporate child goals into functional activities.	3.5	4.3	3.9
26. Review and update goals.	3.5	4.1	3.9
27. Write and follow a flexible agenda for home visits.	2.5	3.6	4.0
28. Evaluate home visits/classroom activities.	2.8	4.0	4.1
29. Collaborate with other community agencies.	3.2	4.0	4.1
30. Training staff on IFSP development.	2.5	3.1	4.2

Table 4

Mean scores across participants from the Special Sprouts IFSP Institute for each item on the consumer satisfaction survey .

ITEM	Mean Scores
Objectives Met	4.4
Topics Covered	4.4
Relevant Material	4.7
Adequate Illustration	4.7
Time Organized	4.9
Information Relevant to Work	4.6
Better Understanding of Subject	4.6
Presenter Prepared	5
Presenter Knowledgeable	5
Presenter Used Activities	4.9
Presenter Easy to Listen to	5
Presenter Valued Input	5
Environment Comfort	4.7
Adequate Breaks	4.9
Good Group Size	5
Good Location	5
Good Day and Time	4.9

*Participants rated on a Liekart Scale (1=Strongly Disagree - 5=StronglyAgree) their satisfaction with the institute.

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Table 2
Self Rating Scale Results for Special Sprouts IFSP Institute

	Where I Am Pre	Where I Am Post	P Scores
1. Understanding P.L. 99-457.			
2. Understand family systems theory.			
3. State program philosophy.			
4. Name variety of assessment instruments for B-3 years.			
5. Choose appropriate assessment instruments.			
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing			
7. Demonstrate skill in writing results assessments.			
8. Name family assessments.			
9. Choose appropriate family assessments.			
10. Demonstrate skills in interviewing families.			
11. Skills in writing results of family assessments.			
12. Communication skills with families including: effective listening (eye contact, silence, paraphrase) effective inquiry (open-ended questions, silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)			
13. Sensitivity to family needs.			
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families			

Table 2 (Cont'd)

	Where I Am Pre	Where I Am Post	P Scores
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members			
16. Communicate assessment results to families.			
17. Prepare families for role in team meetings.			
18. Involve families in goal setting.			
19. Understanding of family empowerment.			
20. Skills in writing functional behavioral objectives.			
21. Writing statements on family strengths and weaknesses.			
22. Writing family goals.			
23. Knowledge of components of an IFSP.			
24. Incorporate family priorities into the IFSP.			
25. Incorporate child goals into functional activities.			
26. Review and update goals.			
27. Write and follow a flexible agenda for home visits.			
28. Evaluate home visits/classroom activities.			
29. Collaborate with other community agencies.			
30. Training staff on IFSP development.			

Table 2
Self Rating Scale Results for Special Sprouts IFSP Institute

	Where I Am Pre	Where I Am Post	P Scores
1. Understanding P.L. 99-457.			
2. Understand family systems theory.			
3. State program philosophy.			
4. Name variety of assessment instruments for B-3 years.			
5. Choose appropriate assessment instruments.			
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing			
7. Demonstrate skill in writing results assessments.			
8. Name family assessments.			
9. Choose appropriate family assessments.			
10. Demonstrate skills in interviewing families.			
11. Skills in writing results of family assessments.			
12. Communication skills with families including: effective listening (eye contact, silence, paraphrase) effective inquiry (open-ended questions, silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)			
13. Sensitivity to family needs.			
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families			

Table 2 (Cont'd)

	Where I Am Pre	Where I Am Post	P Scores
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members			
16. Communicate assessment results to families.			
17. Prepare families for role in team meetings.			
18. Involve families in goal setting.			
19. Understanding of family empowerment.			
20. Skills in writing functional behavioral objectives.			
21. Writing statements on family strengths and weaknesses.			
22. Writing family goals.			
23. Knowledge of components of an IFSP.			
24. Incorporate family priorities into the IFSP.			
25. Incorporate child goals into functional activities.			
26. Review and update goals.			
27. Write and follow a flexible agenda for home visits.			
28. Evaluate home visits/classroom activities.			
29. Collaborate with other community agencies.			
30. Training staff on IFSP development.			

ERIC

BIRTH TO THREE INSERVICE TRAINING PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
	"Family Centered Care"	Film/Activity
	Collecting Family Information	Lecture/Discussion
Session 2:	Overview of Communication & Interview Skills	Activity/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Group Activity
	Overview of Child Assessments	Lecture
Session 3:	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Mock Situation	Group Activity
	Review Components of IFSP	Group Participation
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
Session 4:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives	Lecture/Discussion
	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center -- Division of Child and Family Studies

IFSP INSTITUTE READINGS

SESSION 1:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Philosophy and conceptual framework. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 5-15). Washington, DC: ACCH.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Building positive relationships between professionals and families. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 23-30). Washington, DC: ACCH

Kaiser, A.& Hemmeter, M.L. (1989). Value-based approaches to family intervention. Topics in Early Childhood Special Education, 8(4), 72-86.

Simeonsson R. J. (1988). Unique characteristics of families with young handicapped children. In Bailey, D. B. & Simeonsson, R. J. (Eds.), Family assessment in early intervention (pp. 27-43). Columbus, OH: Merrill.

Smith, B. J., & Strain, P. S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

SESSION 2:

Kjerland, L. & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E. Gibbs & D. Teti (Eds.) Interdisciplinary assessment of infants: A guide for early intervention professionals. Baltimore: Paul H. Brookes.

Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Identifying child and family strengths and needs. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 31-37). Washington, DC: ACCH

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SESSION 3:

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SESSION 4:

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SAMPLE TASKS

ERIC

SPECIAL SPROUTS

Program Brochure
Family Questionnairre

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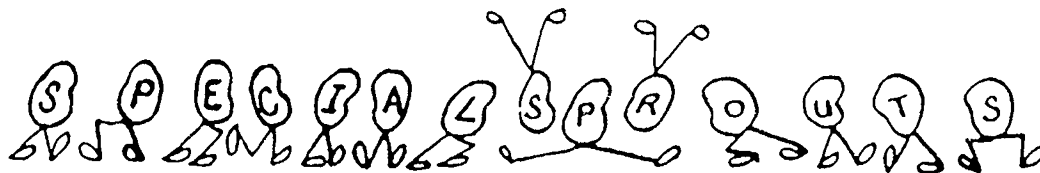

339 Eighth Street • Brooklyn, New York 11215
(718) 965-8573 • Fax (718) 768-6885

How Can We Help?

Child's Name:____________________________ **D.O.B.**____________________

Person Completing Form:____________________ **Date**____________________

****

Each child and family enrolled at Special Sprouts have their own strengths and needs. Please use this form to help us know how we can be most useful to your family. We know that your needs will change from time to time and that this will just be a beginning in helping us to plan together. Answer only those questions that you think will help us to know how we can be most helpful to you and your family:

What do you enjoy most about your child?______________________________

____

____

____.

What concerns you most about your child?______________________________

____

____

____.

What kind of help or information would you like from the people at Special Sprouts?____

____

____

____.

In the next several months, I would like my child to be able to... ____.

Beside my family, other people I would like to include in the assessment and planning meeting for my child and family are... ____.

In the next several months, I would like my family to... ____.

ERIC Full Text Provided by ERIC

How Can Special Sprouts Help?

Our family would like...

Information about:	**We have Enough**	**We would Like More**	**Not Sure**
child development..............	______	______	______
child behavior.................	______	______	______
nutrition/feeding..............	______	______	______
our child's health problems....	______	______	______
our child's development problem	______	______	______
toys or books for our child and how to get them..............	______	______	______
other: ______________________	______	______	______

Help with child care:			
finding daily child care.....	______	______	______
finding babysitters or respite care......................	______	______	______
finding a preschool for my child	______	______	______
teaching the car provider how to take care of our child........	______	______	______
finding ways to pay for child care..........................	______	______	______
evaluating child care settings or/determining appropriate child care settings...........	______	______	______
other: ______________________	______	______	______

To know about community services for our child and family:			
GED and other adult education...	______	______	______
who can help with transportation to doctor's appointments and other special services for my child.........................	______	______	______
food, food stamps, WIC, or other nutrition programs............	______	______	______
housing........................	______	______	______
fuel...........................	______	______	______
clothing.......................	______	______	______
finding a job or job training...	______	______	______
financial assistance...........	______	______	______
individual or family counseling.	______	______	______
other: ______________________	______	______	______

	We have Enough	We would like more	Not Sure
To know more about getting medical care and dental care for our family:			
finding a doctor or dentist.....	______	______	______
getting help paying for health care..........................	______	______	______
getting and using special equipment and supplies for our child.........................	______	______	______
training in how to give First Aid/CPR to my family and others........................	______	______	______
family planning/birth control...	______	______	______
other: ______________________	______	______	______
Help talking about our child:			
to our children, nieces, nephews and to other children.........	______	______	______
to our friends and other relatives....................	______	______	______
to doctors and nurses to get the information and help we want..	______	______	______
to other professionals (social workers, teachers, others) about our baby and ourselves to get the information and help we want..................	______	______	______
to other people we meet.........	______	______	______
other: ______________________	______	______	______
Help planning for the future/transition:			
eligibility and the public school special education process......................	______	______	______
eligibility, legal rights, parent's role visiting other service settings..............	______	______	______
determining the best setting for our child....................	______	______	______
other: ______________________	______	______	______

Please tell us the other ways we might be able to help: ______________________

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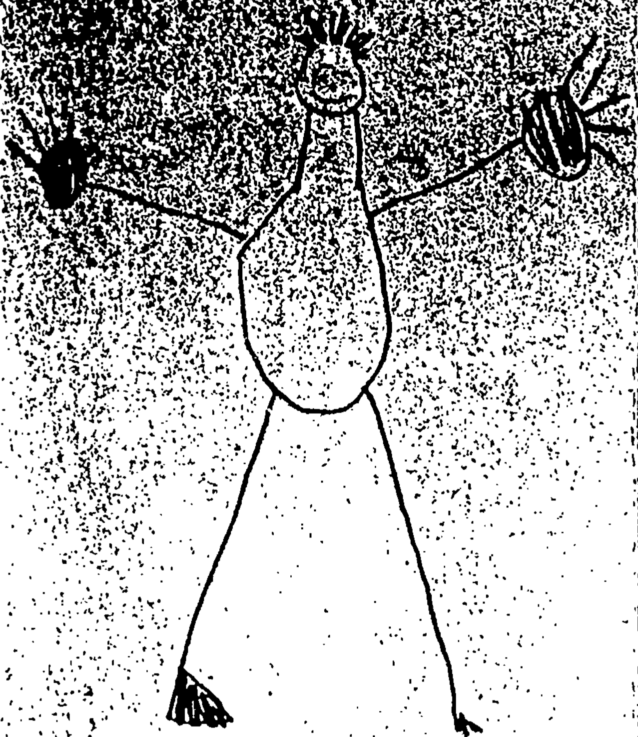
Family-focused Intervention Rating Scale

Child's Name:______________________________ Date:____________________

Person Completing Form:____________________ Relationship to child:__________

Child Care Tasks	Person Responsible	Task Rating: Almost never easy	Sometimes easy	Always easy	Comments
Eating	____________	0	1	2	____________________
Bathing	____________	0	1	2	____________________
Holding/ comforting	____________	0	1	2	____________________
eeping	____________	0	1	2	____________________
Dressing	____________	0	1	2	____________________
Playing	____________	0	1	2	____________________
Meal Prep	____________	0	1	2	____________________
Medical/ nursing care	____________	0	1	2	____________________
Other: ____________	____________	0	1	2	____________________
Other: ____________	____________	0	1	2	____________________



For Further Information

Call

(718) 965-8573

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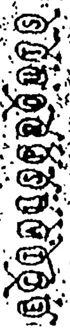
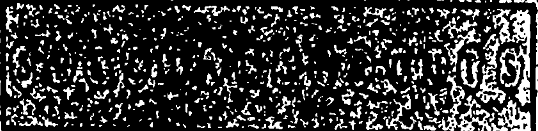
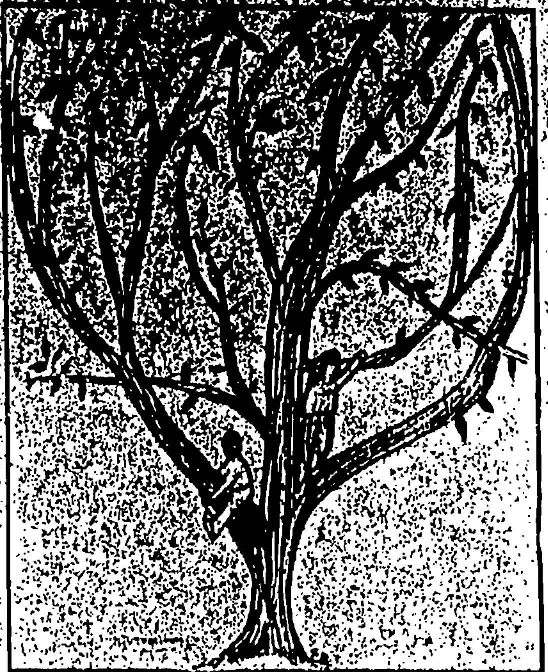


Not-For-Profit Therapeutic Pre-School
(718) 965-8573 339 Eighth Street
(718) 768-6885 Brooklyn, New York 11215





A Not-For-Profit Therapeutic Pre-School for Children With Speech and Language Delays or Developmental Disabilities

Sue Weinstein, M.S., S.A.S.
Executive Director

Special Sprouts Philosophy

Special Sprouts, located in brownstone Brooklyn, has been providing special education to preschool children since 1988. In October, 1991, we expanded our services to children between birth to two years of age. Our Early Intervention Program is strongly committed to the belief that young children are [illegible] connected to their families. Therefore, our program [illegible] to a family-centered [illegible] intervention. [illegible] to ensure [illegible] priorities [illegible] Individ[illegible]

Early Intervention Program

For Children and Their Families

Special Sprouts provides free assessment and therapeutic services to children, between the ages of six weeks and two years of age, who are showing signs of possible delay in any of the following areas:

- o [illegible]
- o [illegible]
- o [illegible]
- o [illegible]

Services

We offer an individualize treatment program for children and their families to meet their needs while building on their strengths.

We provide direct or consultative services from the following professional disciplines:

- o Special Education
- o Occupational Therapy
- o Physical Therapy
- o Speech-Language Pathology
- o Social Work
- o Psychology
- o Medicine

Transportation is provided to and from the Early Intervention Program at no cost to the family.

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INDIVIDUAL FAMILY SERVICE PLAN PROCESS

DATE: June 19, 1992
TIME: 9:00 a.m. - 2:00 p.m.
PLACE: Hawthorne

9:00 - 9:30	coffee and introduction: Phyllis -reasons for the IFSP
9:30 - 10:00	Federal and State Laws: Daphne -components of law/components of IFSP
10:00 - 10:45	Family Systems: Daphne -family driven vs. system driven -exercise/worksheet
10:45 - 11:00	BREAK
11:00 - 12:00	Family Needs: Nancy -needs assessment/interviewing
12:00 - 1:15	IFSP Videotape: Phyllis -initial home visit/evaluation process
1:15 - 2:00	Teaming: Marina -becoming an effective team member -exercise
2:00 - ?	PIZZA!!!

SPECIAL SPROUTS

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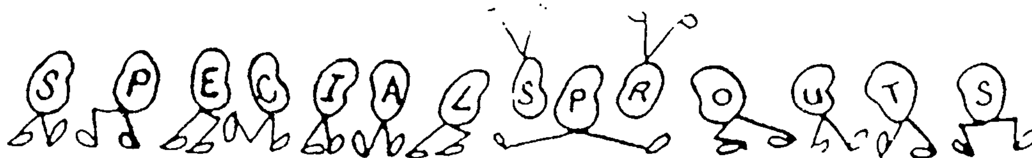

339 Eighth Street • Brooklyn, New York 11215
(718) 965-8573 • Fax (718) 768-6885

How Can We Help?

Child's Name:______ ______ ______ **D.O.B.** 12/23/96

Person Completing Form:___ ______ ___ **Date** 6/1/97

****

Each child and family enrolled at Special Sprouts have their own strengths and needs. Please use this form to help us know how we can be most useful to your family. We know that your needs will change from time to time and that this will just be a beginning in helping us to plan together. Answer only those questions that you think will help us to know how we can be most helpful to you and your family:

What do you enjoy most about your child? Me just being around her as she plays, smiles, laughs, get real antsy at times and just knowing that I have a beautiful daughter who is going to be alright as she begins to grow.

What concerns you most about your child? When she's not eating or when she gets sick. Also like now, I know that a baby her age is supposed to be doing a lot moving around & other things.

What kind of help or information would you like from the people at Special Sprouts? I would like to know whether or not my daughter will be able to walk & do other things that a baby her age should be doing. Also, how long will this process take place?

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In the next several months, I would like my child to be able to... ______

______

______

______

Beside my family, other people I would like to include in the assessment and planning meeting for my child and family are... ______

______

______

______.

In the next several months, I would like my family to... ______

______

______

______.

How Can Special Sprouts Help?

Our family would like...

Information about:	We have Enough	We would Like More	Not Sure
child development.............		✓	
child behavior................		✓ ✓	
nutrition/feeding.............			
our child's health problems....			
our child's development problem		✓	
toys or books for our child and how to get them.............		✓	
other:			

Help with child care:	We have Enough	We would Like More	Not Sure
finding daily child care.....	✓		
finding babysitters or respite care......................	✓		
finding a preschool for my child		✓	
teaching the car provider how to take care of our child.........	✓		
finding ways to pay for child care.........................		✓	
evaluating child care settings or/determining appropriate child care settings..........		✓	
other:			

To know about community services for our child and family:	We have Enough	We would Like More	Not Sure
GED and other adult education...	✓		
who can help with transportation to doctor's appointments and other special services for my child........................		✓	
food, food stamps, WIC, or other nutrition programs............		✓	
housing.......................	✓		
fuel..........................	✓		
clothing......................	✓		
finding a job or job training...			
financial assistance...........		✓	
individual or family counseling.	✓		
other:			

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	We have Enough	We would like more	Not Sure
To know more about getting medical care and dental care for our family:			
finding a doctor or dentist.....	✓		
getting help paying for health care..........................			
getting and using special equipment and supplies for our child.........................		✓	
training in how to give First Aid/CPR to my family and others........................	✓		
family planning/birth control...	✓		
other: ______			
Help talking about our child:			
to our children, nieces, nephews and to other children.........	✓		
to our friends and other relatives....................		✓	
to doctors and nurses to get the information and help we want..		✓	
to other professionals (social workers, teachers, others) about our baby and ourselves to get the information and help we want.................	✓		
to other people we meet.........	✓		
other: ______			
Help planning for the future/transition:			
eligibility and the public school special education process........................		✓	
eligibility, legal rights, parent's role visiting other service settings..............	✓		
determining the best setting for our child....................		✓	
other: ______			

Please tell us the other ways we might be able to help: ______________________

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Family-focused Intervention Rating Scale

Child's Name: ______ ______________ ______ Date: ______________

Person Completing Form: ______________ Relationship to child: ______

Child Care Tasks	Person Responsible	Task Rating: Almost never easy	Task Rating: Sometimes easy	Task Rating: Always easy	Comments
Eating	Me & Grandmother [illegible]	(0) circled	1	2	[illegible]
Bathing	Me + Grandmother	(0) circled	1	2	She [illegible]
Holding/ comforting	Family & Relatives	0	(1) circled	2	
Sleeping	Family	(0) circled	1	2	She sleeps at all kinds of hours
Dressing	Me Family	0	1	(2) circled	
Playing	Me & Family	0	(1) circled	2	
Meal Prep	Me & Grandmother	0	(1) circled	2	She's very picky about what she eat
Medical/ nursing care		0	(1) circled	2	
Other: ______		0	1	2	
Other: ______		0	1	2	

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Family Assessment

INDIVIDUALIZED EDUCATION PROGRAM

CSE Case #

Student's Name

Date of Conference 6/10/92

☐ Reconvened ☐ SBST/CSE Update

☐ Teacher/Provider Update

ACADEMIC/EDUCATION ACHIEVEMENT AND LEARNING RATE; SOCIAL DEVELOPMENT; PHYSICAL DEVELOPMENT

Attach as many pages as necessary.

Date(s) of Evaluation	Area and Type of Instrument Used Test Scores/Results/Teacher Estimate (Specify If Update)	Functional Description of Performance (Include strengths and weaknesses)
6/1/92	Family Assessment Special Sprouts Family Needs Survey	___ 's mother completed the Family Needs Survey. She indicated that her priorities for ___ were in the areas of walking, talking, playing with other children and feeding issues. She also indicated that she is concerned about ___ hearing impairment and would like more information about this area. ___ further reported that she would like to know about financial assistance, food, foodstamps, WIC or other nutrition programs. She also reported a need in the area of parent education in child development, child behavior, appropriate toys for ___ etc. ___ also asked for help in learning how to talk with others, ie, family, MDs, etc. about ___

ERIC

Item No. 25-6300.03

Family Outcomes

INDIVIDUALIZED EDUCATION PROGRAM

CSE Case # ______ Date of Conference ______

Student's Name ______ Reconvened SBST/CSE Update ______

Teacher/Provider Update ______

ANNUAL GOALS AND SHORT TERM OBJECTIVES

(Include all areas/subjects for which special education is indicated. Attach as many pages as necessary.)

ANNUAL GOAL ______ will apply for SSI and WIC

Area Family to obtain additional financial assistance to help meet ______'s additional needs.

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery
Barbara will give ______ telephone number for Social Security Administration (SSA).	6/92	
Connie will call SSA + ask to complete an application for SSI for ______.	7/92	
______ will reapply for WIC.	9/92	

ANNUAL GOAL ______ will attend a series of workshops

Area Family addressing child development issues so that mother will be able to play + interact more appropriately with child.

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery
Staff will provide ______ with literature in the area of child development.	ongoing	
______ will attend the parent groups at Special Sprouts in the fall.	12/92	
______ will speak with teacher and clinician at Special Sprouts regarding ______ individual needs.	ongoing	

ANNUAL GOAL ______ will explore resources for possible

Area Family trips and activities that will be appropriate to ______ needs.

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery
______ will speak with other parents in the Early Intervention group to seek out the name of possible parks, playgrounds, etc. that would be appropriate places to take ______.	8/92	
Staff will periodically provide ______ with parent publications which offer suggestions on possible family outings.	9/92	

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INDIVIDUALIZED EDUCATION PROGRAM

SE Case # ______ Date of Conference ______

Student ______ Reconvened / SBST/CSE Update ______

Teacher/Provider Update ______

ANNUAL GOALS AND SHORT TERM OBJECTIVES

(Include all areas/subjects for which special education is indicated. Attach as many pages as necessary.)

ANNUAL GOAL ______ will explore resources and obtain

Area family information about ______ hearing impairment

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery
will continue to take ______ to Long Island College Hospital for audiological follow-up.	ongoing	
will learn how to care for hearing aids to ensure adequate maintenance of the unit.	9/92	

ANNUAL GOAL ______

Area ______

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery
will obtain information from the audiologist which will help her to understand ______ specific needs.	12/92	
will learn various activities she can do with ______ to improve auditory development	ongoing	

ANNUAL GOAL ______

Area ______

SHORT-TERM OBJECTIVES (Number each objective. Include evaluation method and criteria. Specify language of instruction/ESL for LEP students.)	Projected Date of Review	Date of Mastery

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CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT

Family Questionnaire

ERIC

<u>THE CHILDREN'S SCHOOL FOR EARLY DEVELOPMENT</u>

<u>FAMILY INFORMATION SHEET</u>

NAME: ______________________ DATE: ______________

____
Relationship to child

We would like information about how we, as an Intervention Program can be of help to your family and child. All questions are optional and you can leave any out you wish. Please read each statement and circle the number that applies to your family.

	This is something I feel we have a good handle on	Not Sure	I would like help with this
NEEDS FOR INFORMATION			
l. I would like more information about my child's disability.	1	2	3
2. I would like more nformation about child development, especially motor development.	1	2	3
. I would like nformation on child evelopment from the erspective of language nd communication.	1	2	3
. I would like nformation regarding developmentally appropriate oys and activities for my hild.	1	2	3
. I would like nformation on services hat are presently available or my child.			
I would like information the services my child ght receive in the future.	1	2	3

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chart2 (#10)

NEEDS FOR INFORMATION

1. I would like opportunity to talk with another parent or a couple who have a child with similar disability.	1	2	3
2. I would like to participate in a parent support group of parents whose children are in this program.	1	2	3
3. I would like a referral to, or discuss seeing, a counselor or therapist for myself and/or my spouse or my family.	1	2	3
4. I would like help from professional for my family to work on such things as: support each other during difficult times, discussing problems and reaching solutions, spending more time together, reducing conflict over chores, child care, etc.	1	2	3
5. I would like information on respite services (agencies who provide baby sitter for special children to give parents some free time).	1	2	3

EXPLAINING TO OTHERS

1. I Would like input on how to explain my child's condition to his/her siblings.	1	2	3
2. I would like suggestions in explaining my child's condition to my friends & family.	1	2	3

COMMUNITY SERVICES

1. I would like assistance locating a doctor who understands me and my child's needs.	1	2	3
2. I would like assistance locating a pediatric dentist.	1	2	3

chart2 (#10)

INANCIAL NEEDS

1. I would like information regarding county resources available: ods, housing, medical care, clothing, transportation and other services for my child's special needs.	1	2	3
2. I would like information on how to get special equipment for my child.	1	2	3

1. What are some of your family strengths at this time?

2. What are some concerns you have for your family?

3. Are there other areas that you would like to work on together?

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chart2 (#10)

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APPENDIX K

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Table 1

Participant Demographics for the Alcott School, Programming for Infants, Toddlers and their Families Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
1	Teacher Assistant	A.S.	Early Childhood Education	No	2	3
2	Teacher Assistant	A.S.	EarlyChildhood Education	No	2	2
3	Teacher Assistant	T.A. certific-ate	General Education	No	2	5
4	Site Director	M.S.	Psychology/ Special Education	No	2	15
5	Speech Pathologist	M.A. CCC, SLP	Speech Pathology	No	1	15
6	Special Educator	Post Masters	Special Education	No	2	10
7	Special Educator	B.S.	Special Education	No	1	4

Table 2
Self Rating Scale Results for ALCOTT SCHOOL PROGRAMMING INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	1.86	3.5	3.5
2. Understand family systems theory.	2.28	3.8	3.5
3. State program philosophy.	3.43	4.5	4.8
4. State overall program goals.	3.93	4.5	4.9
5. Name minimum of four assessment instruments for various purposes.	2.0	3.83	4.9
6. Choose appropriate assessment instruments	1.71	3.83	4.8
7. Name a variety of family assessments.	1.71	3.33	4.6
8. Choose appropriate family assessments for various purposes.	1.57	3.5	4.3
9. Demonstrate skills in interviewing families for assessment purposes (e.g., setting and following an agenda, obtaining pertinent information without being intrusive)	1.86	3.83	4.3
10. Communication skills with families including:			
effective listening (eye contact, silence, paraphrase)	3.42	4.1	4.2
effective inquiry (open-ended questions, silence)	3.14	4.1	4.2
effective reflection of feeling ("I hear you saying...")	3.14	4.1	4.0
effective reflection of content (paraphrase)	2.86	4.1	4.0
11. Sensitivity to family needs.	3.14	4.31	4.5
12. Communicate assessment results to families and/or other professionals in understandable terms.	2.57	4.31	4.6
13. Prepare families for their role in team meetings.	2.57	4.17	4.6
14. Involve families in goal setting.	2.57	4.33	4.6

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Table 2 (Cont'd)
Self Rating Scale Results for ALCOTT SCHOOL PROGRAMMING INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Demonstrate an understanding of family empowerment.	2.14	3.67	4.5
16. Demonstrate skills in writing statements on family concerns, priorities and resources.	1.86	4.00	4.10
17. Demonstrate skills in writing family goals.	2.71	4.00	4.20
18. Demonstrate a knowledge of the components of an IFSP.	3.00	4.50	4.50
19. Incorporate goals identified by the family into the IFSP.	2.71	4.50	4.50
20. Demonstrate skills in writing functional child goals from assessment information.	2.71	4.50	4.60
21. Demonstrate skills in writing functional short term behavioral objectives for children.	3.00	4.50	4.50
22. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.	3.43	4.67	4.70
23. Utilize functional activities to address goals and objectives.	3.57	4.67	4.80
24. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.	3.86	4.50	4.80
25. Demonstrate skills in providing instruction to groups of children from one to three years of age.	3.43	4.67	4.80

Table 3

Pre-post test scores for individual participants from the Alcott School Programming for Infants, Toddlers & Their Families Institute.

Participant #	Pre Test	Post Test	Post Test 2
1	42%	66%	55%
2	30%	38%	55%
3	39%	50%	78%
4	61%	75%	73%
Mean Scores	43%	57%	65%

ERIC

Session 6:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives: Definition & Examples	Lecture/Discussion
	Writing Child Outcomes & Objectives: Case Studies	Group Activity
Session 7:	Activity Based Instruction	Lecture/Discussion
	Case Study: Implementing Activity Based Instruction	Group Activity
	Post Measures	

ERIC

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

READINGS

SESSION 1:

Smith, B. J., & Strain, P. S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

McGonigel, M.J., Johnson, B.H. & Kaufman, R.R. (1992). A family-centered process for the Individualized Family Service Plan. Journal of Early Intervention, 15(1), 46-56.

SESSION 2:

Bailey, D. B. (1988). Rationale and model for family assessment in early intervention. In D. B. Bailey & R. J Simeonsson (Eds.), Family assessment in early intervention (pp. 1-25). Columbus, OH: Charles E. Merrill Publishing Company.

Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

SESSION 3:

Bailey, D.B. (1989). Assessment and its importance in early intervention. In D. Bailey & M. Wolery (Eds.), Assessing infants and preschoolers with handicaps (pp. 1-21). Columbus, OH: Charles E. Merrill Publishing Company.

Kjerland, L. & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E. Gibbs & D. Teti (Eds.) Interdisciplinary assessment of infants: A guide for early intervention professionals. Baltimore: Paul H. Brookes.

SESSION 4:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Building positive relationships between professionals and families. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 23-30). Washington, D.C: ACCH.

Bailey, D. B. (1987). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7(2), 59-71.

Deal, A. G., Dunst, C. J., & Trivette, C. M. (1989). A flexible and functional approach to developing Individualized Family Support Plans. Infants and Young Children, 1(4), 32-43.

SESSION 5:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Identifying child and family strengths and needs. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 31-39). Washington, D.C: ACCH.

Bailey, D. B. (1988). Considerations in developing family goals. In D. B. Bailey & R. J. Simeonsson (Eds.), Family assessment in early intervention (pp. 31-39). Columbus, Ohio: Charles E. Merrill Publishing Company.

SESSION 6:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Developing the IFSP: Outcomes, strategies, activities and services. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 41-49). Washington, D.C: ACCH.

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. Topics in Early Childhood Special Education, 2(4), 9-14.

SESSION 7:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Implementing the Individualized Family Service Plan. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 51-60). Washington, D.C: ACCH.

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Ostrosky, M.M. & Kaiser, A.P. (1991). Preschool classroom environments that promote communication. Teaching Exceptional Children, 6-10.

McGee G.G. et al (1991). Use of classroom materials to promote preschool engagement. Teaching Exceptional Children, Summer.

Bricker, D. & Cripe, J. (1992). Application of activity-based intervention. An Activity-Based Approach to Early Intervention. Brookes Publishing, 107-127.

Bailey, D.B. & McWilliam, R.A. (1990). Normalizing early intervention. Topics in Early Childhood Special Education, 10(2), 33-47.

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BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
Family Support/Early Intervention
MRI/Cedarwood Hall, Room 423
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

PRE/POST QUESTIONNAIRE

Name: ______________________________ Date: _______________

1. Public Law 99-457 states that:

   a) states are mandated to provide services for handicapped children from birth through five years of age.

   b) states are mandated to provide services for handicapped children from birth to three years of age.

   c) states determine whether services are provided for handicapped children from birth through five years of age.

   d) states are mandated to provide services for handicapped children from three through five years of age, and can determine whether they will provide services for handicapped children from birth to three years of age.

2. Who has been designated as the lead agency in New York for programs serving handicapped children between the ages of birth and three years?

   a) Department of Education

   b) Department of Health

   c) Department of Mental Retardation

   d) Interagency Coordinating Council

3. A program philosophy is important because the program's ______________________ should share the same philosophical basis.

   a. assessments

   b. curricula

   c. staff

   d. all of the above

   e. a & b

4. The role of families in a family-centered care approach is (circle all that apply):

   a.) To listen and follow advice given by professionals.

   b.) To be coequal members of the intervention tem.

   c.) To answer questions that professionals ask them.

   d.) To make informed choices.

5. The role of the professional in a family-centered care approach is (circle all that apply):

   a.) To determine the priorities of the child and family.

   b.) To assist families in identifying their own resources.

   c.) To complete the IFSP and then share it with the family.

   d.) To provide opportunities for family involvement on the intervention team.

   e.) To ensure that every family fully participates on the intervention team.

6. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

   a) family functions

   b) family life cycle

   c) family characteristics

   d) family interaction

7. Family empowerment means:

   a.) helping families by doing whatever we can

   b.) telling families what they can do to take more power in their lives

   c.) familes making informed choices

   d.) families being their own case managers

8. Which of the following statements are rationales for collaborative goal setting with families?

   a.) Families will cooperate more readily when professionals determine goals and then share them.

   b.) Relationships, trust and respect will be improved.

   c.) Ownership of goals is an important factor in accomplishing them.

      1.) a,c
      2.) b,c
      3.) a,b
      4.) all of the above

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9. Based on the results of a family assessment, the Early Intervention Specialist should decide what the family's concerns and priorities are.

True False

10. What three components are included in an IFSP that are not usually included in an IEP?

____

____

____

11. Name two of the four purposes for assessing young children:

____

____

12. Name two criterion referenced assessments that are used with the birth to three year old population.

____

____

13. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

True False

14. ___________ questions are the most effective means of obtaining information from families.

a) Direct

b) Close-ended

c) Open-ended

9. Based on the results of a family assessment, the Early Intervention Specialist should decide what the family's concerns and priorities are.

True False

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13. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

True False

14. __________ questions are the most effective means of obtaining information from families.

a) Direct

b) Close-ended

c) Open-ended

ERIC

15. Circle, from the list below, those techniques that are considered to be effective means of assessing families.

    a) interview

    b) observing interactions

    c) questionnaire

16. List two principles that must be followed when doing family assessments.

    ____

    ____

17. Goals that address needs prioritized by the family should always be included in the IFSP.

    True   False

18. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a day care for Peter."

    True   False

19. According to P.L. 99-457, IFSP's need to be reviewed every __________ months and rewritten every __________ months.

21. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

    True   False

23. List two characteristics of functional skills for young children:

    ____

    ____

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24. Identify and describe a daily routine or activity and explain how you would functionally address the following 3 objectives for a two year old child who is developmentally delayed, during this routine.
    1. Child will voluntarily release small objects into a containter.
    2. Child will communicate his want for an object by looking at or reaching for one when given a choice of two or more objects.
    3. Child will use 3 simple objects functionally.

____

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25. When organizing children for group instruction, they should always be grouped according to developmental levels (i.e., children at same developmental levels together) otherwise it will be impossible to address their individual instructional goals.

True False

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Birth to Three Inservice Training Project

Name:______________________ Program:______________________ Date:______

Programming for Infants, Toddlers, and their Families: Self Rating Scale

Below are the basic competencies that you will have the opportunity to gain through participation in this institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to achieve for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

AW = Awareness. I have heard about, but don't know it's full scope such as it's principles, components, applications and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	Aw	K	A	M	U	Aw	K	A	M
1. Demonstrate understanding of P.L. 99-457.										
2. Demonstrate understanding of family systems theory.										
3. State program philosophy.										
4. State overall program goals.										
5. Name a minimum of four assessment instruments and their uses with the birth to three year old population.										
6. Choose appropriate assessment instruments for various purposes.										
7. Name a variety of family assessments.										
8. Choose appropriate family assessments for different purposes.										
9. Demonstrate skills in interviewing families for assessment purposes (e.g., setting and following an agenda, obtaining pertinent information without being obtrusive).										

Participant will:	Where I Am					Where I Want To Be				
	U	Aw	K	A	M	U	Aw	K	A	M
10. Demonstrate good communication skills with families including:										
effective listening (eye contact, silence, paraphrase)										
effective inquiry (open-ended questions, silence)										
effective reflection of feeling ("I hear you saying...")										
effective reflection of content (paraphrase)										
11. Demonstrate sensitivity to family needs.										
12. Communicate assessment results to families and/or other professionals in understandable terms.										
13. Prepare families for their role in team meetings.										
14. Involve families in goal setting.										
15. Demonstrate an understanding of family empowerment.										
16. Demonstrate skills in writing statements on family concerns, priorities and resources.										
17. Demonstrate skills in writing family goals.										
18. Demonstrate a knowledge of the components of an IFSP.										
19. Incorporate goals identified by the family into the IFSP.										
20. Demonstrate skills in writing functional child goals from assessment information.										
21. Demonstrate skills in writing functional short term behavioral objectives for children.										
22. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.										
23. Utilize functional activities to address goals and objectives.										
24. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.										
25. Demonstrate skills in providing instruction to groups of children from one to three years of age.										

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 1 - AGENDA

TOPIC	FORMAT
Introductions/Logistics	Informal Discussion
Public Law 99-457	Lecture/Discussion
Program Philosophy	Lecture/Discussion
Stretch Break	
Family Systems Theory/ Family Empowerment	Lecture/Discussion
Lunch	
"Family Centered Care"	Film/Activity
Building Relationships with Families	Discussion
Wrap Up	

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 1 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify the ages of the children mandated to receive services according to P.L. 99-457 and when the services must be in place.

2. be able to identify New York's lead agency for children age birth to three.

3. understand the family systems principles of homeostasis and reverberation.

4. be able to identify the four components of Ann Turnbull's family systems theory.

5. understand the basic principle of family empowerment.

6. be able to identify the philosophy of family centered care.

7. be able to identify the techniques used to collect family information.

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

SESSION 1 READINGS

Smith, B. J., & Strain, P. S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

McGonigel, M.J., Johnson, B.H. & Kaufman, R.R. (1992). A family-centered process for the Individualized Family Service Plan. Journal of Early Intervention, 15(1), 46-56.

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

Session Dates

	Date:	Time:
Orientation	March 19	12:00-1:00
Session 1	March 20	9:30-3:00
Session 2	March 27	3:45-6:15
Session 3	April 2	3:45-6:15
Session 4	April 9	3:45-6:15
Session 5	April 23	3:45-6:15
Session 6	April 30	3:45-6:15
Session 7	May 7	3:45-6:15

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 2 - AGENDA

TOPIC	FORMAT
Logistics	Informal Discussion
Overview of Communication& & Interview Skills	Lecture/Discussion
Stretch Break	
Practice Family Interviews	Group Activity
Brass Tacks	Group Activity
Wrap Up	

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BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 2 - OBJECTIVES

At the end of this session, participants will:

1. be able to name the four phases of a family interview.
2. be able to identify three principles of family assessment.
3. have practiced using communication and interview skills and receive feedback.
4. be able to identify the techniques used to collect family information.
5. have practiced using communication and interview skills and receive feedback.
6. have reviewed and discussed the first two areas of Brass Tacks.

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PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

SESSION 2: READINGS

Bailey, D. B. (1988). Rationale and model for family assessment in early intervention. In D. B. Bailey & R. J Simeonsson (Eds.), Family assessment in early intervention (pp. 1-25). Columbus, OH: Charles E. Merrill Publishing Company.

Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

REFERENCES

Sexton, D. et al (1991). Considerations in using written surveys to identify family strengths and needs during the IFSP process. Topics in Early Childhood Special Education, 11(3), 81-91.

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
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PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 3 - AGENDA

TOPIC	FORMAT
Logistics	Informal Discussion
Child Assessment Tools: Purpose & Characteristics	Lecture/Discussion
Stretch Break	
Methods & Best Practices of Child Assessment	Lecture/Discussion
Team Assessment	Video/Discussion

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT
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New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 3 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify appropriate assessment instruments to use for a specific purpose when assessing infants and toddlers.
2. be able to determine whether a particular assessment instrument is standardized, norm-referenced or criterion-referenced.
3. be able to identify procedures and best practices for assessing infants and toddlers.
4. be familiar with three different developmental assessments that are used with infants and toddlers.

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PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

READINGS

SESSION 3:

Bailey, D.B. (1989). Assessment and its importance in early intervention. In D. Bailey & M. Wolery (Eds.), Assessing infants and preschoolers with handicaps (pp. 1-21). Columbus, OH: Charles E. Merrill Publishing Company.

Kjerland, L. & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E. Gibbs & D. Teti (Eds.) Interdisciplinary assessment of infants: A guide for early intervention professionals. Baltimore: Paul H. Brookes.

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
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New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 4 - AGENDA

TOPIC	FORMAT
Logistics	Informal Discussion
Team Meetings	Discussion
Sharing Assessment Results with Families	Discussion
Stretch Break	
Goal Setting with Families	Lecture/Discussion
Collaborating with Families	Group Activity

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BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Cedarwood Hall
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

SESSION 4 - OBJECTIVES

At the end of this session, participants will:

1. identify purposes of team meetings.
2. be familiar with guidelines for team meetings.
3. be familiar with guidelines for setting goals with families.
4. have had experience using an interactive problem solving model.

BIRTH TO THREE INSERVICE TRAINING PROJECT
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PROGRAMMING FOR INFANTS, TODDLERS & THEIR FAMILIES

READINGS

SESSION 4:

Bailey, D.B. (9187). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7(2), 59-71.

Deal, A.G., Dunst, C.J., & Trivette, C.M. (1989). A flexible and functional approach to developing Individualized Family Support Plans. Infants and Young Children, 1(4), 32-43.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

	Content	Format
Session 1:	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	"Family Centered Care"	Film
	Program Goals	Lecture/Discussion
Session 2:	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
	EI Roles	Discussion
	Why We Assess Families	Discussion
	Types & Methods of Family Assessment	Lecture/Discussion
Session 3:	Overview of Communication & Interview Skills	Lecture/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Group Activity
Session 4:	Child Assessment Tools: Purposes and Characteristics	Lecture/Discussion
	Methods & Best Practices of Child Assessment	Lecture/Discussion
	Team Assessments	Discussion
	Review Assessment	Group Activity
Session 5:	Team Meetings	Discussion
	Sharing Assessment Results with Families	Discussion
	Goal Setting with Families	Lecture/Discussion
	Collaborating with Families	Group Activity

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Session 6:	Review Components of IFSP	Group Participation
	Family Outcomes	Lecture/Discussion
	Writing Family Outcomes	Group Activity
Session 7:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives: Definition & Examples	Lecture/Discussion
	Writing Child Outcomes & Objectives: Case Studies	Group Activity
Session 8:	Overview of Teaching Principles	Lecture/Discussion
	Incidental Teaching	Lecture/Discussion
	Instructional Programs	Lecture
	Case Study: Writing Instructional Programs	Group Activity
Session 9:	IFSP Implementation	Lecture/Discussion
	Transitions	Lecture/Discussion
	Post Measures	

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BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

Programming for Infants, Toddlers and Their Families

The objectives of the Programming for Infants, Toddlers and Their Families Institute were based on the knowledge and skills needed to work effectively with young children with disabilities and their families. Through the course of the institute, the particpants apply the knowledge and skills in their home program by completing competencies. These competencies relate directly to the institute objectives. The general goals of the institute are as follows:

Each participant will:

1) write overall program goals that reflect the philosophy of the program;
2) demonstrate the ability to choose appropriate means for family assessment, demonstrate skills in conducting family assessments through interviews and demonstrate the ability to summarize the results of family assessments;
3) demonstrate the ability to choose appropriate child assessments, demonstrate skills needed to assess children and demonstrate the ability to summarize result of child assesments in writing;
4) work collaboratively with families to determine child and family goals;
5. write IFSP's that include all necessary components and reflect the needs of the child and family;
6) demonstrate the ability to write instructional programs based on an IFSP objectives;
7) demonstrate the ability to implement instructional programs functional activities, utilizing effective instructional delivery and teaching procedures;
8) develop an activities catalog which includes objectives that could be implemented during infants' and toddlers' routine,daily activities either at home or in the classroom;
9) evaluate two published curricula guides designed for use with infants and toddlers.

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PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

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Session 2:

Bailey, D. B. (1988). Rationale and model for family assessment in early intervention. In D. B. Bailey & R. J Simeonsson (Eds.), Family assessment in early intervention (pp. 1-25). Columbus, OH: Charles E. Merrill Publishing Company.

McGonigel & Kaufman, (1992).

Session 3:

Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

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Session 7:

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. Topics in Early Childhood Special Education, 2(4), 9-14.

Session 8:

Session 9:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Implementing the Individualized Family Service Plan. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 51-60). Washington, D.C: ACCH.

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SAMPLE TASKS

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PROGRAMMING FOR INFANTS, TODDLERS AND THEIR FAMILIES

FOLLOW UP ACTIVITIES

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy/Goals	The team will review the program philosophy and goals If deemed necessary they will be updated.	Input from the trainers will be provided as requested.
2) Family Assessment	The participant will: a) review a minimum of two (2) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare - an agenda - open-ended questions During the interview, the partcipant will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments will be completed on a form provided during the training sessions. Written summaries of results and implications for services must include: - family concerns, priorities and resources - implications for programming Summaries will be submitted to the instructor. The instructuor will provide written feedback.

DESCRIPTION	PROGRAM TASK	CRITERIA
3) Child Assessment	The participant will: a) review two (2) developmental assessments including one standardized, for use with the 0-3 population b) choose one assessment to administer to a child in your program for the purpose of developing goals for the IFSP.	 a) Reviews will be completed on a form provided by the instructor and submitted to the instructor for review b) Written score sheets, summaries of the results, and implications for programming must be submitted to the instructor for review.
4) Individualized Family Service Plan	In collaboration with the family and team members the participant will write an IFSP that includes the following components: a) Statement of the infant/toddler's level of development (cognitive, speech/language, psychosocial, motor and self-help). b) Statement of the family's strengths and needs relating to enhancing the child's development c) Statement of major outcomes expected to be achieved for the child and family d) Criteria, procedures and timelines for determining progress e) Specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency and intensity of services f) Projected dates for initiation of services and the anticipated duration of services g) Name of the case manager who is responsible for implementation of the plan and coordination with other agencies h) A transition plan for the delivery of special education services and related services in the child's next environments	The IFSP will be submitted to, discussed with the intervention team and the instructor. The goals and objectives delineated in the IFSP must correspond to the goals prioritized by the family and the intervention team and must be functional.

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Activities Catalog	The participant will: a) choose five (5) routines that occur during an infant/ toddler's typical day (either home or class-room). Examples include arrival, departure, mealtime, art, circle, diapering/ toileting. b) develop and describe for each of the five routines, an activity that will enhance development and that can naturally be implemented as part of the routine. c) address how example goals from each domain (cognition, communication, psychosocial, self-help, and motor) can be incorporated into the activities.	The catalog will be submitted to and approved by the instructor.
6) Family-Centered Practices	The participant will select two (2) parameters from Brass Tacks 2: Individual Interactions with Families to incorporate into current early intervention practices. The selected parameters may be utilized to enhance already existing practices or to inroduce new practices into early intervention services.	Written rationale to support selected parameters must include: -a description of practice prior to implementation of changes -actions taken to enhance or introduce practices -outcomes resulting from changes in practices Rationales will be submitted to the instructor. The instructor will provide written feedback.

Alcott School

Programming for Infants, Toddlers & Their Families

Brainstorming Session: April 2, 1992

Strategies for Changing Assessment Process:

°designate one program day per month as assessment day where no services are delivered.

°perform assessments before the academic year begins.

°designate one hour per week as a scheduled assessment session.

°designate two assessment "teams" of professionals available to perform assessments on a rotating schedule.

°utilize an arena assessment format: one professional interacts with child, one or more professionals record scores.

°utilize substitute teachers during assessments.

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ALCOTT SCHOOL
SESSION 4: APRIL 2, 1992

PROBLEM STATEMENT	STRATEGIES FOR EFFECTIVE TEAMING
How can we use time with social workers more effectively? ***How can we use social workers' strengths as a resource?***	* ask social workers how they envision their role on the team and what strategies they think would help achieve that vision *consumer questionnaire for staff & families re: how to use resource
SOCIAL WORKER'S ROLE AMBIGUOUS	* team envisions role of social work as: providing training, resource for staff, problem solving specific child/family situations, objective participant who has close working relationship with team members *clarify purpose of meeting with social worker & teacher * alternate how time is spent w/social workers: one week in meetings, one week in classrooms * ask social workers to spend more time in classrooms to get to know children. Ask social workers to participate in classroom activities and give them a task.
INEFFECTIVE TEAM MEETINGS (not focused, unproductive	*assign a facilitator to stay on task *rotate responsibility for taking minutes
GIVING ASSESSMENT AND RESULTS	*in a manner which is meaningful to families *in results shared w/families *on written and verbal results *strengths included *limit/explain jargon

APPENDIX L

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Table 1 Participant Demographics for the Sunnyview Rehab. Transdisc. Teaming Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
6	PT	MS	Physical Therapy	Yes	0	2 months
7	ST	MS, CCC, SLP	Speech Pathology	Yes	3	3
8	PT	BS	PT	Yes	3	18
9	Psychologist	MA	Psychologist	Yes	0	5
10	OT	BS	OT	Yes	7	11

Table 2
Self Rating Scale Results for SUNNYVIEW TRANSDISCIPLINARY TEAMING INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	2.80	4.00	4.40
2 Understand family systems theory.	2.60	4.60	4.40
3. State program philosophy.	2.80	4.00	4.40
4. Name variety of assessment instruments for B-3 years.	2.20	3.60	4.40
5. Choose appropriate assessment instruments.	3.00	3.60	4.60
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing	4.20	4.00	4.80
7. Demonstrate skill in writing results assessments.	3.80	3.60	4.80
8. Name family assessments.	3.40	4.00	4.80
9. Choose appropriate family assessments.	3.40	3.60	4.80
10. Demonstrate skills in interviewing families.	4.00	3.60	4.40
11. Skills in writing results of family assessments.	3.60	3.60	4.40
12. Communication skills with families including: effective listening (eye contact, silence, paraphrase) effective inquiry (open-ended questions, silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)	3.20	3.60	4.20
13. Sensitivity to family needs.	3.00	3.80	4.40
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families	3.20	3.40	4.40

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Table 2 (Cont'd)
Self Rating Scale Results for SUNNYVIEW TRANSDISCIPLINARY TEAMING INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	4.20	4.60	4.60
16. Communicate assessment results to families.	3.60	3.60	4.60
17. Prepare families for role in team meetings.			
18. Involve families in goal setting.			
19. Understanding of family empowerment.			
20. Skills in writing functional behavioral objectives.			
21. Writing statements on family strengths and weaknesses.			
22. Writing family goals.			
23. Knowledge of components of an IFSP.			
24. Incorporate family priorities into the IFSP.			
25. Incorporate child goals into functional activities.			
26. Review and update goals.			
27. Write and follow a flexible agenda for home visits.			
28. Evaluate home visits/classroom activities.			
29. Collaborate with other community agencies.			
30. Training staff on IFSP development.			

Table 4
Mean scores across participants from the SUNNYVIEW REHAB CENTER TRANSDISCIPLINARY TEAMING INSTITUTE for each item on the consumer satisfaction survey.

ITEM	Mean Scores
Objectives Met	4.20
Topics Covered	4.60
Relevant Material	5.00
Adequate Illustration	4.80
Time Organized	4.20
Information Relevant to Work	4.00
Better Understanding of Subject	4.80
Presenter Prepared	5.00
Presenter Knowledgeable	5.00
Presenter Used Activities	4.80
Presenter Easy to Listen to	5.00
Presenter Valued Input	5.00
Environment Comfort	4.20
Adequate Breaks	4.40
Good Group Size	5.00
Good Location	4.80
Good Day and Time	4.20

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

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Table 3
<u>Pre-post test scores for individual participants from the SUNNYVIEW REHAB CENTER TRANSDISCIPLINARY TEAMING INSTITUTE</u>

Participant #	Pre Test	Post Test 1	Post Test2
6	65%	95%	95%
7	75%	95%	89%
8	65%	100%	100%
9	45%	90%	90%
10	70%	90%	85%
Mean Scores	**64%**	**94%**	**92%**

ERIC Full Text Provided by ERIC

SUNNYVIEW
AGENDA
OCTOBER 5 and 12, 1992
TRANSDISCIPLINARY TEAMING

Day 1	**CONTENT**
8:30 - 4:00	Pre-evaluation measures/Orientation

BREAK

What is a Team?
- Definition and Purpose

Team Models
- ACTIVITY: "Comparison of Team Models"

Team Development
- Definition
- Steps for Team Development
- Variables to Team Development

LUNCH

Team Effectiveness
- ACTIVITY: "Yardstick" Growth of a Team
- Team Effectiveness and the Assessment Process

BREAK

Improving Team Function
- Key Areas
- Stragegies for Improving Team Function

Summary
- Looking at Follow-up

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Day 2	CONTENT
10:00 - 4:00	Who Can Perform Assessments?

Including Families in the Assessment Process
- Family Centered/directed Approach
- Facilitating Partnerships With Families
- Conducting Team Assessments

BREAK

Writing Family Outcomes
- Goal Setting With Families
- ACTIVITY: Case Study "Marjorie"

LUNCH

Preparing an Integrated Team Report
- Sample Report

VIDEO: Teams in Action
- ACTIVITY sheets

Follow-up Tasks

Post-Institute Questionnaire

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BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

SUNNYVIEW REHABILITATION CENTER TEAMING INSTITUTE READINGS

TEAMING

Holm, M.D., & McCartin, R. (1978). Team functioning and staff development. In M.D. Holm & R. McCartin (Eds.), Early intervention: A team approach (pp. 102-103). Baltimore: University Park Press.

Landerholm, E. (1990). The transdisciplinary team approach to infant intervention programs. Teaching Exceptional Children, 22(2), 66-70.

Lyon, S., & Lyon, G. (1980). Team functioning and staff development: A role release approach to providing integrated educational services for severely handicapped students. Journal of the Association for Persons with Severe Handicaps, 5(3), 250-263.

Orelove, F., & Sobsey, D. (1987). Designing transdisciplinary services. In F. Orelove & D. Sobsey (Eds.), Educating children with multiple disabilities (pp. 1-24). Baltimore: Paul H. Brooks.

ASSESSMENT

Foley, G.M. (1990). Portrait of the arena evaluation In E.D. Gibbs, & D. M. Teti (Eds.), Interdisciplinary assessment of infants (pp. 271-286). Baltimore: Paul H. Brookes.

Kjerland, L., & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E.D. Gibbs, & D.M.Teti (Eds.), Interdisciplinary assessment of infants (pp. 287-297). Baltimore: Paul H. Brookes.

IFSP

Decker, B. (1992). A comparison of the Individualized Education Plan and the Individualized Family Service Plan. The American Journal of Occupational Therapy, 46(3), 247-252.

Kalmanson, B., & Seligman, S. (1992). Family-provider relationships: The basis of all interventions. Infants and Young Children, 4(4), 46-52.

McGonigel, M.J., & Garland, C.W. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. Infants and Young Children, 1(1), 10-21.

McGonigel, M.J., Johnson, B.H. & Kaufman, R.R. (1992). A family-centered process for the Individualized Family Service Plan. Journal of Early Intervention, 15(1), 46-56.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Identifying child and family strengths and needs. In B.H. Johnson, M.J. McGonigel, & R.R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 31-39). Washington, D.C: ACCH.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health (1989). Developing the IFSP: Outcomes, strategies, activities and services. In B.H. Johnson, M.J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 41-49). Washington, DC: ACCH.

Sokoly, M.M., & Dockeki, P.R. (1992). Ethical perspectives on family centered early intervention. Infants and Young Children, 4(4), 23-32.

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FAMILY SUPPORT/EARLY INTERVENTION
WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
NEW YORK MEDICAL COLLEGE

BIRTH TO THREE INSERVICE TRAINING PROGRAM

TEAMING PRE/POST QUESTIONNAIRE

Name: ______________________________ Date: ____________

1. Name the three most commonly utilized team models with a brief definition of each.

____
____
____
____
____
____
____
____
____
____
____
____

2. In the transdisciplinary team model, each team member separately conducts their own assessments and then shares their program plans with one another.

True False

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3. A philosophy that guides the transdisciplinary team model is:

   a. Team members recognize the importance of contributions from other disciplines.

   b. Team members teach, learn, and work together across discipline boundaries to implement unified service plans.

   c. Team members are willing and able to develop, share and be responsible for providing services that are part of the total service plan.

   d. None of the above

4. It is possible to implement the transdisciplinary team model in one part of an early intervention program (e.g. in the intervention process) but not implement it in other parts of an early intervention program (e.g. in the assessment process).

   True False

5. Direct therapy for children is not part of the transdisciplinary model.

   True False

6. List three factors that influence team effectiveness:

   ____
   ____
   ____

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7. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

True False

8. The best way to determine child goals is to address the items the child missed on the assessment.

True False

9. The following is a good example of how *functional* goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

10. Name two ingredients that contribute to an effective team meeting.

____

____

11. Which of the following statements are rationales for collaborative goal setting with families?

a.) Families will cooperate more readily when professionals determine goals and then share them.

b.) Relationships, trust and respect will be improved.

c.) Ownership of goals is an important factor in accomplishing them.

1.) a,c
2.) b,c
3.) a,b
4.) all of the above

12. Goals that address needs prioritized by the family should always be included in the IFSP.

True False

13. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a day care for Peter."

True False

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Birth to Three Inservice Training Project

Name:______________________ Program:______________________ Date:________

Teaming: Self Rating Scale

Below are the basic competencies that you will have the opportunity to gain through participation in this institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to achieve for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

AW = Awareness. I have heard about, but don't know it's full scope such as it s principles, components, applications and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	A	M	U	AW	K	A	M
1. State program philosophy.										
2. Demonstrate understanding of the characteristics of multidisciplinary, interdisciplinary, and transdisciplinary teams.										
3. Describe own team structure.										
4. Describe program's policies and procedures relating to team functioning (e.g., team members, system of communication, meetings, assessment, writing plans/goals, training others, program implementation).										
5. Conduct transdisciplinary assessments.										
6. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing an integrated assessment report										
8. Plan a team meeting, including:										
formulating an agenda										
contacting participants										
preparing families										

Participant will:	Where I Am					Where I Want To Be				
	U	Aw	K	A	M	U	Aw	K	A	M
9. Facilitate a team meeting, including:										
following the agenda										
ensuring opportunity for participating of all members										
ensuring minutes are taken and distributed										
10. Communicate assessment results to families and/or other professionals in understandable terms.										
11. Including families in team meetings.										
12. Develop child and family goals as a team, with families										
13. Demonstrate skills in writing functional behavioral objectives for children across disciplines.										
14. Demonstrate sills in determining family concerns, priorities and resources.										
15. Share knowledge and skills of own discipline with other team members.										
16. Learn knowledge and skills from other team members.										
17. Additional skills desired: (please write in any skills you would like to improve). __________ __________ __________										

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SAMPLE TASKS

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SUNNYVIEW REHABILITATION CENTER
TEAMING INSTITUTE TASKS

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	The team will develop a program philosophy which addresses the following areas: 1) Infant Assessment 2) Family Involvement 3) Team Functioning	Philosophy statement should be written as a team and reviewed with the inservice staff.
2) Current Team Model	The staff will identify their current team model and will describe: a) members of the team (i.e., background and training, percentage of time spent with program) b) roles and responsibilities of team members (include how instruction and therapy are provided) c) frequency and length of team meetings d) purposes of team meetings e) structure of assessments f) development of instructional goals g) barriers to transdisciplinary teaming	The description of the team model should address the components delineated in the program task and will discussed with the inservice staff..
3) Policies and Procedures	The team will develop policies and procedures for the implementation of a transdisciplinary team model. The following issues should be addressed: a) team members b) system of communication c) meetings d) assessment e) writing plans/goals f) including families	The policies and procedures will be discussed with the inservice staff.

DESCRIPTION	PROGRAM TASK	CRITERIA
4) Assessment	The Sunnyview evaluation team will develop a system for conducting joint assessments on infants/toddlers utilizing assessments that address all areas of development. An integrated report format will be used to synthesize results of the assessment. A system for allowing families to be active participants in this process will also be developed.	The team will discuss the joint evaluations with members of the inservice staff. Integrated reports will be subnitted with an opportunity for feedback provided.
5) Team Meetings	A system for conducting regular team meetings will be developed. This system should include a process for the following to happen: a) notifying all team members b) ensuring there is a written agenda c) ensuring there is a meeting facilitator d) ensuring there is a meeting recorder e) ensuring the minutes are distributed to all who attended the meeting as well as those who were absent f) including families in the meetings	Written information on at least two team meetings will be share with the inservice staff. An opportunity to discuss the meetings will be provided.

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DESCRIPTION	PROGRAM TASK	CRITERIA
6) IFSP	In collaboration with each family, the team will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expected duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will discussed with the inservice staff. The goals delineated in the IFSP must correspond to the goals prioritized by the staff and family during meetings and interviews.

PHILOSOPHICAL ASSUMPTIONS

The Sunnyview Transdisciplinary Early Childhood Development Team was developed to provide an individualized, competency-based evaluation for the birth through three year old population. Each child's level of development is assessed across disciplines via formal and informal measures. The focus of the evaluation and intervention is the child and family. Parents are active and participating members of the assessment team as they are believed to be the child's primary interventionist. Team members work towards empowering the family to advocate for appropriate services and to enhance their ability to do their own ongoing assessment of their child. Inter-agency collaboration is considered an integral portion of the follow-up process.

Acquisition of functional skills enables the child to function in current environments while preparing for requirements of future environments. Optimal child development is believed to be dependent upon a variety of factors to include; the child's medical condition, good nutrition, appropriate environmental stimulation, the child caregiver bond, and realistic expectations of the family towards the child. Family strengths and resources are analyzed and put to optimal use.

Family diversity including racial, ethnic and cultural values is highly respected. It is advocated that intervention will be provided in natural environments following normal family routines. Sibling understanding is also considered a priority.

Team members can include a psychologist, speech/language pathologist, occupational therapist, physical therapist, social worker, and audiologist as deemed appropriate for each individual child.

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SUNNYVIEW REHABILITATION HOSPITAL
1270 Belmont Avenue
Schenectady, New York 12308
(518) 382-4550

Transdisciplinary Evaluation

Name:
Date of Evaluation:
Address:
Sex:
Date of Birth:
Age at Evaluation:
Parents/Caregivers:
Examiners:

Reason for Referral:

Assessment Techniques:

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Family Social History:

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Clinical Findings:

Cognition:

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Speech and Language:

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Motor:

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Summary:

Recommendations:

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APPENDIX M

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Table 1 Participant Demographics for the PARC Preschool IFSP Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
1	Social Work Asst.	HS		no	7	7
2	ECSE	BS	Spec. Ed & EL Ed.	no	1	1
3	ECSE	MA	Spec.Ed. & EL Ed.	no	2	3
4	Psychologist	Post Masters	Psychology	Yes	4+	10
5	OT	BS	OT	no	18	18

Table 2
Self Rating Scale Results for PARC IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	1.80	2.00	4.00
2. Understand family systems theory.	2.40	4.00	3.40
3. State program philosophy.	2.20	3.00	3.20
4. Name variety of assessment instruments for B-3 years.	3.20	2.00	4.20
5. Choose appropriate assessment instruments.	3.00	2.00	4.00
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing	3.00	2.00	4.40
7. Demonstrate skill in writing results assessments.	2.80	3.00	4.20
8. Name family assessments.	1.80	2.00	3.00
9. Choose appropriate family assessments.	2.00	2.00	2.60
10. Demonstrate skills in interviewing families.	3.00	4.00	3.80
11. Skills in writing results of family assessments.	2.80	4.00	3.80
12. Communication skills with families including: effective listening (eye contact. silence. paraphrase) effective inquiry (open-ended questions. silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)	3.60	4.00	4.40
13. Sensitivity to family needs.	3.00	5.00	4.00
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families	3.60	5.00	4.20

Table 2 (Cont'd)
Self Rating Scale Results for PARC IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	3.40	5.00	4.20
16. Communicate assessment results to families.	3.20	4.00	4.40
17. Prepare families for role in team meetings.	2.80	5.00	4.00
18. Involve families in goal setting.	3.20	5.00	3.80
19. Understanding of family empowerment.	3.00	5.00	4.00
20. Skills in writing functional behavioral objectives.	3.40	4.00	3.80
21. Writing statements on family strengths and weaknesses.	2.80	5.00	3.40
22. Writing family goals.	2.40	5.00	3.40
23. Knowledge of components of an IFSP.	2.20	4.00	3.60
24. Incorporate family priorities into the IFSP.	2.80	4.00	3.80
25. Incorporate child goals into functional activities.	3.20	4.00	4.00
26. Review and update goals.	3.40	4.00	3.80
27. Write and follow a flexible agenda for home visits.	2.80	3.00	3.40
28. Evaluate home visits/classroom activities.	2.60	3.00	3.40
29. Collaborate with other community agencies.	2.40	4.00	3.80
30. Training staff on IFSP development.	2.20	3.00	3.20

Table 3
Pre-post test scores for individual participants from the PARC PRESCHOOL IFSP INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
1	28%	84%	97%
2	25%	87%	92%
3	33%	84%	97%
4	58%	97%	92%
5	35%	89%	95%
Mean Scores	**36%**	**88%**	**94%**

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Table 4
Mean scores across participants from the PARC PRESCHOOL IFSP INSTITUTE for each item on the consumer satisfaction survey

ITEM	Mean Scores
Objectives Met	4.60
Topics Covered	4.80
Relevant Material	5.00
Adequate Illustration	4.60
Time Organized	4.80
Information Relevant to Work	4.20
Better Understanding of Subject	4.80
Presenter Prepared	5.00
Presenter Knowledgeable	5.00
Presenter Used Activities	5.00
Presenter Easy to Listen to	5.00
Presenter Valued Input	5.00
Environment Comfort	5.00
Adequate Breaks	5.00
Good Group Size	5.00
Good Location	5.00
Good Day and Time	4.40

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

BIRTH TO THREE INSERVICE TRAINING PROJECT

Family Support/Early Intervention
Institute for Human Development
New York Medical College

INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
Session 2:	"Family Centered Care"	Film/Activity
	Collecting Family Information	Lecture/Discussion
	Overview of Communication & Interview Skills	Activity/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Home Activity
Session 3:	Overview of Child Assessments	Lecture
	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Case Study	Group Activity
Session 4:	Review Components of IFSP	Group Participation
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
Session 5:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives	Lecture/Discussion
Session 6:	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
Institute for Human Development
New York Medical College

IFSP INSTITUTE READINGS

SESSION 1:

McGonigel, M. J., Johnson, B. H. & Kaufman, R. R. (1991). A family centered process for the Individualized Family Service Plan. Journal of Early Intervention, 15(1), 46-56.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Building positive relationships between professionals and families. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 23-30). Washington, DC: ACCH

SESSION 2:

Kaiser, A.& Hemmeter, M.L. (1989). Value-based approaches to family intervention. Topics in Early Childhood Special Education, 8(4), 72-86.

Kalmanson, B., & Seligman, S. (1992). Family-provider relationships: The basis of all interventions. Infants and Young Children, 4(4), 46-52.

Smith, B.J. & Strain, P.S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

SESSION 3:

Kjerland, L. & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E. Gibbs & D. Teti (Eds.) Interdisciplinary assessment of infants: A guide for early intervention professionals. Baltimore: Paul H. Brookes.

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Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

SESSION 4:

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Deal, A.G., Dunst, D.J., & Trivette, C.M. (1989). A flexible and functional approach to developing Individualized Family Support Plans. Infants and Young Children, 1(4), 32-43.

Decker, B. (1992). A comparison of the Individualized Education Plan and the Individualized Family Service Plan. The American Journal of Occupational Therapy, 46(3), 247-252.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Developing the IFSP: Outcomes, strategies, activities and services. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 41-49). Washington, DC: ACCH.

SESSION 5:

Rainforth, B. & Salisbury, C. L. (1988). Functional home programs: A model for therapists. Topics in Early Childhood Special Education, 7(4), 33-45.

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. Topics in Early Childhood Special Education, 2(4), 9-14.

SESSION 6:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Implementing the Individualized Family Service Plan. In B. H. Johnson, M.J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 51-60). Washington, DC: ACCH.

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	"Family Centered Care	Film
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
Session 2:	Child Assessment Tools: Purposes and Characteristics	Lecture/Discussion
	Methods & Best Practices of Child Assessment	Lecture/Discussion
	Review Assessments	Group Activity
Session 3:	Why We Assess Families	Lecture/Discussion
	Types & Methods of Family Assessment	Lecture/Discussion
	Overview of Communication & Interview Skills	Lecture/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Group Activity
Session 4:	Team Meetings	Discussion
	Sharing Assessment Results with Families	Discussion
	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Mock Situation	Group Activity
Session 5:	Review Components of IFSP	Group Participation
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity

Birth to Three Inservice Training Project

Name________________________ Program________________________ Date______________

INDIVIDUALIZED FAMILY SERVICE PLAN: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the IFSP institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demon strate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. Demonstrate understanding of P.L. 99-457.										
2. Demonstrate understanding of family systems theory.										
3. State program philosophy.										
4. Name a variety of assessment instruments and their uses with the birth to three year old population.										
5. Choose appropriate assessment instruments for various purposes.										
6. Demonstrate skills in administering assessments to young children: through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing results of child assessments.										
8. Name a variety of family assessments.										
9. Choose appropriate family assessments for different purposes.										

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Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
10. Demonstrate skills in interviewing families for assessment purposes (e.g., setting and following an agenda, obtaining pertinent information without being intrusive).										
11. Demonstrate skills in writing results of family assessments.										
12. Demonstrate good communication skills with families including:										
effective listening (eye contact, silence, paraphrase)										
effective inquiry (open-ended questions, silence)										
effective reflection of feeling ("I hear you saying...")										
effective reflection of content (paraphrase)										
13. Demonstrate sensitivity to family needs.										
14. Plan a team meeting, including:										
formulating an agenda										
contacting participants										
preparing families										
15. Facilitate a team meeting, including:										
following the agenda										
ensuring opportunity for participation of all members										
16. Communicate assessment results to families and/or other professionals in understandable terms.										
17. Prepare families for their role in team meetings.										
18. Involve families in goal setting.										
19. Demonstrate an understanding of family empowerment.										
20. Demonstrate skills in writing functional behavioral objectives for the child.										
21. Demonstrate skills in writing statements on family strengths and weaknesses.										
22. Demonstrate skills in writing family goals.										
23. Demonstrate a knowledge of the components of an IFSP.										
24. Incorporate goals identified by the family into the IFSP.										
25. Incorporate child goals into functional activities.										
26. Review and update goals.										

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Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
27. Write and follow a flexible agenda for home visits/ classroom activities.										
28. Evaluate home visits/classroom activities.										
29. Demonstrate an ability to collaborate with other community agencies.										
30. Demonstrate skills in training staff on various aspects of IFSP development.										
31. Additional skills desired: (please write in any skills you would like to improve.) __________ __________ __________ __________ __________ __________										

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SERVICE PLANS

SESSION 2 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify the philosophy of family centered care.

2. be able to identify the techniques used to collect family information.

3. be able to name the four phases of a family interview.

4. be able to identify three principles of family assessment.

5. have practiced using communication and interview skills and receive feedback.

6. have developed questions that they might include in collecting family information for their program.

7. have reviewed and discussed the first two areas of the Brass Tacks.

BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 3 - OBJECTIVES

At the end of this session, participants will:

1. be able to determine whether a particular assessment instrument is standardized, norm - referenced or criterion referenced and explain their uses.

2. be able to identify procedures and best practices for assessing infants and toddlers.

3. be familiar with guidelines for setting goals with families.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 4 - OBJECTIVES

At the end of this session, participants will:

1. be able to define the concept of **outcomes.**

2. be able to identify the difference between outcomes and objectives.

3. be able to identify the components of a behavioral objective.

4. have had practice writing family outcomes using a process and product format.

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FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SERVICE PLANS

SESSION 5 - OBJECTIVES

At the end of this session, participants will:

1. be able to determine functional child outcomes.

2. be able to develop child outcomes and objectives.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 6 - OBJECTIVES

At the end of this session, participants will:

1. have had practice writing functional child outcomes and corresponding objectives, complete with conditions, behavior and criteria.

2. be able to describe and identify transition plans.

SAMPLE TASKS

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Must include the three areas delineated in program task and must be subm[illegible]d to and discussed wi[illegible] instructor.
2) Child Assessment	The student will: a) review a minimum of three (3) developmental assessments including at least one standardized assessment for the 0-3 population. b) choose two (2) of the assessments to administer to three children (two who are developmentally delayed and one who is developing normally). One developmentally delayed child and one normal child must be of the same chronological age. When assessing the two developmentally delayed children, a second staff member or project staff member, who is familiar with the instrument, must accompany the student and score the child separately to determine reliability.	Written reviews of the assessments must include: - Name of assessment, author, publisher and address - Cost - Validity, reliability and norming sample data - Population recommended for - Domains assessed - Materials needed - Training needed - Type of scores obtained - Type of test (standardized, criterion referenced, etc.) - Ease of administration - Judgment a[illegible] to usefulness - Strengths and weaknesses Written summaries of the results must include: - scores obtained - skills exhibited - child's strengths and weaknesses - implications for programming Handwritten summaries of results and implications for programming must be submitted to, discussed with and approved by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASKS	CRITERIA
3) Family Assessment	The student will: a) review a minimum of three (3) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare: - an agenda - open-ended questions During the interview, the student will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments must include information on: - Rationale - Norming sample - Areas tested - Types of scores obtained - Judgments as to usefulness - Strengths and limitations Reviews must be submitted to and approved by the instructor. The instructor will observe the family interview and provide written feedback. Written summaries of results and implications for services must include: - scores obtained - family strengths and needs - implications for programming Summaries will be submitted to, discussed with and approved by the instructor.
4) Team Meeting	The student will facilitate two (2) team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the student will: a) develop a written agenda b) delineate roles and responsibilities of participants c) prepare families for their role in the meeting	The instructor will observe the team meetings and provide written feedback. The student will submit a written summary of the results of the meetings and discuss them with the instructor.

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Goal Setting	In collaboration with the family and members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	a) The family goals will reflect the needs identified by the family during the assessment process. The goals will be operationalized and non-intrusive to the family. Goals will be reviewed by the instructor. b) The child goals will reflect the needs of the child as identified by the family and the team assessment process. Goals must be operationalized and reviewed by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) IFSP	In collaboration with each family,and team members the student will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expe .ed duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will be submitted to, discussed with, and approved by the program supervisor, team, and instructor. The goals delineated in the IFSP must correspond to ·he goals prioritized by the :ff and family during meetings and interviews.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
7) Implementation of IFSP	The student will implement each of the IFSP's through contacts with the child and family, either in the home or through a center-based program. At least one of these contacts must be a home visit. Implementation of the IFSP will include: a) following written flexible agenda for a home/center visit which includes child and family IFSP objectives to be addressed during the home/center visits, and activities to address the IFSP objectives b) data collection procedures c) other evaluation procedures	The instructor will review the agenda, objectives, activities and data for the first three (3) visits, and will accompany student on at least one (1) home/center visit. Outcome of the visits will be discussed with the instructor. The instructor will also review evaluation procedures.

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Putnam Associated Resource Centers

Individualized Family Service Plan

Child's Name: Date:

DOB:

This plan was developed jointly by the following people:
(Signatures of staff & parents)

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Brief Summary Statement: (Family's strengths and needs related to enhancing development of child)

Infant/Toddler Needs:

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Infant Toddler Needs:
Physical development (vision, hearing, health):

Sensory processing:

Speech/Language development:

Psycho/Social development:

Self-Help/Adaptive:

Cognitive Development:

Family Needs/Concerns:

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Other Services Outside of PARC:

1.

2.

3.

4.

5.

Date of IFSP Meeting: ______________________

Parent Signature: ______________________

____

Service Evaluator/Provider Signature:

____

____

Care Coordinator: (circle one) Putnam County

Dutchess County

This person will be identified within a timely manner to work with the family.

Outcome Statement

Provision of the following early intervention services:

	Frequency (# of sessions and length)	Intensity (# of days)	Site	Method (Ind., Group)
1.				
2.				
3.				

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This will be reviewed together within 45 days to develop further what our expectations are, to determine progress, to make modifications or revisions, as needed.

Next review date: ____________________

Six month review date: ____________________

Annual review date: ____________________

Date of initiation of service: ____________

Duration: ____________________

Transition services were discussed with the family and training was begun with parents around future placement.

Parental consent was obtained to send information to the local school district to ensure continuity of services, including evaluation and assessment information and copies of IFSPs.

Yes __________ No __________ District ____________________

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Putnam Associated Resource Centers

Individualized Family Service Plan

Child's Name: Date: March 26, 1993

DOB: 10-5-90

This plan was developed jointly by the following people:
(Signatures of staff & parents)

Margaret Mahoney (Teacher)
Lucille Esposito S.W.A
Nancy [illegible] Prog Director

Brief Summary Statement: (Family's strengths and needs related to enhancing development of child).

Family is very aware of capabilities and limitations. Family is capable of relating & skills to the team and informing of their family needs & concerns. Family would like input in regards to discipline and corrective measures. Family feels a need to work in a cooperative manner with the team inregards to this.

Infant/Toddler Needs:

needs exposure to peers and a classroom setting

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Infant Toddler Needs:

Physical development (vision, hearing, health):

Sensory processing:

OT evaluation to be done once adjustment to program has been established

Speech/Language development:

will continue to develop a variety of sounds and eventually name objects Danny will demonstrate an understanding of the spoken language i.e. follow directions

Psycho/Social development:

will develop appropriate peer interactions and play skills

Self-Help/Adaptive:

will continue to and expand his non verbal communication skills in order to indicate his needs

Cognitive Development:

Family wants to be challenged and stimulated with appropriate cognitive tasks and activities.

Family Needs/Concerns:

Family needs to continue to be educated and observe other programs. Therapists to work with parents to identify concerns.

~~[illegible]~~

Mother expressed desire for appropriate role models for communication + asked if this exists in small group.

Family and program ~~to~~ initiate a period of

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her Services Outside of PARC:

1. - pediatrician
2.
3.
4.
5.

Date of IFSP Meeting: March 26, 1993

Parent Signature: X

Service Evaluator/Provider Signature: (Teacher)

Care Coordinator: Putnam County
(circle one)
Dutchess County

This person will be identified within a timely manner to work with the family.

Outcome Statement

Provision of the following early intervention services:

	Frequency (# of sessions and length)	Intensity (# of days)	Site	Method (Ind., Group)
1. Speech	2x	6-1-2 ratio 5 1/2 days	PARC	Individual and group In class & pullout
2. Education - To include in-house mainstreaming into larger group				
3. Team Meetings - monthly to start			At school	

4. Phone contacts with teacher - on-going

5. Transportation

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This will be reviewed together within 45 days to develop further what our expectations are, to determine progress, to make modifications or revisions, as needed.

Next review date: 6 MO.

Six month review date: 10-93

Annual review date: ______

Date of initiation of service: 4-93

Duration: 12 MO.

Transition services were discussed with the family and training was begun with parents around future placement.

Parental consent was obtained to send information to the local school district to ensure continuity of services, including evaluation and assessment information and copies of IFSPs.

(Yes) ______ No ______ District Put. Valley CSD

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Agency

Putnam Association for Retarded Children, Inc. Philosophy

The Putnam Association for Retarded Citizens is a nonprofit human service agency, guided by the belief that a developmental disability, whether it be mental retardation, cerebral palsy, epilepsy, autism or other neurological impairment, is not a static condition; that the developmentally disabled can achieve and flourish within an accepting society.

Toward those goals, the agency has sought to develop programs which address the very speci l needs of an often times multihandicapped clientele through advocacy and the opportunity to demonstrate capabilities rather than incapabilities.

Five program units are sponsored by Putnam Association for Retarded Citizens that foster personal growth. They are: Vocational Rehabilitation, Clinical Treatment, Day Treatment, Early Intervention and Residential Services.

Putnam Association of Retarded Citizens constantly seeks to encourage goal oriented behaviors through appropriate task assignment and supervision. The agency facilitates maturation and encourages aspiration towards higher levels of functioning.

The Board of Directors, composed of parents of the developmentally disabled as well as interested community friends and business persons, expends ceasel ss voluntary efforts in the service of the ideals upon which the chapter was founded.

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Putnam Association for Retarded Children
Early Intervention Services

EARLY INTERVENTION PHILOSOPHY

Our philosophy towards children's services begins with viewing children in the context of their families. Our goal is to promote and enhance the child's functioning in the educational setting as much as possible so that he can function more effectively in his home and in the community. Within this framework, we look at the specific child's strengths and needs within a developmental and a functional context, and we begin to intervene in these areas of development: self-care, cognitive, language, fine motor, gross motor. We intervene as a professional team - an interdisciplinary, combined effort - which enlists the support of the family throughout the process. Through consistent, goal-directed, skilled, professional intervention, we assist the child's development. We provide guidance to families to educate them to advocate for their child.

Some of our services are preventative, in nature, while others are remedial or rehabilitative. The guide to the type of intervention is always where the child is at developmentally at a particular point in time.

While our methods of intervention are founded in our staff's knowledge of early childhood development and in our staff's ability to treat developmentally disabled children, our approach is not solely based on our ability to apply this technology. We do not eliminate any child from services if his/her family does not subscribe to our approach completely. Our philosophy is flexible enough to accommodate families with different needs and value systems and beliefs.

It is our goal to provide the most normalized preschool experience as possible for all of our children. For each child, the experience will be quite different. We build in the principle of normalization by structuring the full day program as close to a nursery curriculum as possible. Our model is based on a curriculum that is designed around developmental needs at various stages of the child's development.

In the same way that our actions are guided by the principle of normalization, we seek to place children in the least restrictive classroom setting possible. Our intention is to intervene early in the process of development with the long-term goals of reducing the need for specialized services and placing the child in the least restrictive educational setting at 5 years of age.

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II. Overall Parent Participation Philosophy

We believe that as parents are members of the treatment team that they need to be involved in decision making on that level from the beginning. As with all treatment team members, we are looking for the input of the parent. That is, the advice and recommendations with regard to the best possible program for the child. Since we are intervening so early in the life of these children, our desire is not to lose the parent in our program, but rather to be able to incorporate them so that our program is sustained and so that the child is enriched by the parents' presence and involvement.

During the past 15 years, extensive research into child development has documented the importance of the child's attachment bond as an "organizing force" which facilitates early learning in infants and toddlers. In addition to promoting learning and problem-solving, securely-attached preschoolers can be more easily comforted by caregivers and will seek out support from their environment to explore and to further learning. Thus, "the parent as the primary caregiver has a very special significance as a force for learning in the life of the handicapped infant".

As "shared caregivers", we are supplementing this process of emotional bonding and nurturance. We will encourage the bonding and attachment of program infants and their parents.

Research has shown that, regardless of whether infants are home-reared or day-care reared, a caregiver who interacts with the child and is responsive to the child's cues enhances the child's functioning and language development.

It is our aim to support and sustain the family through providing educational and therapeutic services to the child. We believe that the school has a responsibility to parents, primarily to educate them about the process of intervention, so that they can become better advocates for their children throughout the life process. We also believe that parents have a responsibility to our school to assist our programs and to encourage them to be all that they can be. We believe that by enabling parents to be full fledged contributing members of the treatment team by being involved in the decision making process, that we are giving them the ability to have some control over the welfare and interests of their children and over all our children.

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II. A. Rationale for Parent Participation/Parent Training

Parent Participation/Parent Training is one of the ways the PARC Early Intervention Services addresses the needs of the children. Parent participation and parent training are essential aspects of EIS because:

-Ongoing information from a child's parents is necessary in order to accurately assess a child's needs and develop an appropriate service plan.

-The children in the preschool are at the ages where they have a strong need for an attachment to their parents. Involving the parents in the child's program helps the process by which the child learns to feel safe in the non-home environment. Children's behavior when they are with their parents and are feeling fully relaxed and comfortable often differs from that in a group educational setting. It is important for both staff and parents to be aware of these differences in behavior.

-The preschool incorporates professionals from a variety of disciplines. Thus the services offered to the children are complex and diverse and parents need to be educated regarding these services so that they can understand what is happening with their child and can better assist in planning for their future. Handicapped children need their parents to advocate for them. The parents need training in order for them to understand the process and what their role is. As preschool is the initial step in the educational process, the educating of parents at this stage needs to begin with the basics.

-Children respond to consistency and, by training and working with parents, aspects of the intervention provided in school can be carried over at home. At the most a child is in school at PARC for 5 hours a day. That leaves 19 hours during which the child is at home. Information passed on to a parent which benefits the child at home can have a far greater effect than services provided directly to the child. The goal of many of the skills worked on at EIS is that they become the generalized ability of the child. Parents need to understand this basic principle of the program and learn how to assist with this process. This can only happen with regular interaction between parents and staff.

-Most parents, especially first-time parents, have little or no knowledge regarding infant/child development prior to having children. Parents of all children have questions

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regarding their child's development, and many are interested in learning what is known about child/infant development. Special needs parents have an increased need for information as they want to know about normal development as well as their child's special needs. PARC is one avenue parents can explore for the information they need.

-Parents, especially those of special needs children, often have a need to talk and share their feelings and concerns about their child. Providing parents with opportunities to talk with staff and hopefully ease some of their concerns will ultimately benefit the child as well. Parents who have been given proper information or have had their anxiety decreased are more likely to interact with their child in a healthy and beneficial way.

II. B. The Treatment Team

A child's treatment team includes his/her teacher, therapists and other staff who have assessed the child, social worker, the assistant director and parents.

The team members work independently and conjointly on establishing appropriate goals, monitoring the child's progress and making recommendations for needed services both through PARC and other resources. All team members are responsible for seeking out information and communicating information regarding the child's functioning to all other team members. All team members should be familiar with all aspects of the child's program. Team members (except for parents) who directly provide services to the child are required to put in writing the specific goals established and periodic progress reports. Parents are specifically responsible for providing the team information regarding the child's functioning outside of school and for making attempts to understand the various approaches and methods recommended by PARC staff.

II. C. Therapeutic/Educational Approach

The children's needs are addressed through a combined educational and therapeutic approach. Opportunities are available for both group instruction and individual therapy. Due to the child's needs for consistency and repeated opportunities for and the complexity of the skills to be learned, there is significant overlap between the individual therapy sessions and the classroom experience. In working with young children, opportunities for direct therapeutic intervention present themselves for brief periods (at times less than one minute) throughout the day. In order to take advantage of these opportunities, both the therapists and teachers must be prepared to offer the child the most

child most. The teacher offers the therapist information regarding the child's overall behavior outside of the therapy session.

Therapists and teachers develop goals which complement each other in a variety of developmental areas. The therapist is viewed as one resource available in our environment to facilitate growth and develop in a specific area. A therapist, an occupational therapist or physical therapist, may develop an adaptive device for a child which further increases his capacity for mobility, thereby facilitating, the learning process.

Educators assess where intervention is needed and sort out a child's strengths which need to be maintained and challenge a child's needy areas which have to be changed. The educator can determine which factors facilitate learning (strengths) and which factors inhibit learning (needs). The therapists then help to determine how the team can make a difference through therapeutic intervention.

It is impossible to separate out the educational part of our approach from the therapeutic part because it is a totally integrated approach as we apply it to looking at each individual child.

One of the goals of therapy for each child is that the child develops the ability to have his/her specific needs met in a less artificial and more normalized setting. Both the teacher and therapist must be familiar with the activity of the child in either setting in order to assess the child's need for increased/decreased therapy. The ultimate goal of individual therapy in all disciplines as was stated in our statement of philosophy, is to reduce the need for specialized, restrictive, services and to increase the child's ability to function and to achieve his potential so that he may function in the most normalised, least restrictive educational setting.

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APPENDIX N

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Table 1 Participant Demographics for the COARC HUDSON IFSP INSTITUTE

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
11	Early childhood home based teacher	MA	Spec. Ed./EL. Ed.	no	2	14
12	Special Educator	MS	Special Education	no	1	8
13	PT	BS	PT	no	2	3
14	Special Educator	MS	Special Education	Yes	1 Month	12
15	OT	AAS	OT	no	1	4
16	Early childhood home based teacher	BA	N - 6	no	1 Month	5
17	Speech Pathologist	MS	Speech Therapy	no	2	13
18	Early Childhood Special Educator	MS	Spec. Ed.	no	2 Months	2
19	Adminiatrator	MS & MSW	Social Work &Spec. Ed.	no	2	4
20	Family Service Specialist	BS	Secondary Ed. & English	no	2	6

Table 2
Self Rating Scale Results for COARC IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	2.50	3.70	3.78
2. Understand family systems theory.	2.20	3.30	4.00
3. State program philosophy.	2.70	3.00	3.56
4. Name variety of assessment instruments for B-3 years.	3.00	3.30	3.78
5. Choose appropriate assessment instruments.	3.00	3.30	3.78
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing	3.40	3.60	3.89
7. Demonstrate skill in writing results assessments.	3.30	3.10	4.11
8. Name family assessments.	1.80	2.70	3.56
9. Choose appropriate family assessments.	1.80	2.80	3.78
10. Demonstrate skills in interviewing families.	2.80	3.10	3.56
11. Skills in writing results of family assessments.	2.70	2.80	3.56
12. Communication skills with families including: effective listening (eye contact, silence, paraphrase) effective inquiry (open-ended questions, silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)	3.40	3.90	4.11
13. Sensitivity to family needs.	3.50	3.90	4.56
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families	3.00	3.60	4.00

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Table 2 (Cont'd)
Self Rating Scale Results for COARC IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	3.30	4.90	4.33
16. Communicate assessment results to families.	3.30	3.90	4.11
17. Prepare families for role in team meetings.	2.80	3.60	4.00
18. Involve families in goal setting.	2.90	3.70	4.89
19. Understanding of family empowerment.	2.80	3.40	4.00
20. Skills in writing functional behavioral objectives.	2.70	3.80	3.67
21. Writing statements on family strengths and weaknesses.	2.80	3.50	3.89
22. Writing family goals.	2.80	3.10	4.00
23. Knowledge of components of an IFSP.	2.90	3.30	4.33
24. Incorporate family priorities into the IFSP.	2.90	3.80	4.33
25. Incorporate child goals into functional activities.	3.50	3.40	4.11
26. Review and update goals.	3.50	3.50	4.44
27. Write and follow a flexible agenda for home visits.	3.50	3.90	4.33
28. Evaluate home visits/classroom activities.	3.30	3.70	4.22
29. Collaborate with other community agencies.	3.10	3.70	4.00
30. Training staff on IFSP development.	2.80	3.80	3.78

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Table 3
Pre-post test scores for individual participants from the COARC HUDSON IFSP INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
11	41	87%	79%
12	46%	89%	91%
13	51%	97%	84%
14	61%	84%	91%
15	23%	87%	51%
16	30	97	91%
17	43%	71%	
18	58	92	88%
19	51	82	74%
20	35	94	95%
Mean	**44%**	**88%**	**83%**

Table 4
Mean scores across participants from the COARC HUDSON IFSP INSTITUTE for each item on the consumer satisfaction survey.

ITEM	Mean Scores
Objectives Met	4.40
Topics Covered	4.40
Relevant Material	4.90
Adequate Illustration	4.90
Time Organized	4.60
Information Relevant to Work	4.80
Better Understanding of Subject	4.60
Presenter Prepared	5.00
Presenter Knowledgeable	5.00
Presenter Used Activities	4.70
Presenter Easy to Listen to	4.90
Presenter Valued Input	5.00
Environment Comfort	3.90
Adequate Breaks	4.60
Good Group Size	4.60
Good Location	4.80
Good Day and Time	4.40

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

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INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
Session 2:	"Family Centered Care"	Film/Activity
	Collecting Family Information	Lecture/Discussion
	Overview of Communication & Interview Skills	Activity/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Home Activity
Session 3:	Review Components of IFSP	Group Participation
	Overview of Child Assessments	Lecture
	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Case Study	Group Activity
	Group Participation	
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
Session 4:	Play Based Assessment	Film/Activity
	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives	Lecture/Discussion
Session 5:	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

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Birth to Three Inservice Training Project

Name_______________ Program_______________ Date_______________

TRANSDISCIPLINARY TEAMING: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Transdisciplinary Teaming institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. Demonstrate understanding of the characteristics of multidisciplinary, interdisciplinary, and transdisciplinary teams.										
3. Describe own team structure.										
4. Describe program's policies and procedures relating to team functioning (e.g., team members, system of communication,meetings, assessment, writing plans/ goals, training others, program implementation).										
5. Conduct transdisciplinary assessments.										
6. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing results of assessments										
8. Plan a team meeting, including:										
formulating an agenda										
contacting participants										
preparing families										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
8. Facilitate a team meeting, including:										
following the agenda										
ensuring opportunity for participation of all members										
ensuring minutes are taken and distributed										
9. Demonstrate good communication skills with families and professionals including:										
effective listening (eye contact, silence, paraphrase)										
effective inquiry (open-ended questions, silence)										
effective reflection of feeling ("I hear you saying...")										
effective reflection of content (paraphrase)										
10. Communicate assessment results to families and/or other professionals in understandable terms.										
11. Prepare families for their role in team meetings.										
12. Develop child and family goals as a team.										
13. Demonstrate skills in writing functional behavioral objectives for children across disciplines.										
14. Write instructional programs that incorporate skills from more than one discipline.										
15. Conduct instructional programs within naturally occuring activities that incorporate skills from more than one discipline.										
16. Share knowledge and skills of own discipline with other team members.										
17. Learn knowledge and skills from other team members.										
18. Demonstrate skills in training staff on various aspects of transdisciplinary teaming.										
19. Additional skills desired: (please write in any skills you would like to improve.) __________ __________ __________										

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BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
Institute for Human Development
New York Medical College

IFSP INSTITUTE READINGS

SESSION 1:

McGonigel, M. J., Johnson, B. H. & Kaufman, R. R. (1991). A family centered process for the Individualized Family Service Plan. Journal of Early Intervention, 15(1), 46-56.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Building positive relationships between professionals and families. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 23-30). Washington, DC: ACCH

SESSION 2:

Kaiser, A.& Hemmeter, M.L. (1989). Value-based approaches to family intervention. Topics in Early Childhood Special Education, 8(4), 72-86.

Kalmanson, B., & Seligman, S. (1992). Family-provider relationships: The basis of all interventions. Infants and Young Children, 4(4), 46-52.

Smith, B.J. & Strain, P.S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

SESSION 3:

Kjerland, L. & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In E. Gibbs & D. Teti (Eds.) Interdisciplinary assessment of infants: A guide for early intervention professionals. Baltimore: Paul H. Brookes.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Identifying child and family strengths and needs. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 31-37). Washington, DC: ACCH.

Wachs, T. & Sheehan, R. (1988). Issues in the linkage of assess to intervention. In R. Sheehan & T. Wachs (Eds.) Assessment of young developmentally delayed children (pp. 397-406). New York: Plenuim Press.

Winton, P. J., & Bailey, D. B. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal of the Division for Early Childhood, 12(3), 195-207.

SESSION 4:

Bailey, D. B. (1987). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7(2), 59-65.

Deal, A.G., Dunst, D.J., & Trivette, C.M. (1989). A flexible and functional approach to developing Individualized Family Support Plans. Infants and Young Children, 1(4), 32-43.

Decker, B. (1992). A comparison of the Individualized Education Plan and the Individualized Family Service Plan. The American Journal of Occupational Therapy, 46(3), 247-252.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Developing the IFSP: Outcomes, strategies, activities and services. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 41-49). Washington, DC: ACCH.

SESSION 5:

Rainforth, B. & Salisbury, C. L. (1988). Functional home programs: A model for therapists. Topics in Early Childhood Special Education, 7(4), 33-45.

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. Topics in Early Childhood Special Education, 2(4), 9-14.

SESSION 6:

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Implementing the Individualized Family Service Plan. In B. H. Johnson, M.J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized FamilyService Plan (pp. 51-60). Washington, DC: ACCH.

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

IFSP PRE/POST TEST

Name: ______________________ Date: ______________________

1. Public Law 99-457 states that:

   a) states are mandated to provide services for handicapped children from birth through five years of age.

   b) states are mandated to provide services for handicapped children from birth to three years of age.

   c) states determine whether services are provided for handicapped children from birth through five years of age.

   d) states are mandated to provide services for handicapped children from three through five years of age, and can determine whether they will provide services for handicapped children from birth to three years of age.

2. Who has been designated as the lead agency in New York for programs serving handicapped children between the ages of birth and three years?

   a) Department of Education

   b) Department of Health

   c) Regional Planning Group

   d) Interagency Coordinating Council

3. Homeostasis is the family systems principle that means, "what effects one member of the family effects all others."

True False

4. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

a) family functions

b) family life cycle

c) family characteristics

d) family interaction

5. Family empowerment means:

a) helping families by doing whatever we can

b) telling families what they can do to take more power in their lives

c) families making informed choices

d) families being their own case managers

6. What three components are included in an IFSP that are not usually included in an IEP?

____

____

____

3. Homeostasis is the family systems principle that means, "what effects one member of the family effects all others."

True False

4. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

a) family functions

b) family life cycle

c) family characteristics

d) family interaction

5. Family empowerment means:

a) helping families by doing whatever we can

b) telling families what they can do to take more power in their lives

c) families making informed choices

d) families being their own case managers

6. What three components are included in an IFSP that are not usually included in an IEP?

____

____

____

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7. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

Screening (1 instrument):

____

Determining Eligibility (2 instruments):

____________________ ____________________

Program Planning (2 instruments):

____________________ ____________________

Program Evaluation (1 instrument):

____

8. Name two standardized assessments that are used with the birth to three year old population.

____

____

9. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a __________ assessment.

   a) standardized

   b) criterion referenced

   c) norm-referenced

   d) a and c

10. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

    True   False

11. Based on the results of a family assessment, the Early Intervention Specialist should decide what the family's strengths and concerns are.

    True   False

12. What are the four phases of a family interview?

    ____________________   ____________________

    ____________________   ____________________

13. List four reasons why it's important to have team meetings.

    ____

    ____

    ____

    ____

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14. Goals that address needs prioritized by the family should always be included in the IFSP.

True False

15. According to P.L. 99-457, IFSP's need to be reviewed every _________ months and rewritten every _________ months.

16. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

17. _______________ questions are the most effective means of obtaining information from families.

a) Direct

b) Close-ended

c) Open-ended

18. Circle, from the list below, those techniques that are considered to be effective means of assessing families.

a) interview

b) observing interactions

c) questionnaire

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19. List three principles that must be followed when doing family assessments.

____

____

____

20. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a daycare for Peter."

True False

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Must include the three areas delineated in program task and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review a minimum of three (3) developmental assessments including at least one standardized assessment for the 0-3 population. b) choose two (2) of the assessments to administer to three children (two who are developmentally delayed and one who is developing normally). One developmentally delayed child and one normal child must be of the same chronological age. When assessing the two developmentally delayed children, a second staff member or project staff member, who is familiar with the instrument, must accompany the student and score the child separately to determine reliability.	Written reviews of the assessments must include: - Name of assessment, author, publisher and address - Cost - Validity, reliability and norming sample data - Population recommended for - Domains assessed - Materials needed - Training needed - Type of scores obtained - Type of test (standardized, criterion referenced, etc.) - Ease of administration - Judgment as to usefulness - Strengths and weaknesses Written summaries of the results must include: - scores obtained - skills exhibited - child's strengths and weaknesses - implications for programming Handwritten summaries of results and implications for programming must be submitted to, discussed with and approved by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
3) Family Assessment	The student will: a) review a minimum of three (3) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare: - an agenda - open-ended questions During the interview, the student will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments must include information on: - Rationale - Norming sample - Areas tested - Types of scores obtained - Judgments as to usefulness - Strengths and limitations Reviews must be submitted to and approved by the instructor. The instructor will observe the family interview and provide written feedback. Written summaries of results and implications for services must include: - scores obtained - family strengths and needs - implications for programming Summaries will be submitted to, discussed with and approved by the instructor.
4) Team Meeting	The student will facilitate two (2) team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the student will: a) develop a written agenda b) delineate roles and responsibilities of participants c) prepare families for their role in the meeting	The instructor will observe the team meetings and provide written feedback. The student will submit a written summary of the results of the meetings and discuss them with the instructor.

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Goal Setting	In collaboration with the family and members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	a) The family goals will reflect the needs identified by the family during the assessment process. The goals will be operationalized and non-intrusive to the family. Goals will be reviewed by the instructor. b) The child goals will reflect the needs of the child as identified by the family and the team assessment process. Goals must be operationalized and reviewed by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) IFSP	In collaboration with each family,and team members the student will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expected duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will be submitted to, discussed with, and approved by the program supervisor, team, and instructor. The goals delineated in the IFSP must correspond to the goals prioritized by the staff and family during meetings and interviews.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
7) Implementation of IFSP	The student will implement each of the IFSP's through contacts with the child and family, either in the home or through a center-based program. At least one of these contacts must be a home visit. Implementation of the IFSP will include: a) following written flexible agenda for a home/center visit which includes child and family IFSP objectives to be addressed during the home/center visits, and activities to address the IFSP objectives b) data collection procedures c) other evaluation procedures	The instructor will review the agenda, objectives, activities and data for the first three (3) visits, and will accompany student on at least one (1) home/center visit. Outcome of the visits will be discussed with the instructor. The instructor will also review evaluation procedures.

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APPENDIX O

ERIC Full Text Provided by ERIC

Table 1 Participant Demographics for the WILLIAMSBURG IFSP INSTITUTE

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
21	PT	MA	PT	no	2 1/2	25
22	OT	BS	OT	no	5	14
23	Administrator	MS/SAS	Spec. Ed.& Administration	yes	11	11
24	Speech Pathologist	MS	Speech	no	6	6
25	Social Worker	MSW	Social Work	no	5	6
26	Speech Pathologist	MS	Speech	no	3	5
27	Social Worker	MSW	Social Work	no	2	10
28	Speech Pathologist	MS	Speech	yes	2	6
29	Early Childhood Special Educator	MS	Special Education	yes	4	4
30	Psychologist	Ph.D	Psychology	yes	25	30

Table 2
Self Rating Scale Results for WILLIAMSBURG IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	2.50	4.33	3.44
2. Understand family systems theory.	2.30	4.33	2.78
3. State program philosophy.	1.80	4.22	4.00
4. Name variety of assessment instruments for B-3 years.	3.60	4.56	4.33
5. Choose appropriate assessment instruments.	3.30	4.33	3.78
6. Demonstrate skills in administering assessments to young children: through observation structuring the environment to elicit skills through direct testing	4.00	4.38	4.33
7. Demonstrate skill in writing results assessments.	4.00	4.67	4.44
8. Name family assessments.	1.60	4.72	2.89
9. Choose appropriate family assessments.	1.40	4.44	3.00
10. Demonstrate skills in interviewing families.	2.30	4.33	3.33
11. Skills in writing results of family assessments.	2.30	4.33	3.33
12. Communication skills with families including: effective listening (eye contact. silence. paraphrase) effective inquiry (open-ended questions, silence) effective reflection of feeling ("I hear you saying...") effective reflection of content (paraphrase)	3.50	4.78	4.22
13. Sensitivity to family needs.	3.50	4.67	4.11
14. Plan a team meeting, including: formulating an agenda contacting participants preparing families	3.30	4.67	3.78

Table 2 (Cont'd)
Self Rating Scale Results for WILLIAMSBURG IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	3.50	4.67	3.78
16. Communicate assessment results to families.	3.60	4.56	4.00
17. Prepare families for role in team meetings.	2.80	4.67	3.33
18. Involve families in goal setting.	3.00	4.67	3.33
19. Understanding of family empowerment.	2.50	4.50	3.44
20. Skills in writing functional behavioral objectives.	4.00	4.88	4.33
21. Writing statements on family strengths and weaknesses.	2.50	4.44	3.22
22. Writing family goals.	2.70	4.56	3.22
23. Knowledge of components of an IFSP.	2.10	4.56	3.22
24. Incorporate family priorities into the IFSP.	1.70	4.67	3.22
25. Incorporate child goals into functional activities.	3.40	4.78	4.00
26. Review and update goals.	3.60	4.67	4.11
27. Write and follow a flexible agenda for home visits.	3.00	4.56	3.44
28. Evaluate home visits/classroom activities.	3.22	4.57	3.33
29. Collaborate with other community agencies.	3.00	4.44	3.56
30. Training staff on IFSP development.	1.63	4.56	3.11

Table 3
Pre/Post test scores for individual participants from the WILLIAMSBURG IFSP INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
21	16%	62%	60%
22	51%	92%	100%
23	51%	95%	80%
24	40%	62%	78%
25	57%	97%	
26	40%	92%	84%
27	38%	62%	54%
28	46%	95%	81%
29	24%	95%	95%
30	62%	97%	97%
Mean	**42%**	**85%**	**81%**

Table 4
Mean scores across participants from the WILLIAMSBURG IFSP INSTITUTE for each item on the consumer satisfaction survey.

ITEM	Mean Scores
Objectives Met	5.00
Topics Covered	5.00
Relevant Material	5.00
Adequate Illustration	5.00
Time Organized	4.90
Information Relevant to Work	5.00
Better Understanding of Subject	5.00
Presenter Prepared	5.00
Presenter Knowledgeable	5.00
Presenter Used Activities	4.50
Presenter Easy to Listen to	4.50
Presenter Valued Input	5.00
Environment Comfort	5.00
Adequate Breaks	4.50
Good Group Size	4.50
Good Location	5.00
Good Day and Time	5.00

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

ERIC Full Text Provided by ERIC

INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
Session 2:	"Family Centered Care"	Film/Activity
	Collecting Family Information	Lecture/Discussion
	Overview of Communication & Interview Skills	Activity/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Home Activity
Session 3:	Review Components of IFSP	Group Participation
	Overview of Child Assessments	Lecture
	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Case Study	Group Activity
	Group Participation	
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
Session 4:	Play Based Assessment	Film/Activity
	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives	Lecture/Discussion
Session 5:	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

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Birth to Three Inservice Training Project

Name____________________ Program____________________ Date__________

INFANT CURRICULA: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Infant Curricula institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. State overall program goals.										
3. Name a minimum of four assessment instruments and their uses with the birth to three year old population.										
4. Choose appropriate assessment instruments for various purposes.										
5. Demonstrate skills in administering assessments to young children: through observation,										
structuring the environment to elicit skills,										
through direct testing.										
6. Communicate assessment results to families and/or other professionals in understandable terms.										
7. Collaborate with families in the development of goals for their children.										
8. Develop functional child goals and objectives from assessment information.										
9. Demonstrate skills in writing functional short term behavioral objectives for children.										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
10. Demonstrate skills in utilizing a variety of teaching techniques with young children including:										
incidental teaching										
utilizing naturalistic cues										
arranging the environment to facilitate skill acquisiton										
11. Demonstrate skills in responding to child cues.										
12. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.										
13. Utilize functional activities to address goals and objectives.										
14. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.										
15. Demonstrate skills in providing instruction to groups of children from one to three years of age.										
16. Additional skills desired:										

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

Transdisciplinary Teaming Institute

The objectives of the Transdisciplinary Teaming Institute are based on the knowledge and skills needed to develop and implement the transdisciplinary team model. Through the course of the institute, the participants apply the knowledge and skills in their home program by completing competencies. These competencies relate directly to the objectives of the institute. The general goals of the institute are as follows:

Each participant will:

1) ensure that the program has a written philosophy that includes a statement on teaming;
2) identify their program's current team model;
3) develop policies and procedure for the implementation of a trandisciplinary team model in regards to: team members, system of communication, meetings, assessment, development of goals and objectives, training others and the implementation of goals and objectives;
4) observe professionals from other disciplines assessing infants and toddlers and demonstrate the ability to conduct a joint assessment with at least one other team member;
5) facilitate team meetings, including formulating agendas, delineating roles and responsibilities and preparing families for their role in the meeting;
6) work collaboratively with team members to determine child goals and objectives that include all encessary components and reflect the needs ofthe child;
7) develop instructional programs that incorporate skills from more than one area of development;
8) implement goals and objectives delineated in the instructional programs through functional activities carried out in the home or center-based program.

BIRTH TO THREE INSERVICE TRAINING PROJECT
Family Support/Early Intervention
New York Medical College

INDIVIDUALIZED FAMILY SERVICE PLANS

SESSION 1 - AGENDA

TOPIC	FORMAT
Logistics	Informal Discussion
Public Law 99 - 457	Lecture/Discussion
Program Philosophy	Lecture/Discussion
Break	
Family Systems Theory/ Empowerment	Lecture/Discussion
Wrap - Up	

BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 2 - AGENDA

TOPIC	FORMAT
Logistics	Informal Discussion
Family Centered Care	Activity/Discussion
Collecting Family Information	Discussion
Break	
Overview of Communication Skills	Lecture/Discussion Activity
Interview Skills	Lecture
Review Family Assessment Practice Interviews	Group Activity

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 3 - AGENDA

TOPIC	FORMAT
Logistics	
Child Assessment	Video/Discussion
Including Families in Team/ Goal Setting	Video/Discussion
Break	
Case Study	Discussion

BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 4 - AGENDA

TOPIC	FORMAT
Logistics	
Review Components of IFSP	Group Participation
Developing Outcomes & Objectives; Definitions & Examples	Lecture/Discussion
Break	
Writing Family Outcomes and Objectives: Case Studies	Group Activity
Case Study: Writing Outcomes & Objectives	Discussion

BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 5 - AGENDA

TOPIC	FORMAT
Choosing Child Outcomes	Lecture/Discussion
Determining Functional Child Outcomes	Activity/Discussion
Break	
Developing Child Outcomes & Objectives	Lecture/Discussion

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SERVICE PLANS

SESSION 2 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify the philosophy of family centered care.

2. be able to identify the techniques used to collect family information.

3. be able to name the four phases of a family interview.

4. be able to identify three principles of family assessment.

5. have practiced using communication and interview skills and receive feedback.

6. have developed questions that they might include in collecting family information for their program.

7. have reviewed and discussed the first two areas of the Brass Tacks.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 3 - OBJECTIVES

At the end of this session, participants will:

1. be able to determine whether a particular assessment instrument is standardized, norm - referenced or criterion referenced and explain their uses.

2. be able to identify procedures and best practices for assessing infants and toddlers.

3. be familiar with guidelines for setting goals with families.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SUPPORT PLANS

SESSION 4 - OBJECTIVES

At the end of this session, participants will:

1. be able to define the concept of **outcomes.**

2. be able to identify the difference between outcomes and objectives.

3. be able to identify the components of a behavioral objective.

4. have had practice writing family outcomes using a process and product format.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
FAMILY SUPPORT/EARLY INTERVENTION
NEW YORK MEDICAL COLLEGE

INDIVIDUALIZED FAMILY SERVICE PLANS

SESSION 5 - OBJECTIVES

At the end of this session, participants will:

1. be able to determine functional child outcomes.

2. be able to develop child outcomes and objectives.

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BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

IFSP PRE/POST TEST

Name: ______________________ Date: ______________________

1. Public Law 99-457 states that:

   a) states are mandated to provide services for handicapped children from birth through five years of age.

   b) states are mandated to provide services for handicapped children from birth to three years of age.

   c) states determine whether services are provided for handicapped children from birth through five years of age.

   d) states are mandated to provide services for handicapped children from three through five years of age, and can determine whether they will provide services for handicapped children from birth to three years of age.

2. Who has been designated as the lead agency in New York for programs serving handicapped children between the ages of birth and three years?

   a) Department of Education

   b) Department of Health

   c) Regional Planning Group

   d) Interagency Coordinating Council

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3. Homeostasis is the family systems principle that means, "what effects one member of the family effects all others."

   True   False

4. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

   a) family functions

   b) family life cycle

   c) family characteristics

   d) family interaction

5. Family empowerment means:

   a) helping families by doing whatever we can

   b) telling families what they can do to take more power in their lives

   c) families making informed choices

   d) families being their own case managers

6. What three components are included in an IFSP that are not usually included in an IEP?

   ____

   ____

   ____

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3. Homeostasis is the family systems principle that means, "what effects one member of the family effects all others."

True　　　　　　　　False

4. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

a) family functions

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d) family interaction

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b) telling families what they can do to take more power in their lives

c) families making informed choices

d) families being their own case managers

6. What three components are included in an IFSP that are not usually included in an IEP?

____

____

____

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7. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

   Screening (1 instrument):

   ____

   Determining Eligibility (2 instruments):

   ______________________ ______________________

   Program Planning (2 instruments):

   ______________________ ______________________

   Program Evaluation (1 instrument):

   ____

8. Name two standardized assessments that are used with the birth to three year old population.

   ____

   ____

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9. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a __________ assessment.

   a) standardized

   b) criterion referenced

   c) norm-referenced

   d) a and c

10. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

    True   False

11. Based on the results of a family assessment, the Early Intervention Specialist should decide what the family's strengths and concerns are.

    True   False

12. What are the four phases of a family interview?

    ____________________   ____________________

    ____________________   ____________________

13. List four reasons why it's important to have team meetings.

    ____

    ____

    ____

    ____

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14. Goals that address needs prioritized by the family should always be included in the IFSP.

True False

15. According to P.L. 99-457, IFSP's need to be reviewed every _________ months and rewritten every _________ months.

16. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

17. ________________ questions are the most effective means of obtaining information from families.

a) Direct

b) Close-ended

c) Open-ended

18. Circle, from the list below, those techniques that are considered to be effective means of assessing families.

a) interview

b) observing interactions

c) questionnaire

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19. List three principles that must be followed when doing family assessments.

____

____

____

20. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a daycare for Peter."

True False

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BIRTH TO THREE INSERVICE TRAINING PROJECT

INSTITUTE CONTRACT

This agreement is to confirm that ______________________ will participate in the ________________ institute and understands that this participation includes the following components:

1) Allowing support and release time (if necessary) for staff attend the institute sessions. Participants include the following:

<u>Name</u> <u>Position</u>

2) Attendance at a minimum of two meetings with the instructor prior to the start of the institute. The purposes of the meetings are: a) to clarify details of the institute to the participants, and b) to complete necessary forms.

3) Attendance by all participants at each of the training sessions. The trainings will be held at ______________________ on the following dates/times:

Session 1 ____

Session 2 ____

Session 3 ____

Session 4 ____

Session 5 ____

Session 6 ______________________________

Session 7 ______________________________

Session 8 ______________________________

Session 9 ______ ________________________

4) Participation in follow up by each of the participants to include: a minimum of two meetings per month for consultation and feedback on the completion of the program tasks. Tasks must be completed within six months of the last session. Follow up will be available for up to one year after the training sessions have ended.

______	______________	______	______________
Date	Program Supervisor	Date	Training Staff

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SAMPLE TASKS

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Must include the three areas delineated in program task and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review a minimum of three (3) developmental assessments including at least one standardized assessment for the 0-3 population. b) choose two (2) of the assessments to administer to three children (two who are developmentally delayed and one who is developing normally). One developmentally delayed child and one normal child must be of the same chronological age. When assessing the two developmentally delayed children, a second staff member or project staff member, who is familiar with the instrument, must accompany the student and score the child separately to determine reliability.	Written reviews of the assessments must include: - Name of assessment, author, publisher and address - Cost - Validity, reliability and norming sample data - Population recommended for - Domains assessed - Materials needed - Training needed - Type of scores obtained - Type of test (standardized, criterion referenced, etc.) - Ease of administration - Judgment as to usefulness - Strengths and weaknesses Written summaries of the results must include: - scores obtained - skills exhibited - child's strengths and weaknesses - implications for programming Handwritten summaries of results and implications for programming must be submitted to, discussed with and approved by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
3) Family Assessment	The student will: a) review a minimum of three (3) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare: - an agenda - open-ended questions During the interview, the student will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments must include information on: - Rationale - Norming sample - Areas tested - Types of scores obtained - Judgments as to usefulness - Strengths and limitations Reviews must be submitted to and approved by the instructor. The instructor will observe the family interview and provide written feedback. Written summaries of results and implications for services must include: - scores obtained - family strengths and needs - implications for programming Summaries will be submitted to, discussed with and approved by the instructor.
4) Team Meeting	The student will facilitate two (2) team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the student will: a) develop a written agenda b) delineate roles and responsibilities of participants c) prepare families for their role in the meeting	The instructor will observe the team meetings and provide written feedback. The student will submit a written summary of the results of the meetings and discuss them with the instructor.

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Goal Setting	In collaboration with the family and members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	a) The family goals will reflect the needs identified by the family during the assessment process. The goals will be operationalized and non-intrusive to the family. Goals will be reviewed by the instructor. b) The child goals will reflect the needs of the child as identified by the family and the team assessment process. Goals must be operationalized and reviewed by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) IFSP	In collaboration with each family,and team members the student will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expected duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will be submitted to, discussed with, and approved by the program supervisor, team, and instructor. The goals delineated in the IFSP must correspond to ·he goals prioritized by the .ff and family during meetings and interviews.

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
7) Implementation of IFSP	The student will implement each of the IFSP's through contacts with the child and family, either in the home or through a center-based program. At least one of these contacts must be a home visit. Implementation of the IFSP will include: a) following written flexible agenda for a home/center visit which includes child and family IFSP objectives to be addressed during the home/ center visits, and activities to address the IFSP objectives b) data collection procedures c) other evaluation procedures	The instructor will review the agenda, objectives, activities and data for the first three (3) visits, and will accompany student on at least one (1) home/center visit. Outcome of the visits will be discussed with the instructor. The instructor will also review evaluation procedures.

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PROGRAM PHILOSOPHY

Williamsburg Developmental School is a half day centerbased Early Intervention and Preschool program for children with special needs age birth- five years. The commitment of the staff is to help each child work towards the realization of his/her potential.

The introduction of formal programs at such an early age is based on the concept that environmental influences occurring in the earliest months and years of life have a highly significant and powerful impact on the child's development.

The most important environmental influence on the child is the family. In recognition of this the school reaches out to the family in a collaborative effort to create an individualized program for the child with attention to cultural and ethnic background. Effective programming requires consideration of individual differences for quality service delivery.

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Child Assessment Review

Name of Assessment: Preschool Language Scale - 3 (PL[S-3])

Author: Ila Lee Zimmerman; Violette G. Steiner; Roberta Evatt Pond

Publisher: The Psychological Corporation, Harcourt Brace Jovanovich Inc.

Address: 555 Academic Court
San Antonio, Texas 78204-2498

1993 Cost: $89 includes picture book, manual and 12 record forms in English

Population Recommended For:
children ages 2 weeks through 6 yrs 11 months or older children functioning developmentally in this age range

Type of Test: (standardized, criterion referenced, etc.)
standardized, norm-referenced test

Not recommended for retarded adults or for assessing gifted children.

Validity Data: Research shows evidence for 1) content validity (test has thorough & balanced sample of language behaviors, 2) construct validity (consistently differentiates language disordered children from those not and 3) concurrent validity (highly correlated with scores from other valid measures of language ability

Reliability Data:
Good test-retest reliability and inter-rater reliability (.98) correlation

Norming Sample Data:
1,200 children ages 2 weeks to 6 years 11 months with 50% male and 50% female and representation of race, geographic region and education level of parent (based on the 1980 Census of Population, 1986 update

Training Needed:
- need knowledge of PLS-3 test administration & scoring
- need to be sensitive to the needs of the child being evaluated
- need to know PLS-3 and adhere to administration procedures
- need to record and score responses correctly

Materials Needed:
picture manual; examiner's manual; record form and the following materials (cellophane, teddy bear, ba[ll], shoe box, key or ring, 3 plastic spoons, 3 plastic cups, child['s] sock (white), 8 blocks, watch w/ a 2nd hand

Domains Assessed:
↓
Receptive and expressive language in young children. Supplemental tests assess articulation, conversational skills and communication

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Type of Scores Obtained: Standard score, percentile rank and an age equivalent

Ease of Administration: Easy to administer with jargon free description of tasks. Takes under an hour to administer but may need to time out breaks for poor atten

Usefulness of Assessment: Gives good sample of child's communication skills especially if supplemental tests are used. Use test results for establishing therapy goals and understanding child's learning strengths/weaknesses.

Strengths and Weaknesses:

Strengths	Weaknesses
- Easy to administer	- standardized primarily on majority population (70%) 15% of standardized sample was Black and 12% was Latino. This reduces test validity for our WDS children
- colorful pictures and ADL manipulatives	- inappropriate for children who refuse to perform in a structured test situation
- is reliable & valid especially for majority population children.	- some appropriate responses are not accepted as correct eg "over there" incorrect vs "on the chair" correct
- pinpoints child's communication strengths and weaknesses	
- works best as a screening tool for infants	

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APPENDIX P

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Table 1
Participant Demographics for the NORTHSIDE INFANT CURRICULA INSTITUTE

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
31	Administrator/ Supervisor	MEd	Spec. ED/ Admin.	No	2	30
32	ECSE	MEd	ECSE/Bilingual	Yes	2.5	11
33	Psychologist	MSW	Psych/Social Work	No	3	15.5
34	Speech Pathologist	MS	Speech	Yes	3	15
35	Nurse	BS	Nursing	Yes	4 Months	4 Months
36	Teacher/Librarian	MS	Spec. ED	No	3	6
37	Administrator Psychologist	Ph.D.	Psychology	Yes	13	17

Table 2
Self Rating Scale Results for NORTHSIDE INFANT CURRICULA INSTITUTE

	Where I Am Pre	Where I Am Post	Where I Am Post 2
1. State program philosophy	2.71	3.00	3.29
2. State overall program goals	3.14	3.17	3.29
3. Name a minimum of four assessment instruments and their uses with the birth to three year old population.	2.14	3.33	3.14
4. Choose appropriate assessment instruments for various instruments.	2.57	3.00	3.14
5. Demonstrate skills in administering assessments to young children: through observation, structuring the environment to elicit skills, through direct testing.	3.14	3.33	3.29
6. Communicate assessment results to families and/or other professionals in understandable terms.	3.43	3.67	3.29
7. Collaborate with families in the development of goals for their children.	4.14	3.00	3.29
8. Develop functional child goals and objectives from assessment information.	4.00	3.00	3.43
9.Demonstrate skills in writing functional short term behavioral objectives for children.	3.86	3.00	3.43
10. Demonstrate skills in utilizing a variety of teaching techniques with young children including: least prompts graduated guidance incidental teaching utilizing naturalistic cues arranging the environment to facilitate skill acquistion.	3.57	2.50	3.43
11. Demonstrate skills in responding to child cues.	3.14	3.00	3.67
12. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.	3.71	3.17	3.50

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Table 2 (Cont'd)
Self Rating Scale Results for NORTHSIDE INFANT CURRICULA INSTITUTE

	Where I Am Pre	Where I Am Post	Where I Am Post 2
13. Utilize functional activities to address goals and objectives.	3.71	3.00	3.50
14. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.	3.29	3.00	3.67
15. Demonstrate skills in providing instruction to groups of children from one to three years of age.	3.57	3.00	3.67
16. Develop or modify teaching materials to facilitate skill acquistion in children with sensory or physical impairments.	3.00	3.00	3.83
17. Name two curricular guides for use with children to three ;years of age.	1.86	3.00	3.50

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Table 3
Pre-post test scores for individual participants from the NORTHSIDE INFANT CURRICULA INSTITUTE

Participant #	Pre Test	Post Test 1	Post Test2
31	65%	100%	95%
32	77%	100%	100%
33	46%	100%	100%
34	69%		
35	23%	69%	85%
36	50%		
37	50%	100%	100%
Mean	**54%**	**94%**	**96%**

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Table 4
Mean scores across participants from the NORTHSIDE IFSP INSTITUTE for each item on the consumer satisfaction survey

ITEM	Mean Scores
Objectives Met	4.00
Topics Covered	4.17
Relevant Material	4.83
Adequate Illustration	4.50
Time Organized	4.50
Information Relevant to Work	4.17
Better Understanding of Subject	4.17
Presenter Prepared	4.83
Presenter Knowledgeable	4.83
Presenter Used Activities	4.17
Presenter Easy to Listen to	4.17
Presenter Valued Input	4.67
Environment Comfort	4.83
Adequate Breaks	4.83
Good Group Size	4.83
Good Location	4.83
Good Day and Time	4.33

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

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BIRTH TO THREE INSERVICE TRAINING PROJECT

INFANT CURRICULA INSTITUTE

	Content	Format
Session 1:	Introductions	
	Program Philosophy	Lecture Discussion
	"Family Centered Care"	Film
	Program Goals	Lecture Discussion
Session 2:	Child Assessments: Purposes & Characteristics	Lecture Discussion
	Methods and Best Practices of Child Assessment	Lecture Discussion
	Review Assessments	Group Activity
Session 3:	Developing Outcomes & Objectives	Lecture Discussion
	Reviewing Sample Outcomes & Objectives	Discussion
	Writing Child Outcomes & Objectives: Case Study	Group Activity
Session 4:	Overview of Instruction	Lecture Discussion
	Context of Instruction: Activities in an Infant Toddler's Day	Group Activity
	Addressing Goals within and Across Activities	Lecture Activity
	Incidental Teaching	Video Discussion
Session 5:	Analyzing Environments	Lecture
	Review ITERS	Discussion
	Creating a Child Centered Environment for Infants & Toddlers	Video
	Arranging Settings for Children	Group Activity

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 1 - OBJECTIVES

At the end of this session, participants will:

1. become familiar with Public Law 99-457 as it relates to services in New York State.
2. be able to identify the importance of having a program philosophy.
3. have reviewed sample early intervention program philosophies.
4. have viewed and discussed the film "Family Centered Care".
5. have developed at least one early intervention program goal.

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

SESSION 1 - READINGS

Bailey, D. B., Jens, K. G., & Johnson, N. (1983). Curricula for handicapped infants. In S. G. Garwood & R. R. Fewell (Eds.), Educating handicapped infants (pp. 387-415). Rockville, MD: Aspen Systems Corporation.

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Philosophy and conceptual framework. In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 5-10). Washington, DC: ACCH.

REFERENCES

Public Law 99-457, Education of All Handicapped Children Act, Amendments of 1986.

Smith, B. J., & Strain, P. S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. Topics in Early Childhood Special Education, 8(1), 37-47.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 1 - AGENDA

TIME	TOPIC	FORMAT
10 mins.	Introductions & Logistics	Informal Discussion
20 mins.	Overview of Philosophy	Lecture/Discussion
45 mins.	"Family Centered Care"	Film/Discussion
10 mins.	Break	
35 mins.	ARC'S Early Intervention Program Philosophy	Discussion

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 1 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify the importance of having a program philosophy.
2. have viewed and discussed the film "Family Centered Care".
3. have reviewed their program philosophy.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health C nter--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

SESSION 1 - READINGS

National Early Childhood Technical Assistance System & Association for the Care of Children's Health. (1989). Philosophy and conceptual framework In B. H. Johnson, M. J. McGonigel, & R. R. Kaufman (Eds.), Guidelines and recommended practices for the Individualized Family Service Plan (pp. 5-10). Washington, DC: ACCH.

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Gallagher, J.J., Trohanis, P.T., & Clifford, R. M. (Eds.). (1989). Policy implementation & P.L. 99-457: Planning for young children with special needs. Baltimore, MD: Paul Brooks Publishing Company.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
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INFANT CURRICULA

SESSION 2 - AGENDA

TIME	TOPIC	FORMAT
15 mins.	Logistics	
40 mins.	Child Assessment Tools: Purposes and Characteristics	Lecture/Discussion
15 mins.	Methods and Best Practices of Child Assessment	Lecture/Discussion
10 mins.	Break	
40 mins.	Review Assessments	Small Group Activity

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 2 - OBJECTIVES

At the end of this session, participants will:

1. be able to identify appropriate assessment instruments to use for a specific purpose when assessing infants and toddlers.
2. be able to determine whether a particular assessment instrument is norm-referenced or criterion-referenced.
3. become familiar with two different developmental assessments that are used with infants and toddlers.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 2 - READINGS

Bailey, D. B. (1989). Assessment and its importance in early intervention. In D. B. Bailey and M. Wolery (Eds.), Assessing infants and preschoolers with handicaps (pp. 1-21). Columbus, OH: Merrill Publishing Co.

REFERENCES

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Gibbs, E. D., & Teti, D. M. (Eds.) (1990). Interdisciplinary assessment of infants. Baltimore, MD: Brookes Publishing Company.

Meisels S. J., & Provence, S. (1989). Screening and assessment: Guidelines for identifying young disabled and developmentally vulnerable children and their families. Washington, DC: National Center for Clinical Infant Programs.

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 3 - AGENDA

TIME	TOPIC	FORMAT
10 mins.	Logistics	
20 mins.	Choosing Child Outcomes	Lecture/Discussion
20 mins.	Determining Functional Child Objectives	Activity/Discussion
45 mins.	Developing Child Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
10 mins.	Break	
45 mins.	Writing Child Outcomes & Objectives: Case Study	Group Activity
30 mins.	Discuss Case Study	Discussion

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 3- **OBJECTIVES**

At the end of this session, participants will:

1. be able to identify the difference between goals and objectives.

2. be able to identify the components of a behavioral objective.

3. have had practice writing functional goals and objectives for infants and toddlers.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 3 - READINGS

Bailey, D. B. & Wolery, M. (1984). Determining instructional targets. In D. B. Bailey & M. Wolery (Eds.), Teaching infants and preschoolers with handicaps. Columbus, OH: Charles E. Merrill Publishing Company. (Chapter 2)

Willoughby-Herb, S. J. (1983). Selecting relevant curricular objectives. Topics in Early Childhood Special Education, 2(4), 9-14.

REFERENCE

Peterson, N., Thompson, B., Allen, K. E., & Brackman, B. (1987). Program planning, teaching and interdisciplinary considerations. In N. L. Peterson (Ed.), Early intervention for handicapped and at-risk children. Denver, CO: Love Publishing Company. (Chapter 11)

BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 4 - AGENDA

TIME	TOPIC	FORMAT
10 mins.	Logistics	
30 mins.	Goals/Objectives	Group Activity
40 mins.	Overview of Instruction	Lecture/Discussion/Video
10 mins.	Break	
30 mins.	Format for Developing Goals Within and Across Activities	Lecture

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 4 - OBJECTIVES

At the end of this session, participants will:

1. be familiar with the definition and principles of activity based instruction.
2. be familiar with instructional strategies for infants and toddlers.
3. be able to identify typical activities in which infants and toddlers participate and identify goals that could be addressed within those activities.
4. have had practice implementing goals and objectives into the routines and activities of a child they are currently serving.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 4 - READINGS

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Pediatric Research and Training Center. (1988). An introduction to programming for groups in early childhood special education. Farmington, CT: Division of Child and Family Studies, Department of Pediatrics, University of Connecticut Health Center.

SESSION 4: ACTIVITY BASED INSTRUCTION

Topic:	Overview of Instruction
Format:	Lecture
Time:	30 minutes

I. DEFINITION OF ACTIVITY BASED INSTRUCTION

A. Use of typical age appropriate routines to teach many skills in one activity and one skill in many activities.

B. Show example overheads: Teaching the application of one skill across many tasks and teaching many skills across one activity.

II. BENEFITS OF ACTIVITY BASED INSTRUCTION

A. Enhances generalization of skills

B. Assists in working on functional goals

C. More closely approximates real life learning situations

D. Can be implemented both in group or individual settings

III. INSTRUCTION

In order to integrate skills into routines thorough instructional planning must occur. The following principles of instructional programming should be applied when working with infants and toddlers.

A. Instruction should always occur during the **daily routines and activities** of an infant/toddler's day, whether at home or at school.

B. Allow children to **initiate** what they are interested in playing with or attending to and direct your instruction based on those initiations. Children with disabilities often become bound to responding only to adult cues because that is how we typically teach them.

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C. The environment should be designed in such a way as to promote child learning and play.

D. Materials should be **adapted** to meet needs of individual children.

E. Materials used to teach skills should be **chronologically age appropriate.**

F. Skills taught should be based on **developmentally appropriate, functional targets.**

G. Skills need to be taught across a variety of people, settings and materials so that they are **generalized.**

H. [illegible]

I. Child should be an active participant
- imitation
- recognize materials
- physical guidance if necessary

[illegible]

[illegible]

[illegible]

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UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 5 - AGENDA

TIME	TOPIC	FORMAT
10 mins.	Logistics	
25 mins.	Analyzing Environments/ Review ITERS	Lecture/Discussion
30 mins.	Creating a Child Care Environment for Infants & Toddlers	Video
20 mins.	Arranging Settings for Children	Group Activity
35 mins.	Post Measures	

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UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 5 - OBJECTIVES

At the end of this session, participants will:

1. identify the importance of child centered environments.
2. have become familiar with the Infant/Toddler Environment Rating Scale.
3. identify ways of arranging the environment to facilitate skill acquisition.
4. have completed institute post measures.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center - Division of Child and Family Studies

INFANT CURRICULA

SESSION 5 - READINGS

Olds, A. R. (1982). Designing play environments for children under 3. Topics in Early Childhood Special Education, 2(3), 87-95.

REFERENCES

Bailey, D. B. & Wolery, M. (1984). Designing preschool environments. General considerations. In D. B. Bailey & M. Wolery (Eds.), Teaching infants and preschoolers with handicaps (pp. 118-130). Columbus, OH: Merrill Publishing Co.

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Harms, T., Creyer, D., & Clifford, R. (1986). Infant toddler environment rating scale. An Adaptation of the Early Childhood Environment Rating Scale. Harms and Clifford, New York: Teachers College Press.

Kritchevsky, S., & Prescott, E. (1969). Planning environments for young children: Physical space. Washington, DC: NAEYC.

Musselewhite, C. R. (1986). Adaptive play for children with special needs: Strategies to enhance communication and learning. Boston, MA: College-Hill Press.

Project ETC/Exceptional Training for Caregivers. (1990). Special training for special needs, module five: Program implementation. Minneapolis, MN: Greater Minneapolis Day Care Association, and Portage, WI: The Portage Project.

SESSION 5: TEACHING PROCEDURES & INSTRUCTIONAL PROGRAMS

Topic:	Incidental Teaching
Format:	Video/Discussion
Time:	40 minutes

I. INTRODUCTION

Incidental Teaching: interactions a child has with the environment which arise either naturally or through afforded opportunities, where child responsiveness and interactions with the environment provide a basis for both sustaining and elaborating in the child's behaviors.

II. STEPS

A. Ensure the child's responsiveness to the environment through the provision of opportunities that secure and maintain the child's attention.

B. Focus attention on those aspects of the environment that maintain attention.

C. Elicit and sustain the child's interactions with the environment.

D. Work for and sustain elaboration in the child's topography of behavior.

E. Work for and sustain conventionalization as a part of response elaboration.

Source: Project Sunrise (1986). Incidental Teaching. Family Infant Preschool Program, Morgantown, North Carolina.

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BIRTH TO THREE INSERVICE TRAINING PROJECT
UCONN Health Center--Division of Child and Family Studies

INFANT CURRICULA INSTITUTE

Pre/Post test

Name: ______________________________ Date: _______________

1. A program philosophy is important because the program's _________________ should share the same philosophical basis.

   a. assessments

   b. curricula

   c. staff

   d. all of the above

   e. a & b

2. Name two standardized assessments (where results are expressed in standard scores) that are used with the birth to three year old population.

   ____

   ____

3. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a _________________ assessment.

   a. standardized

   b. criterion-referenced

   c. norm-referenced

   d. a & c

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4. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

   Screening (list one instrument):

   ____

   Determining Eligibility (list two instruments):

   ______________________ ______________________

   Program Planning (list two instruments):

   ______________________ ______________________

   Program Evaluation (list one instrument):

   ____

5. When assessing a young child, birth to three years, a standardized, norm-referenced test will give the most accurate picture of what the child can do.

   True False

6. The best way to determine child goals is to address the items the child missed on the assessment.

   True False

7. List three characteristics of a functional skill.

   ____

   ____

   ____

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8. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

9. What are two principles of activity based teaching?

____

____

10. Give three examples of typical activities that occur either in the home or in the classroom and briefly describe how you could address an object permanence objective within each activity. (Continue on back, if necessary.)

____

____

____

____

11. When organizing children for group instruction, they should always be grouped according to developmental levels (i.e., children at same developmental levels together) otherwise it will be impossible to address their individual instructional goals.

True False

12. Develop and describe below, one art activity in which the following IFSP objectives could be incorporated:

    a. Jay will rotate either wrist to turn an object (eg. scooping with a spoon, turning a knob on the radio, wind up toy or doorknob)
    b. Given a social situation, Jay will initiate turn-taking, 90% of the time.
    c. In a given activity, Jay will initiate requests for assistance and/or materials, 90% of the time.

____

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13. State one way in which the environment may affect a young child's performance/behavior?

____

____

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Birth to Three Inservice Training Project

Name________________________ Program________________________ Date__________

INFANT CURRICULA: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the Infant Curricula institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a √ in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. State program philosophy.										
2. State overall program goals.										
3. Name a minimum of four assessment instruments and their uses with the birth to three year old population.										
4. Choose appropriate assessment instruments for various purposes.										
5. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
6. Communicate assessment results to families and/or other professionals in understandable terms.										
7. Collaborate with families in the development of goals for their children.										
8. Develop functional child goals and objectives from assessment information.										
9. Demonstrate skills in writing functional short term behavioral objectives for children.										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
11. Demonstrate skills in utilizing a variety of teaching techniques with young children including:										
least prompts										
graduated guidance										
incidental teaching										
utilizing naturalistic cues										
arranging the environment to facilitate skill acquisiton										
12. Demonstrate skills in responding to child cues.										
13. Demonstrate skills in incorporating more than one objective (from different domains) into a single activity.										
14. Utilize functional activities to address goals and objectives.										
15. Be able to name functional activities that occur during the day during which programming for infants and toddlers can take place.										
16. Demonstrate skills in providing instruction to groups of children from one to three years of age.										
17. Develop or modify teaching materials to facilitate skill acquisition in children with sensory or physical impairments.										
18. Name two curricular guides for use with children birth to three years of age.										
19. Additional skills desired:										

SAMPLE TASKS

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PROGRAM TASKS
INFANT CURRICULA INSTITUTE

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, the current program philosophy will be reviewed and updated as determined necessary by the program director and staff.	Must address family involvement, delivery of services and team functioning and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review three (3) developmental assessments including one standardized, for use with the 0-3 population.	a) Reviews will be completed on a form provided by the instructor and submitted to the instructor for review
3) Curriculum Evaluation	The student will present a written evaluation of one curricular guide designed for use with infants and must address at least the following domains: a) language development b) motor development c) self - help d) pre- academic sensorimotor skills e) social development	The evaluations must address the following components , and must use examples from the curricula to illustrate points: a) basic information re: author, publisher b) comrehensiveness of coverage, and points of skill sequences c) use of behavioral objectives d) degree of task analysis e) attention to functional skills f) potential for use an an assessment teaching device g) availability of a system for student performance monitoring h) appropriateness rigidity of instructional materials i) adequacy of criterion - levels established j) attention to problems of skill generalization and maintenance k) adaptability to functional alternatives l) general usability and necessary modifications

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4) Instructional Programs	Based on short term goals from an infant or toddler's IFSP or IEP, the student will design, write, and implement over a period of at least 4 weeks, one (1) instructional program in various curricular domains. Each instructional program will include the following components: a) statement of the instructional objective that includes: -behaviors specified in operational terms -criteria for achievement -conditions under which the behaviors will occur b) task analysis of instructional sequence delineating component and prerequisite skills of the identified objective c) description of task presentation (antecedent conditions including arrangement of the environment) d) reinforcement techniques used e) error correction procedure used f) selection of measurement procedures (how will data be taken, what behaviors will be measured?) g) criteria for movement to the next step in the instructional sequence h. baseline performance data i. systematic evaluation (how often, methods), and modification of the instructional program	Programs must be approved by the instructor prior to implementation . They must include the delineated components.

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DESCRIPTION	PROGRAM TASK	CRITERIA
5) Activities catalog	The student will: a) Choose five (5) routines that occur during an infant's typical day (either home or classroom). Examples include: arrival, departure, mealtime, art, circle, diapering toileting. b) For each of the five routines, observe and evaluate, teacher or assistant teacher, during one (1) activity in that routine . c) Address how example goals from each domain (gross motor, fine motor, cognition, self-help, social) can be incorporated into the activities. Suggest modifications to teacher or assistant teacher if necessary.	The catalog will be submitted to and approved by the instructor. It will contain the following: a) explanation of the classroom and teacher observed. (age of students, teacher's background, type of activity or routine observed) b) delineate your suggestions or modifications to the activity. what were the problems seen? c) if no modification were necessary, what were the positive strategies you observed?
6) Prosthetic Materials	Given an infant with a sensory , physical or significant performance deficit, and an instructional objective, the student will : Develop teaching materials, modify existing materials, design an environmental prosthesis, or design a functional alternative to facilitate skill aquistition.	The product must enable the infant to progress in meeting a specific objective as demonstrated through data and observation. The product must be as unobtrusive as possible and be approved by the instructor.

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APPENDIX Q

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Table 1 Participant Demographics for the NEW MEDICO IFSP INSTITUTE

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
38	PT	BS	PT	yes	4	12
39	Social Worker	MS	Spec. Ed	yes	5	7
40	Social Worker	MSW	Social Worker	no	1	4
41	Social Worker	MSW	Social Work	no	1	1
42	Early Childhood Special Educator	BA	Secondary Ed.	no	1	3
43	Nurse	RN	Nursing	no	16	20
44	Recreation Therapist	BA		no	1	1
45	Social Worker	MSW	Social Work	yes	13	13
46	Speech Pathologist	MS	Speech	yes	2	4 1/2
47	Speech Pathologist	MS	Speech	yes	5	7
48	Psychologist	MS	Psychology	no	1	1

Table 2
Self Rating Scale Results for NEW MEDICO IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. Understanding P.L. 99-457.	2.18	3.64	4.55
2. Understand family systems theory.	2.45	3.73	4.45
3. State program philosophy.	2.09	3.55	4.36
4. Name variety of assessment instruments for B-3 years	2.00	3.45	4.45
5. Choose appropriate assessment instruments.	2.18	3.27	4.36
6. Demonstrate skills in administering assessments to young children: through observation; structuring the environment to elicit skills; through direct testing	2.55	3.64	4.45
7. Demonstrate skill in writing results assessments.	2.27	3.73	4.45
8. Name family assessments.	2.00	3.45	4.45
9. Choose appropriate family assessments.	1.91	3.27	4.27
10. Demonstrate skills in interviewing families.	2.73	4.00	4.45
11. Skills in writing results of family assessments.	2.18	3.64	4.55
12. Communication skills with families including: effective listening (eye contact, silence, paraphrase); effective inquiry (open-ended questions, silence); effective reflection of feeling ("I hear you saying..."); effective reflection of content (paraphrase)	3.64	4.09	4.55
13. Sensitivity to family needs.	4.00	4.09	4.45
14. Plan a team meeting, including: formulating an agenda; contacting participants; preparing families	3.64	3.91	4.36

Table 2 (Cont'd)
Self Rating Scale Results for NEW MEDICO IFSP INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
15. Facilitate a team meeting, including: following the agenda ensuring opportunity for participation of all members	3.64	3.82	4.27
16. Communicate assessment results to families.	3.55	3.82	4.18
17. Prepare families for role in team meetings.	3.27	3.82	4.18
18. Involve families in goal setting.	3.36	3.82	4.18
19. Understanding of family empowerment.	3.00	4.00	4.36
20. Skills in writing functional behavioral objectives.	2.64	3.45	4.27
21. Writing statements on family strengths and weaknesses.	2.64	3.55	4.36
22. Writing family goals.	2.64	3.55	4.55
23. Knowledge of components of an IFSP.	2.09	3.55	4.45
24. Incorporate family priorities into the IFSP.	2.18	3.55	4.55
25. Incorporate child goals into functional activities.	2.73	3.82	4.45
26. Review and update goals.	3.00	4.00	4.27
27. Write and follow a flexible agenda for home visits.	2.45	3.64	4.36
28. Evaluate home visits/classroom activities.	2.73	3.45	4.09
29. Collaborate with other community agencies.	2.73	3.36	4.27
30. Training staff on IFSP development.	1.82	3.00	4.36

Table 3
Pre-post test scores for individual participants from the NEW MEDICO IFSP INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
38	42%	95%	100%
39	28%	89%	95%
40	33%	92%	100%
41	35%	83%	95%
42	24%	88%	95%
43	0%	89%	100%
44	11%	92%	100%
45	42%	89%	100%
46	45%	89%	100%
47	51%	91%	95%
48	33%	85%	85%
Mean	**32%**	**89%**	**97%**

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Table 4

Mean scores across participants from the NEW MEDICO IFSP INSTITUTE for each item on the consumer satisfaction survey .

ITEM	Mean Scores
Objectives Met	4.27
Topics Covered	4.55
Relevant Material	4.73
Adequate Illustration	4.55
Time Organized	4.55
Information Relevant to Work	4.18
Better Understanding of Subject	4.45
Presenter Prepared	4.64
Presenter Knowledgeable	4.64
Presenter Used Activities	4.18
Presenter Easy to Listen to	4.55
Presenter Valued Input	4.73
Environment Comfort	4.55
Adequate Breaks	4.27
Good Group Size	4.64
Good Location	4.73
Good Day and Time	4.55

*Participants rated on a Likert Scale (1=Strongly Disagree - 5 = Strongly Agree) their satisfaction with the institute.

Birth to Three Inservice Training Project

Name____________________ Program____________________ Date__________

INDIVIDUALIZED FAMILY SERVICE PLAN: SELF RATING SCALE

Below are the basic competencies that you will have the oppurtunity to gain through participation in the IFSP institute. We are asking you to rate your perceived current level of expertise and to select the level of competency you would like to acheive for each of the items listed below.

To rate both present and desired level of expertise, place a in the appropriate column.

U = Unfamiliar. This is new to me. I know nothing about it, e.g., I've never heard of it. What is it?

Aw = Awareness. I have heard about it , but I don't know it's full scope such as it's principles, components, applications, and modifications. I need information.

K = Knowledge. I know enough about this to write or talk about it. For example, I know what it is but I'm not ready to use it in my program. I need practice and feedback.

A = Application. I am ready to apply this. For example, I can design, modify, and use it in my program.

M = Mastery. I am ready to work with other people to help them learn this. For example, I feel confident enough to demonstrate this to others.

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
1. Demonstrate understanding of P.L. 99-457.										
2. Demonstrate understanding of family systems theory.										
3. State program philosophy.										
4. Name a variety of assessment instruments and their uses with the birth to three year old population.										
5. Choose appropriate assessment instruments for various purposes.										
6. Demonstrate skills in administering assessments to young children:										
through observation,										
structuring the environment to elicit skills,										
through direct testing.										
7. Demonstrate skills in writing results of child assessments.										
8. Name a variety of family assessments.										
9. Choose appropriate family assessments for different purposes.										

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Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
10. Demonstrate skills in interviewing families for assessment purposes (e.g., setting and following an agenda, obtaining pertinent information without being intrusive).										
11. Demonstrate skills in writing results of family assessments.										
12. Demonstrate good communication skills with families including:										
effective listening (eye contact, silence, paraphrase)										
effective inquiry (open-ended questions, silence)										
effective reflection of feeling ("I hear you saying...")										
effective reflection of content (paraphrase)										
13. Demonstrate sensitivity to family needs.										
14. Plan a team meeting, including:										
formulating an agenda										
contacting participants										
preparing families										
5. Facilitate a team meeting, including:										
following the agenda										
ensuring opportunity for participation of all members										
16. Communicate assessment results to families and/or other professionals in understandable terms.										
17. Prepare families for their role in team meetings.										
18. Involve families in goal setting.										
19. Demonstrate an understanding of family empowerment.										
20. Demonstrate skills in writing functional behavioral objectives for the child.										
21. Demonstrate skills in writing statements on family strengths and weaknesses.										
22. Demonstrate skills in writing family goals.										
23. Demonstrate a knowledge of the components of an IFSP.										
?4. Incorporate goals identified by the family into the IFSP.										
25. Incorporate child goals into functional activities.										
6. Review and update goals.										

Participant will:	Where I Am					Where I Want To Be				
	U	AW	K	AP	M	U	AW	K	AP	M
27. Write and follow a flexible agenda for home visits/ classroom activities.										
28. Evaluate home visits/classroom activities.										
29. Demonstrate an ability to collaborate with other community agencies.										
30. Demonstrate skills in training staff on various aspects of IFSP development.										
31. Additional skills desired: (please write in any skills you would like to improve.) ______ ______ ______ ______ ______ ______										

BIRTH TO THREE INSERVICE TRAINING OUTREACH PROJECT

Family Support/Early Intervention
MRI/Institute for Human Development
New York Medical College

IFSP PRE/POST TEST

Name: ______________________ Date: ______________________

1. Public Law 99-457 states that:

   a) states are mandated to provide services for handicapped children from birth through five years of age.

   b) states are mandated to provide services for handicapped children from birth to three years of age.

   c) states determine whether services are provided for handicapped children from birth through five years of age.

   d) states are mandated to provide services for handicapped children from three through five years of age, and can determine whether they will provide services for handicapped children from birth to three years of age.

2. Who has been designated as the lead agency in New York for programs serving handicapped children between the ages of birth and three years?

   a) Department of Education

   b) Department of Health

   c) Regional Planning Group

   d) Interagency Coordinating Council

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3. Homeostasis is the family systems principle that means, "what effects one member of the family effects all others."

   True   False

4. According to Ann Turnbull's model, recreation, education, support and finances are all components of:

   a) family functions

   b) family life cycle

   c) family characteristics

   d) family interaction

5. Family empowerment means:

   a) helping families by doing whatever we can

   b) telling families what they can do to take more power in their lives

   c) families making informed choices

   d) families being their own case managers

6. What three components are included in an IFSP that are not usually included in an IEP?

   ____

   ____

   ____

7. Below are four possible purposes for assessing young children between the ages of birth and three years. For each of the purposes, please list one or two (as indicated) assessment instruments that would be appropriate to use.

   Screening (1 instrument):

   ____

   Determining Eligibility (2 instruments):

   ______________________ ______________________

   Program Planning (2 instruments):

   ______________________ ______________________

   Program Evaluation (1 instrument):

   ____

8. Name two standardized assessments that are used with the birth to three year old population.

   ____

   ____

ERIC

9. The Carolina Curriculum for Handicapped Infants and Infants At Risk is an example of a _________ assessment.

   a) standardized

   b) criterion referenced

   c) norm-referenced

   d) a and c

10. When assessing young children, birth to three years, a standardized test will give the most accurate picture of the child's skills.

    True   False

11. Based on the results of a family assessment, the Early Intervention Specialist should decide what the family's strengths and concerns are.

    True   False

12. What are the four phases of a family interview?

    ____________________   ____________________

    ____________________   ____________________

13. List four reasons why it's important to have team meetings.

    ____

    ____

    ____

    ____

ERIC

14. Goals that address needs prioritized by the family should always be included in the IFSP.

True False

15. According to P.L. 99-457, IFSP's need to be reviewed every _________ months and rewritten every _________ months.

16. The following is a good example of how functional goals should be written: "Child will pick up a raisin using a pincer grasp and place it in a bottle with a 1/2 inch opening on three out of four trials."

True False

17. _________________ questions are the most effective means of obtaining information from families.

a) Direct

b) Close-ended

c) Open-ended

18. Circle, from the list below, those techniques that are considered to be effective means of assessing families.

a) interview

b) observing interactions

c) questionnaire

ERIC

19. List three principles that must be followed when doing family assessments.

____

____

____

20. The following is a good example of a family outcome. "The interventionist will assist the Jones family in finding a daycare for Peter."

True False

PEDIATRIC RESEARCH AND TRAINING CENTER
UCONN HEALTH CENTER - DIVISION OF CHILD AND FAMILY STUDIES
BIRTH TO THREE INSERVICE TRAINING PROJECT

CONSUMER SATISFACTION SHEET
INSTITUTE FOLLOW UP

Name: ________________ Date: ____________________
Agency: ________________ Institute: ________________

Please rate the following statements on a scale of 1 through 5:

1 indicating that you strongly disagree with the statement,
2 indicating that you mildly disagree with the statement,
3 indicating neutral,
4 indicating that you mildly agree with the statement,
5 indicating that you strongly agree with the statement.

	Strongly Disagree		Neutral		Strongly Agree
TASKS					
1. The tasks were related to the course content. Please list any which were not related.	1	2	3	4	5
2. The tasks were relevant to my present job situation.	1	2	3	4	5
3. The tasks were individualized to meet my needs.	1	2	3	4	5
4. There was adequate support provided to complete the tasks.	1	2	3	4	5
5. The tasks were easy to accomplish.	1	2	3	4	5
6. The tasks enabled me to perform better at my job.	1	2	3	4	5

ERIC

7. The criteria for the tasks were well defined and easy to understand.	1	2	3	4	5
8. Overall, the institute was beneficial to me.	1	2	3	4	5

QUESTIONS

1. What did you find most helpful about the institute?

2. What did you find least helpful about the institute?

3. What additional information would you like to see included in future IFSP institutes?

4. What will you do differently as a result of this institute?

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NEW MEXICO REHABILITATION AND SKILLED NURSING CENTER
OF THE CAPITAL DISTRICT

PHILOSOPHY AND PURPOSE STATEMENT

Policy:

It is the policy of this facility and cognitive/educational service to provide comprehensive, integrated, and individualized services to pediatric, adolescent, and young adult patients experiencing a or an injury. Services provided will be functional and relevant to the individual patient needs, which allows them to maximize their cognitive rehabilitation as a part of their treatment plans.

Approximately two hundred thousand children, school age and younger, are hospitalized annually in the United States following head injury. Fifteen to twenty thousand of these children require prolonged hospitalization with moderate to severe brain injury. The increasing number of survivors of severe head injury combines with systematically decreasing lengths of stay in acute care hospitals to produce a need for specialized rehabilitation programs for children with brain injury.

Currently, many of these children receive no rehabilitative services. Others are treated in adult center where the social environment is not appropriate for children and where the staff members, typically lack expertise in child development and pediatric rehabilitation.

Because of the pervasiveness and insignificance of cognitive deficits following traumatic brain injury, cognitive rehabilitation has come to be preceived as one the keystones of rehabilitation following severe closed head injury. Although the label is new, much that falls under the heading "cognitive rehabilitation" has a traditional home in such rehabilitative disciplines as special education, speech language therapy psychology, occupational therapy, recreation therpy. Integrating these diverse aspects of rehabilitation under one programatic umbrella serves the purpose addressing cognitive disfunction comprehensively and systematically. Also by integreating the cognitve treatment across the nursing staff, therapists and families, we create an active therapeutic alliance to ensure treatment goals and therapeutic activities are integrated throughout the patient's day.

Cognitive/Educational rehabilitation is simply the attempt to help clients do things that they would like to do or should be able to do, but cannot do because of cognitive deficits. Cognition requests the acquisition and use of knowledge.

Clinicians who deliver any aspect of cognitive rehabilitation to brain injuried children (this includes the members of the rehabilitation team) must be familiar with mnormal cognitive development. Patterns of cognitive development guide assessment and treatment of children. Although developmental cognitive psychologists continue to dispute about which cognitive factors develop with age and which aspects of development are primary [illegible] dimensions of

centration to decentration: Development ranges from an exclusive concern with self and the immediate surroundings to an ability to take other people's perspectives and to consider events that are distant in time and space. Following brain injury, children, adolescents and young adults often appear 'egocentric" which may be explained in part by regression to an earlier developmental level in this aspect of cognitive functioning.

concrete to abstract: Development ranges from an ability to consider only concrete things and people and to solve problems only by trial and error to the ability to consider abstract attributes, relationships and principles, to think about possibilities, and to solve problems in a hypothetical manner. Traumatically brain injured children are often considered "concrete" in that they have relatively severe problems withhigher levels of meaning (e.g., detecting main ideas, drawing inferences, interpreting nonliteral language) and with organized problem solving.

surface to depth: Development ranges from attention to superficial (usually perceptual) characteristics of things and people to a focus on underlying causes and inferred meanings.

growth of the knowledge base: One of the most obvious and important, yet under-rated, aspects of cognitive development is the addition to one's knowledge base of factual information as well as general principles, associationa; ties, and much more. It is believed that growth in the knowledge base is largely responsible for increasingly efficient processing of information and learning of new information. Often much of the child's pretraumatically acquired information is recovered following the injury. If, in the other hand, the child evidences a depleted knowledge base, this may account for some of the apparent weakness in cognitive processing and for some of the child,s unusual behavior.

increased capacity and efficiency: Development includes increased speed of processing, capacity of working memory, and flexibility of thinking and acting. Among the most pervasive cognitive deficits following brain injury are slowness in thinking and responding, relatively severe breakdowns in processing with increases in the amount of information to be processed, and inflexibility in shifting from thought to thought or activity to activity.

improved situational discrimination: Development ranges from indiscriminate behavior to an appreciation of the situational appropriateness of specific types of behavior. Head injured children often behabe inappropriately in relation to situational demands; in addition, they frequently have difficulty learning under what circumstances they should use a compensatory strategy that has been acquired in a training context. This accounts for much of the "generalization problem" that is highlighted in the literature on brain injury.

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Improved "metacognitive" functioning: Development includes increasingly deliberate and goal-directed behavior, improved ability to plan and monitor activity (including cognitive activity), and increasingly "strategic" behavior. Being strategic--that is, recognizing a problem in relation to a goal, adopting a well-concieved plan to circumvent the problem, implementing the plan, monitoring the plan's effectiveness, and making modifications as needed--is a relatively late development, at least in relation to cognitive and academic problems. Developmentally normal preschoolers and early grade school-age children may be taught cognitive strategies as rote behaviors, but have difficulty putting them to use in their real-world activities.

An understanding of cognitive development plays several important roles in rehabilitation. First, it enables professionals to make accurate judgements about the effects of the injury. A preschooler who is egocentric, impulsive, and non-strategic, and who lacks situational discrimination may simply be a normal preschooler.

Second, normal development places certain limits on approaches to cognitive rehabilitation with young children. For example, where as adults may be encouraged to compensate in a deliberate way for reisual cognitive deficits, this is not a reasibabke goal for preschoolers and young school-age children. The mela cognitive maturity that is presupposed when teaching compensatory cognitive stratigies is normally not present in the young children. In most instances cognitive startegy use and application may not appear with some children until several years into their schooling.

The cognitive rehabilitation of young adults also must be an integrated interdisciplinary approach that focuses on the functional needs of the young adults and addresses the social, psychological, vocational, and cognitive skills that will allow the patient to function more autonomonously regarding independent living skills. The cognitive rehabilitation of young adutls must consider reasoning skills, problem solving, abstract thinking, work related skills, personal life skills, activities of daily living, and other competencies that allow the individual to maximize the ability to live a productive life once they return to their community.

Original Date:
Revision Date:
Completed By:

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INDIVIDUALIZED FAMILY SERVICE PLAN INSTITUTE

	Content	Format
Session 1:	Introductions	Informal Discussion
	P. L. 99-457	Lecture/Discussion
	Program Philosophy	Lecture Discussion
	Family Systems Theory	Lecture/Discussion
	Family Empowerment	Lecture/Discussion
Session 2:	"Family Centered Care"	Film/Activity
	Collecting Family Information	Lecture/Discussion
	Overview of Communication & Interview Skills	Activity/Discussion
	Practice Interviews	Group Activity
	Review Family Assessments Instruments	Home Activity
	Review Components of IFSP	Group Participation
Session 3:	Overview of Child Assessments	Lecture
	Goal Setting with Families	Lecture/Discussion
	Goal Setting with Families: Case Study	Group Activity
	Group Participation	
	Developing Outcomes & Objectives: Definitions & Examples	Lecture/Discussion
	Writing Family Outcomes & Objectives: Case Studies	Group Activity
	Play Based Assessment	Film/Activity
Session 4:	Choosing Child Outcomes	Lecture/Discussion
	Determining Functional Child Outcomes	Activity/Discussion
	Developing Child Outcomes & Objectives	Lecture/Discussion
Session 5:	Writing Child Outcomes & Objectives: Case Studies	Group Activity
	Transition Plans	Lecture/Discussion
	Post Measures	

SAMPLE TASKS

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
1) Program Philosophy	In conjunction with the staff from the student's own program, a program philosophy will be developed. At a minimum the following areas will be addressed: 1) Child Development 2) Family Involvement 3) Delivery of Services	Must include the three areas delineated in program task and must be submitted to and discussed with instructor.
2) Child Assessment	The student will: a) review a minimum of three (3) developmental assessments including at least one standardized assessment for the 0-3 population. b) choose two (2) of the assessments to administer to three children (two who are developmentally delayed and one who is developing normally). One developmentally delayed child and one normal child must be of the same chronological age. When assessing the two developmentally delayed children, a second staff member or project staff member, who is familiar with the instrument, must accompany the student and score the child separately to determine reliability.	Written reviews of the assessments must include: - Name of assessment, author, publisher and address - Cost - Validity, reliability and norming sample data - Population recommended for - Domains assessed - Materials needed - Training needed - Type of scores obtained - Type of test (standardized, criterion referenced, etc.) - Ease of administration - Judgment as to usefulness - Strengths and weaknesses Written summaries of the results must include: - scores obtained - skills exhibited - child's strengths and weaknesses - implications for programming Handwritten summaries of results and implications for programming must be submitted to, discussed with and approved by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
3) Family Assessment	The student will: a) review a minimum of three (3) family assessments b) administer two (2) family assessments for the purpose of developing goals for the IFSP. At least one assessment must be administered through a family interview. Prior to the interview, the student must prepare: - an agenda - open-ended questions During the interview, the student will demonstrate the communication skills of - effective listening - effective inquiry - effective reflection of feeling - effective reflection of content	Written reviews of the two assessments must include information on: - Rationale - Norming sample - Areas tested - Types of scores obtained - Judgments as to usefulness - Strengths and limitations Reviews must be submitted to and approved by the instructor. The instructor will observe the family interview and provide written feedback. Written summaries of results and implications for services must include: - scores obtained - family strengths and needs - implications for programming Summaries will be submitted to, discussed with and approved by the instructor.
4) Team Meeting	The student will facilitate two (2) team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the student will: a) develop a written agenda b) delineate roles and responsibilities of participants c) prepare families for their role in the meeting	The instructor will observe the team meetings and provide written feedback. The student will submit a written summary of the results of the meetings and discuss them with the instructor.

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
5) Goal Setting	In collaboration with the family and members of the intervention team, the student will develop individualized goals to meet the needs of both the family and child.	a) The family goals will reflect the needs identified by the family during the assessment process. The goals will be operation- alized and non-intrusive to the family. Goals will be reviewed by the instructor. b) The child goals will reflect the needs of the child as identified by the family and the team assessment process. Goals must be operationalized and reviewed by the instructor.

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PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
6) IFSP	In collaboration with each family,and team members the student will write two (2) IFSP's that will include the following components: a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help) b) a statement of the family's strengths and needs relating to enhancing the child's development c) a statement of major outcomes expected to be achieved for the child and family d) short-term behavioral objectives for each major outcome that are written in operational terms and specify functional activities in which they occur e) the criteria, procedures, and timelines for determining progress f) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service g) the projected dates for the initiation of services and expected duration h) the name of the case manager who is responsible for implementation of the plan and coordination with other agencies i) a transition plan for the delivery of special education services and related services in the child's next environments	IFSP's will be submitted to, discussed with, and approved by the program supervisor, team, and instructor. The goals delineated in the IFSP must correspond to he goals prioritized by the ff and family during meetings and interviews.

ERIC

PROGRAM TASKS
IFSP Institute

DESCRIPTION	PROGRAM TASK	CRITERIA
7) Implementation of IFSP	The student will implement each of the IFSP's through contacts with the child and family, either in the home or through a center-based program. At least one of these contacts must be a home visit. Implementation of the IFSP will include: a) following written flexible agenda for a home/center visit which includes child and family IFSP objectives to be addressed during the home/center visits, and activities to address the IFSP objectives b) data collection procedures c) other evaluation procedures	The instructor will review the agenda, objectives, activities and data for the first three (3) visits, and will accompany student on at least one (1) home/center visit. Outcome of the visits will be discussed with the instructor. The instructor will also review evaluation procedures.

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NEW MEXICO REHABILITATION AND SKILLED NURSING CENTER
OF THE CAPITAL DISTRICT

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<u>centration to decentration</u>: Development ranges from an exclusive concern with self and the immediate surroundings to an ability to take other people's perspectives and to consider events that are distant in time and space. Following brain injury, children, adolescents and young adults often appear "egocentric" which may be explained in part by regression to an earlier developmental level in this aspect of cognitive functioning.

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Revision Date:
Completed By:

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APPENDIX R

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Table 1 Participant Demographics for the Dutchess County Health Department Transdisc. Teaming Institute

ID Number	Position	Highest Degree	Area of Certification	Formal Training with 0-3 Population	Years of Experience with 0-3 Population	Years of Experience in Your Field
49	Administrator	MS	Special Ed.	No	10	3
50	Psychologist	M.Ed.	Psychology	No	0	1
51	Nurse	BS	Nursing	Yes	8	13
52	Social Worker	MSW	Social Work	Yes	2	10
53	Nurse	BS	Nursing	Yes	5	20
54	Ea. Ch. Spec. Ed.	M.Ed.	Special Ed.	Yes	5	8
55	Parent	None	None	No	0	0
56	Family Serv. Coor.	BA	None	Yes	3	14
57	Physical Ther.	BS	Physical Therapy	Yes	4	8
58	Ea.Ch. Spec. Ed.	MA	Special Ed.	No	6	15
59	Speech Path.	BS	Speech Path.	Yes	5	6
60	Coordinator	MA	Psychology	Yes	7	7

Table
Self Rating Scale Results for DUTCHESS COUNTY TRANSDISCIPLINARY TEAMING INSTITUTE

	Where I Am Pre	Where I Am Post 1	Where I Am Post 2
1. State program philosophy.	2.40	4.92	5.00
2. Demonstrate understanding of the characteristics of multidisciplinary, interdisciplinary, and transdisciplinary teams.	2.50	4.58	4.92
3. Describe own team structure.	2.30	4.08	4.67
4. Describe program's policies and procedures relating to team functioning (e.g., team members, system of communication, meetings, assessment, writing plans/goals, training others, program implementation).	2.20	4.42	4.58
5. Conduct transdisciplinary assessments.	2.10	4.50	4.92
6. Demonstrate skills in administering assessments to young children: through observation; structuring the environment to elicit skills; through direct testing	2.90	4.42	4.83
7. Demonstrate skills in writing an integrated report.	2.20	4.17	4.75
8. Plan a team meeting, including: formulating an agenda; contacting participants; and preparing families.	2.20	4.25	4.83
9. Facilitate a team meeting including: following an agenda; ensuring opportunity for participating of all members; and ensuring minutes are taken and distributed.	2.50	4.25	4.83
10. Communicate assessment results to families and/or other professionals in understandable terms..	2.90	4.25	4.75
11.Include families in team meetings.	3.00	4.33	4.75
12. Develop child and family goals as a team, with families.	2.90	4.25	4.75
13. Demonstrate skills in writing functional behavioral objectives for children across disciplines.	2.80	4.42	4.92
14. Demonstrate skills in determining family concerns, priorites and resources.	2.60	4.25	4.58
15. Share knowledge and skills of own discipline with other team members.	2.60	4.33	4.58
16. Learn knowledge and skills from other team members.	2.60	4.33	4.92

ERIC

Table 3
Pre-post test scores for individual participants from the DUTCHESS COUNTY DEPARTMENT OF HEALTH TRANSDISCIPLINARY TEAMING INSTITUTE

Participant #	Pre Test	Post Test	Post Test 2
49	40%	95%	100%
50	40%	100%	100%
51	50%	90%	95%
52	45%	90%	100%
53	65%	100%	100%
54	65%	95%	100%
55	75%	95%	100%
56	60%	100%	100%
57	35%		
58	35%	95%	100%
59	65%	95%	100%
60	50%	100%	100%
Mean	**52.1%**	**87.9%**	**99%**

ERIC

Table 4
Mean scores across participants from the DUTCHESS COUNTY DEPARTMENT OF HEALTH TRANSDISCIPLINARY TEAMING INSTITUTE for each item on the consumer satisfaction survey .

ITEM	Mean Scores
Objectives Met	5.00
Topics Covered	5.00
Relevant Material	4.91
Adequate Illustration	4.91
Time Organized	5.00
Information Relevant to Work	4.91
Better Understanding of Subject	5.00
Presenter Prepared	5.00
Presenter Knowledgeable	5.00
Presenter Used Activities	4.91
Presenter Easy to Listen to	5.00
Presenter Valued Input	5.00
Environment Comfort	4.91
Adequate Breaks	4.73
Good Group Size	4.82
Good Location	4.91
Good Day and Time	4.73

*Participants rated on a Likert Scale (1=Strongly Disagree - 5=Strongly Agree) their satisfaction with the institute.

First draft from TTI charts. Needs to be reviewed per "Coordinated Standards and Procedures" and draft regulations. (5/93)

Early Intervention Program - Initial Contact Goals

PHASE I Phone contact with parent (For referral made by someone other than the parent, or in writing, the Initial Service Coordinator will call the parent.)

- Introduce self and role. Confirm the request for referral if it was made by someone other than the parent.
- Provide information on the program.
- Confirm interest in participation.
- Explore options for further contact face to face: where, transportation, translator?

(Send out letter confirming logistics and parent handbook prior to meeting with parent.)

PHASE II Face to face The overall information exchange will be governed by the family but facilitated by the Initial Service Coordinator. Our goals are to:

- Impart a feeling of hope.
- Inform the parents of their rights.
- Gain a better understanding of child and family, through formal (Family Assessment) and informal means. This may be easier if meeting is in child's home.
- Give family concrete information on what happens next, timelines, schedules.
- Gain a sense of family's desire to move at what pace.
- Develop a screening/evaluation plan: Where, when, what evaluations?

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DEPARTMENT OF COMMUNICATION DISORDERS
St. Francis Hospital
North Road, Poughkeepsie, NY
914/431-8800

**REVISED DRAFT
REFERRAL TO SPEECH-LANGUAGE PATHOLOGIST IF CHILD IS NOT DEMONSTRATING AT LEAST 2 OR MORE SKILLS WITHIN 6 MONTHS OF HIS/HER CHRONOLOGICAL AGE

0 -3 MONTHS

* BABY IS NOISY (COOS, GURGLES, CRIES, "RASPBERRIES")
* ALERTS/QUIETS TO VOICE AND NEW SOUNDS
* MOVES EYES TOWARD SOUND SOURCE

3-6 MONTHS

* RESPONSIVE, VOCAL, INTERACTIVE BABY
* BABBLES (SPONTANEOUS AND IMITATIVE)
  DIFFERENT CRIES (HUNGER, WET, ATTENTION)
* TURNS HEAD TOWARD SOUND
* SMILES RESPONSIVELY
* ANTICIPATION/RECOGNITION FAMILIAR PEOPLE AND ROUTINES I.E. FEEDING
* FEEDING-SUCKLING PATTERN PRIMARILY LIQUIDS MAY BEGIN INFANT CEREAL OR PUREES
* PLAYS ACTIVELY
* BRINGS TOYS/HANDS TO MOUTH

6-9 MONTHS

* VERY ATTENTIVE TO SPEAKER
* VARIETY OF SOUNDS IN BABBLING
* RESPONDS TO SIMPLE GESTURES I.E. UP
* LOOKS AT COMMON OBJECTS/FAMILY WHEN NAMED
* VOCALIZES FOR ATTENTION
* SOME SOCIAL GAMES I.E. PATA-A-CAKE
* FEEDING-SOFT TEXTURES AND TEETHING BISCUITS MAY BEGIN TO HOLD BOTTLE
* RESPONSE TO "NO"

9-12 MONTHS

* GIVES OBJECT ON REQUEST WITH GESTURE
  FIRST WORDS EMERGE (MAMA, DADA) (CLOSER TO 12 MOS.)
  VOCALIZES DURING PLAY
* MOUTH IS CLOSED WITH LITTLE DROOLING
* SELF FINGER FEEDING

12-15 MONTHS

* FOLLOWS ONE STEP DIRECTIONS WITH GESTURES
* TWO TO THREE OTHER WORDS BESIDES MAMA, DADA
* SPEECH SOUNDS LIKE "GIBBERISH" (LONG STRINGS OF BABBLING THAT SOUND LIKE REAL CONVERSATON)
* BEGINS TO UNDERSTAND ACTION WORDS
* POINTS TO SOME BODY PARTS ON REQUEST
* NAMES SOME OBJECTS IMITATES ANIMAL SOUNDS
* ASKS FOR MORE
* SHAKES HEAD "NO"
* CUP DRINKING MAY BEGIN, SPOON FEEDING SOFT CHEWABLES

15-21 MONTHS

* PLAYS SIMPLE GAMES WITH PEOPLE
* ANSWERS SIMPLE "WHAT'S THIS" QUESTIONS
* ASKS "WHATS' THAT"
* IMITATES NEW WORDS
* USES LANGUAGE VERSUS POINTING (5-20-WORDS)
* IMITATES AND BEGINS USING TWO WORD PHRASES
· PRETEND PLAY
* SELF SPOON FEEDING/STRAW DRINKING (TABLE FOODS)

21-24 MONTHS

* USING REAL WORDS AND COMBINES WORDS MOST OF THE TIME
* ASKS QUESTIONS
* LISTENS TO STORIES
* NAMES PICTURES
* VERBALIZES "NO"
* BEGINS TO "TALK ABOUT" EXPERIENCES

24-30 MONTHS

* UNDERSTANDS MANY WORDS
* USES APPROXIMATELY 200 WORDS
* ANSWERS -WH QUESTIONS
* FOLLOWS TWO STEP DIRECTIONS
* COMBINING 3 TO 4 WORDS IN SIMPLE SENTENCES

30-36 MONTHS

* SPEECH IS CLEAR 80% OF THE TIME
* CONCEPTS UNDERSTOOD I.E. SIZE, SPACE, COLORS EMERGING
* DRAMATIC PLAY BEGINS
* USES ACTION WORDS AND VERB TENSES
* LISTENS TO 20 MINUTE STORY
* STANDARD TESTING IS NOW APPROPRIATE

OTHER WARNING SIGNS

VERY HIGH/LOW ACTIVITY LEVEL

EXCESSIVE DROOLING AFTER 12 MONTHS VERY OPEN MOUTH POSTURE

LIMITED ATTENTION SPAN

HISTORY OF FAMILY HEARING IMPAIRMENT

LACK OF RESPONSE TO SOUND AFTER 6-9 MONTHS

VOICE VERY MONOTONE, BARKING QUALITY, VERY NASAL OR HOARSE IN THE ABSENCE OF ILLNESS/ALLERGY

SIGNIFICANT DROPOFF IN VOCALIZATION AFTER 18-24 MONTHS

FREQUENT EAR INFECTIONS

FEEDING PROBLEMS (EXCESSIVE GAGGING/VOMITING/COUGHING/POOR CHEWING)

BILINGUAL CHILDREN-PARENT REPORTS DIFFICULTIES IN PRIMARY LANGUAGE I.E. DOESN'T FOLLOW DIRECTIONS, SPEECH IS NOT CLEAR, NOT COMBINING WORDS BY AGE 2 YEARS (CHECK FOR LANGUAGE UNDERSTANDING AND USE IN PRIMARY LANGUAGE FIRST USING CRITERIA ABOVE).

DOWNS SYNDROME, CP, CLEFT PALATE, HEARING IMPAIRED, MR, OTHER NEUROLOGICAL IMPARIMENTS SHOULD BE REFERRED

POOR EYE CONTACT

EXCESSIVE IMITATION OF WORDS/SOUNDS/SENTENCES--PERSEVERATIVE IN NATURE

DOH Criteria

~~illegible~~
(Nurse)

<u>Considerations for involving a nurse during at least the initial evaluation:</u>

1. For children who are medically fragile. (The child may have a Public Health Nurse involved who is monitoring the coordination of care for a child, or in-home skilled nursing through a private agency. If a PHN is involved, they will be involved in setting up and/or monitoring the development of a care plan.)

2. For children who are technology-dependent. (Again, for monitoring the progress of physical health and development, care plans, etc.)

3. For children who otherwise have limited life expectancies.

4. For children for whom infectious disease control might be an issue.

5. For Health Guidance/Anticipatory guidance and safety, when there are concerns about parenting skills, parent-child interactions, learning signs and symptoms of illness, etc. (ex.: teenage parents, developmentally disabled parents or parents with histories of mental illness, etc.).

6. For children who are at-risk but determined not eligible for early intervention services. (Regular developmental monitoring can be provided through the IHAP program.)

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DoH
PT/OT

Criteria for Physical and/or Occupational Therapy Evaluations

Referrals .....
if more than 2 are present:

* "w" sitting
* ankles which appear weak or turn in
* excessive drooling
* muscle stiffness when diapering or dressing
* favors one hand
* shoulders always elevated
* neck back often; arching of body and/or neck
* hands do not come together after 4 months
* lower extremities always move together
* hands which remain fisted after 3 months
* arms are kept in a fencing position
* poor head control after 4 months
* irritability with changes in environment
* jittery movements; shaky movements
* aversion to touch or textures
* consistent feeding problems
* doesn't turn to sound after 4 months
* standing/walking on toes
* cannot sit unsupported after 8 months
* cannot readily move from one position to another
* whole hand grasp after 10 months
* one or two arms held stiffly during an activity
* poor coordination of movement; frequent falling
* leaning to one side or the other consistently
* poor eye contact
* excessive activity; difficulty attending
* child is "floppy"
* child is difficult to console

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PT/OT

REHABILITATION PROGRAMS, INC.
Medical Rehabilitation Clinic
230 North Road
Poughkeepsie, New York 12601

OBSERVATIONS THAT MAY INDICATE A REFERRAL FOR OT OR PT
(3 + 5 YEAR OLDS)

_____ Has trouble holding head up when sitting.
_____ Difficulty with swallowing, chewing, drinking.
_____ Stumbles and falls more frequently than others his age.
_____ Has trouble with buttons & zippers.
_____ Has difficulty throwing or catching a large ball.
_____ Is hyperactive.
_____ Cannot tolerate upsets in plans and expectations.
_____ Oversteps or understeps obstacles.
_____ Frequently uses arms to support head or leans very close to paper.
_____ Has difficulty orienting self to new places.
_____ Doesn't stumble or fall, yet wants physical assistance.
_____ Has an unusual fear of falling or of heights.
_____ Is alarmed if suddenly pushed off balance.
_____ Uses the stair banister more than the other children (4-5 yr)
_____ Is distractible; poor attention span.
_____ Unable to manage toileting, grooming.
_____ Large movements are clumsy or awkward.
_____ Appears weak, has poor endurance.
_____ Walks on toes.
_____ Stiffens when you try to help (position body, dress, undress).
_____ Is heedless, lacks concern for safety in movements.
_____ Moves too slowly or too quickly.
_____ Has extreme tightness at any joint which limits function.
_____ Is unable to keep up with peers in gym class or playground.
_____ Dislikes rough-housing, somersaults, rolling on floor, jumping.
_____ Is not skillful with either hand, tends to switch hands.
_____ Becomes tired easily.
_____ Is accident prone; has many little accidents (i.e. spilling milk).
_____ Walks and runs into furniture or walls, cannot stop or change direction with control.
_____ Sitting posture is poor/slouched; child frequently fidgets in seat.
_____ Is slow to learn new games or new motor skills.
_____ Walks with assistive devices (braces, artificial limbs, etc.)
_____ Uses upper limb assistive devices (braces, splints, etc.)
_____ Avoids play involving various textures (clay, shaving cream, etc.)
_____ Sits, can't sit without hand support.
_____ Body asymmetry; (doesn't use one hand e.g.)
_____ Can't cross body midline.
_____ Leans on people or furniture for support.
_____ Eyes don't seem to work together.

A child may be more likely to need a referral if he/she exhibits several of these signs.

BEST COPY AVAILABLE

Draft of Family Tool

Family Name:______________________ Date:______________

How Can We Help?

All children and families have their own unique strengths and needs. The following questions will help tell us how we can be most helpful to your family. We understand that your needs will change from time to time but this will help us begin to plan together with you. Please answer only those questions you feel are most helpful.

1. What pleases you most about your child?

2. What concerns you about your child?

3. What kind of help or information do you want from us?

4. What would you like your child to be able to do in the next several (six?) months?

5. Is there any help or information you would like for your family in the next six months?

6. How would you describe your family's daily or weekly routine? (We would like to consider your normal schedule in planning services, and plan activities to help you at home.)

7. Who are the people you would like to include in the planning

Family Name: ______________________ Date: ______________

How Can We Help?

Our family would like:

Information about:

- typical child development ____
- child behavior ____
- nutrition/feeding ____
- our child's health problems ____
- how to play with or talk to my child effectively ____
- equipment or supplies which might help my child and how to get them ____
- helping our other children understand this child's delays ____
- other: ______________________

____

Help with child care:

- finding daily child care ____
- finding babysitters ____
- finding respite care ____
- teaching care providers how to take care of my child ____
- finding ways to pay for day care or babysitters/respite care ____
- finding out about what makes a good child care program ____
- other: ______________________

____

To know about community services for our child and family:

- transportation to services ____
- financial assistance ____
- adult education or vocational training programs ____
- housing ____
- fuel ____
- clothing ____
- individual or family counselling ____
- services for our other child/children (please describe: ____

____

REHABILITATION PROGRAMS, INC.
REHAB SCHOOL/MEDICAL REHAB CLINIC
230 NORTH ROAD
POUGHKEEPSIE, NY 12601
Infant & Parent Program

It is the belief of the Social Work Department that families of disabled children are presented with unique issues, problems, and needs for support. It is also the belief of the Department that without the assistance of community services these families might not cope as effectively with the problems they must face.

It is also the premise of the majority of social workers that _any_ family with a child who has special needs should be offered social work intervention. This is so because the birth of a child with developmental delays and/or medical problems constitutes a crisis in family life, according to the definition of "crisis" within the social work profession.

Given the above philosophy, our primary mission is to support the family in its social context so that it can provide the infant or preschooler an optimum environment for development. Our mission is also to assess family needs on an individual basis and then offer appropriate services. Our services should provide the assistance, support, and encouragement families of handicapped children require in helping them meet their child's needs within their individual family system.

Additionally, the Social Work Department provides staff with supportive services geared to enhance the staff's ability to understand each family situation. This helps assure that family service provision is _family_ centered.

The areas of intervention can be many and are dependent upon the individual family. The areas in which families most often require social work intervention are:

1. In coping with feelings of grief, uncertainty, and unrealized expectations for their child.

2. In dealing with the stress of having a disabled child on the family system (including the impact on the marital relationship and on siblings).

3. In establishing new resources.

4. In dealing with parenting issues unique to being the parent of a disabled child as well as those common to all parents, but which may present specific challenges to the parent of a disabled child (such as separation).

5. Advocacy.

6. In problem solving.

7. In coordination of services.

8. In obtaining information re: the condition of the child.

These services take place in the context of a supportive and therapeutic relationship with the family (which is in and of itself a service).

A social work assessment is fundamental to establishing a working relationship and identifying the family's strengths and needs.

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APPENDIX S

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PRE/POST/FOLLOW-UP TES. JATA ACROSS PROGRAMS

Program	N =	Pre-test mean	Post-test mean	% Change	T-Score & probability	Follow-up mean	% Change	T-Score & probability
Greenwich ARC	6	53.17	88.50	35.33	t=2.72 p<.042	88.83	35.66	t=2.67 p<.044
Rainbow Program	8	51.00	61.13	10.13	t=1.88 p<.103			
Boces II Infant Prog.	7	65.86	86.71	20.85	t=5.58 p<.001	85.29	19.43	t=3.95 p<.005
UCP Westchester	7	50.42	78.57	28 15	t=4.28 p<.005	78.40	27.98	t=5.58 p<.005
Sullivan Diagnostic	6	50.17	78.17	28.00	t=8.39 p<.000			
East River	5	31.20	72.60	41.40	t=7.77 p<.001	73.00	41.80	t=9.34 p<.001
WARC - Children School for Early Development	10	46.70	76.40	29.70	t=7.10 p<.002	92.50	45.80	t=10.60 p<.000
Special Sprouts	6	46.66	83.83	37.17	t=35.53 p<.000	72.50	25.84	t=4.66 p<.019
Alcott School	6	45.43	60.00	14.57	t=35.53 p<.003	65.25	19.82	t=3.52 p<.039
Sunnyview Rehab	5	64.00	94.00	30.00	t=6.32 p<.003	100.00	36.00	t=7.06 p<.002
Putnam ARC	5	35.80	88.20	52.40	t=13.78 p<.000	94.60	58.80	t=9.21 p<.001
Columbia ARC	10	43.90	88.00	44.10	t=9.07 p<.00	82.66	38.76	t=8.37 p<.000
Williamsburg Developmental School	10	42.50	84.40	41.90	t=6.70 p<.000	72.90	30.40	t=2.84 p<.019
Northside Center	7	54.29	67.00	12.71	t=.66 p<.532	68.57	14.28	t=.72 p<.498
New Medico Rehab	11	31.27	89.27	58.00	t=12.58 p<.000	96.82	65.55	t=13.29 p<.000
Dutchess Co. Health	11	52.08	95.91	43.83	t=10.70 p<.000	99.55	47.47	t=11.71 p<.000

OVERALL MEANS

N =	Pre-test mean	Post-test mean	% Change	T-Score & probability	Follow-up mean	% Change	T-Score & probability
120	47.78	80.79	33.20	t=7.97 p<.043	83.63	36.26-	t=6.66 p<.045

INSTITUTE SELECTION BY PROGRAM

PROGRAM	IFSP	TRANSDISCIPLINARY TEAMING	INFANT CURRICULA	PROGRAMMING FOR INFANTS
Greenwich ARC			X	
Rainbow Program			X	
Boces II Infant Prog.		X		
UCP Westchester		X		
Sullivan Diagnostic	X			
East River		X		
WARC- Children School for Early Development	X			
Special Sprouts	X			
Alcott School				X
Sunnyview Rehab		X		
Putnam ARC	X			
Columbia ARC	X			
Williamsburg Developmental School	X			
Northside Center			X	
New Medico Rehab	X			
Dutchess Co. Health		X		

APPENDIX T

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Appendix T

B-3 manual

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APPENDIX U

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INDIVIDUALIZED FAMILY SERVICE PLAN:

MANUAL FOR PARTICIPANTS IN THE PROCESS

DRAFT

This project was supported in part by Grant #H024D10052 from the Office of Special Education And Rehabilitation Services, U. S. Department of Education, Early Childhood Program for Young Children with Disabilities. The Grant, the Birth to Three Inservice Outreach Project, was directed by Mary Beth Bruder, Ph.D. at the Westchester Institute for Human Development, Valhalla, New York.

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1992

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The need for the development of this manual grew from lengthy discussions facilitated by the Westchester-Rockland-Putnam County Regional Planning Group. The latter group was supported by the New York State Department of Health efforts to implement P. L. 99-457 during the planning years prior to passage of NYS legislation, the Early Intervention Bill of 1992. This legislation is also known as Chapter 428. A subcommittee comprised of the authors of this manual operationalized the concerns of the larger planning group which represented a variety of interests: families with children with disabilities, direct service providers, administrative units such as the local DOH officials, Early Childhood Direction Center representatives, child care resource and referral agencies, and personnel preparation preservice and inservice faculty.

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INDIVIDUALIZED FAMILY SERVICE PLAN:

MANUAL FOR PARTICIPANTS IN THE PROCESS

DRAFT

1. PURPOSE AND AUDIENCE

The manual can be used by parents and professionals who are planning and implementing early intervention services for infants or toddlers with a disability based on the philosophy of the federal guidelines initially represented in P. L. 99-457, the 1986 amendment to the Education for All Handicapped Children Act, now called the Individuals with Disabilities Education Act (IDEA). The purpose of this manual is to provide information about the **Individualized Family Service Plan (IFSP)**:

*WHAT it is.

*WHY develop it.

*HOW you do it.

This manual begins the IFSP process at the point that the infant or toddler is referred for evaluation to determine the possible need for early intervention services. Early intervention services may include:

*family training, respite, counseling, and home visits
*special education
*speech therapy
*audiology
*occupational therapy
*physical therapy
*psychological services
*service coordination
*some medical services for necessary diagnostic and evaluation procedures

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*early identification, screening, and assessment services
*health services necessary to enable the infant or toddler to benefit from the other early intervention services.

The first step in the IFSP process is the collection of information about the infant or toddler in relation to his/her family's concerns, resources, and priorities. In the IFSP process, a family can consist of the individual(s) who is legally responsible for the infant/toddler and those people they consider as part of their family. Based on the information collected during the assessment of the infant/toddler and their family situation, a plan is generated. This plan takes place in a team atmosphere. The team is made up of a group of people with similar purpose and goals. The team consists of those members who have expertise - the professionals in regard to early development and the family in regard to their infant/toddler. This team collaborates in their shared responsibility to plan for the infant/toddler.

2. WHAT IS AN INDIVIDUALIZED FAMILY SERVICE PLAN?

A. Definition:

The IFSP is the result of a collaborative process in which the family makes informed choices as to their infant/toddler's present and future needs. It is the result of the review with the family of their concerns, resources, and priorities in relation to their infant/toddler with disabilities. The ultimate goal of the IFSP is to foster the development of the infant/toddler with disabilities.

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The IFSP is an ongoing, constantly changing plan of action.

B. **Components**

* Current description of the child
* Family concerns, resources, and priorities
* Major outcomes for the child and family
* Criteria, procedures, and timelines for determining progress
* Specific early intervention services including method of provision in a naturally occurring environment, frequency, and intensity
* Projected dates for initiation of service and duration
* Designated service coordinator
* Procedures for transition from early intervention to preschool services.

3. WHY DEVELOP AN INDIVIDUALIZED FAMILY SERVICE PLAN?

The passage of federal legislation (P.L. 99-457) and NYS legislation (Early Intervention Bill of 1992) supports the philosophy described in the following characteristics of the Individualized Family Service Plan.

***Federal policy of Part H, the legislation that oversees early intervention for infants and toddlers**

"The Congress finds that there is an urgent and substantial need

(1) to enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay,

(2) to reduce the education costs to our society, including our Nation's schools, by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age,

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(3) to minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society, and

(4) to enhance the capacity of families to meet the special needs of their infants or toddlers with disabilities. (P. L. 99-457, 1986)

***Appropriateness**

Infants/toddlers live within all different types of families. These different types of families are the main force shaping the infant/toddler's life. Any plan that involves an infant/toddler must respect the values, priorities, resources, and concerns of the family as they raise their child.

***Naturally occurring environments**

Infant's/toddler's with disabilities and their families need the opportunity to participate in community and family activities that are typical to the family's life style. The team develops the IFSP to support the infant's/toddler's inclusion with his/her typically developing peers in activities, functions, routine situations that are usual to the family and their infant/toddler.

***Family directed**

Children are naturally part of some type of family unit. The IFSP helps the family identify their concerns, resources, and priorities in relation to providing an environment in which their infant/toddler can achieve his/her potential. Each family brings to the IFSP process their uniqueness. Each professional brings to the IFSP process their uniqueness. These unique characteristics show up as culture, ethnicity, religious affiliation, community affiliation, educational background, family systems, professional networks and personality characteristics. The ultimate goal of the IFSP, as described in the federal legislation and cited previously lays the basis for family directed IFSPs.

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***An ongoing, portable statement to share**

The documentation of the Individualized Family Service Plan in its written form stands as a statement that families can readily use to share with individuals interested in their child's development. Such use resembles a "baby book" sometimes used by pediatricians as an ongoing record of developmental visits.

4. HOW DO YOU DEVELOP AN INDIVIDUALIZED FAMILY SERVICE PLAN?

A. Team Process

A team of people develop the Individualized Family Service Plan. The team consists of the family, the initial service coordinator, a representative of the evaluation team and other members as requested by the family. The team that continues the IFSP process after the initial plan represents the family, the service coordinator, a representative of the monitoring agency if appropriate, and those other members mutually agreed upon by the family and service coordinator. The team process involves the communication of:

- a clearly defined purpose,
- collaboration of participants in the establishment of goals,
- clearly defined operating procedures,
- discussion of competition, vested interests, and turf,
- recognition of different opinions,
- method of conflict resolution,
- clear definition of roles and responsibilities,
- time commitment.

B. **Service Coordination**

The service coordinator assists and enables infant/toddler and his/her family to receive the rights, procedural safeguards and services that are authorized under the state's Early Intervention legislation. Early Intervention legislation requires that NYS provide service coordination as part of the requirement to examine the need for early intervention services for an infant or toddler who seems to show a developmental delay. Service coordinators help the families pull together all the available services from across the systems that affect the infant/toddler within their family. The service coordinator starts, facilitates, and maintains the Individualized Family Service Plan process. It is the role of the service coordinator to assist the family and professionals as they:

* collect all the information from assessments, records, resources that relate to the infant/toddler,
* focus on those concerns that require immediate attention and those that can wait,
* facilitate the interactions of the family and professionals to get an accurate picture of the infant/toddler,
* interpret jargon and professional shorthand,
* investigate the resources within and outside the family that support the infant/toddler's participation in natural environments with infants/toddlers without disabilities,
* determine a set of realistic, achievable goals that form a plan of action,
* develop a procedure that monitors movement toward these goals,
* collect all the information the family and professionals need to make an informed decision about what will work for this unique infant/toddler and family.

The responsibilities of the service coordinator should include:

* scheduling regular opportunities for the family and professionals to collaborate in planning for the child, to review the infant/toddler's development, to coordinate the services, providers, and responsibilities.
* establishing a schedule for delivery of services that meets the needs of the infant/toddler based on the team's recommendations,
* monitoring the implementation of the goals and maintaining records of the outcomes,
* maintaining on-going records of the team activities and provision of services,
* ensuring follow through by all team members on all aspects of service delivery,
* ensuring integration of the services across all the providers.

In a coordinated system, the family and infant/toddler actively participate in a productive, constructive process that views the infant/toddler from his/her family's perspective. This is the ultimate goal of service coordination.

C. **Collaborative Goal Setting** or **Developing Major Outcomes**

Collaborative goal setting begins as early as a family's sharing their concerns about their child or when they seek information from early intervention professionals. Collaborative goals are the product of all the information shared between the family and professionals. **In the federal legislation that relates to providing services to infants and toddlers**

identified with disabilities (Part H of P. L 99-457), collaborative goals are called major outcomes. These major outcomes reflect the changes a family would like to see for their infant or toddler. These changes can include adjustments and adaptations to family resources that have a bearing on the infant's or toddler's ability to function within their family and community.

Multiple sources should be used to collect information that the family considers important and useful. Sources of information could include:

1. discussion with families
2. observation of the infant or toddler in his/her natural setting
3. information shared from individuals familiar with the child such as extended family, neighbors, and professionals.

Based on this **assessment material**, the team made up of the family and professionals, and facilitated by the service coordinator, develops **goals or statements of outcomes**. These goals design the plan which provides structure for the services for this infant or toddler within his/her family's priorities.

1. What is a goal or major outcome?

A goal is a statement that describes what the infant/toddler or family will be able to do within a prescribed period of time. Time frames vary depending on many factors. These factors could include health issues, family priorities, or availability of resources. The **IFSP** must be reviewed within six months and evaluated at the end of one year. Best practices implies that the review and evaluation is ongoing with formalization at the six and twelve month time period.

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2. How do you develop a goal?

Based on the assessment material, the team integrates the key concerns and how they can be addressed. This requires:

* communication
* collaboration
* negotiation
* family-driven team process
* realistic expectations
* use of vocabulary that is familiar to everyone.

3. What criteria define long term goals or outcomes?

Socially valid: The goals are valued by the family.

Functional: The goals foster the infant/toddler's independence within their family and community.

Achievable: The infant/toddler and family can be successful.

Realistic: The goals are based on the assessment.

Normalized: The goals foster the infant's or toddler's inclusion in the typical activities of the family and community.

Measurable: Change can be observed.

4. How do you implement the goals?

Mutually agreed upon goals design the plan which provides the structure for the services for the infant/toddler within his/her family's priorities. That is why this process is collaborative. The **service coordinator** insures that the services are in place to help attain collaboratively identified and mutually agreed upon goals. The configuration of these services: intensity, frequency, types, duration, and setting, will be unique to each

infant/toddler and family. This is the ultimate outcome of the **individualized** family service plan.

5. How do you determine the goals were met?

The criteria for developing goals also defines the criteria to determine if goals were met. Relying on the information collected through observation, anecdotal records, data sheets, formal testing, family's and interventionist's reports, the team determines if the mutually agreed upon goals have been achieved. Therefore, the major questions that the outcome data answers are:

* Is the infant or toddler any more independent?
* Is the infant or toddler better equipped to participate in family and community activities?
* Does the family continue to have the necessary resources to provide an environment conducive to the continued development of this infant or toddler?

If the family and service coordinator agree the infant or toddler has not only reach the goals developed by the team but no longer requires early intervention services this will be documented in writing. The infant or toddler in such a circumstance is no longer considered in the category of developmentally delayed.

D. **Language of the IFSP**

The KISS principle: keep it simply simple.

* Free of professional jargon and terminology;
* Explanations of abbreviations when they are used;
* Free of innuendo;
* Identification of facts versus opinion and clinical judgment.

5. HOW WILL THE IFSP BE FUNDED?

Funding for services for each infant/toddler and their family will utilize multiple funding sources in an innovative manner based on the individual family situation. The service coordinator, service providers, and family must be alert to funding opportunities in relation to early intervention for infants and toddlers. Funding from the local early intervention governmental agency is considered the last source of payment after all other sources are exhausted.

6. THE IFSP PROCESS: TWO CASE STUDIES

The following case studies can be used as a guide to help you clarify your understanding of the IFSP process. As you read along, there will be questions to help you think through the process of developing an IFSP.

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ROBERT: A CASE STUDY

Robert is a three month old boy who was born in a local community hospital. His parents, Jane and Paul, moved to this area from the midwest about a year ago. Jane's company moved them here and Paul is starting a new business. Both of their families reside in the midwest. Robert is their first child. Jane has three months maternity leave left. All insurance benefits are through her company. Robert's pediatrician identified a congenital condition immediately following his birth. Within a few days of birth, the doctors had to control a series of seizures that occurred. It is expected that Robert will stay on seizure medication for an indefinite period of time. Robert's weight gain is erratic and of concern. Jane and Paul took Robert home from the hospital with trepidation but have found comfort and support from their neighbors in their condominium community. Members of Paul's family which is large have offered to come and stay for a while but Paul and Jane suggested they hold off for a while. Jane's brother from California also offered help through members of his church group who have similar experiences with a birth of a child identified with a congenital condition.

Paul is concerned about the continued medical costs. He also wonders if Robert will enjoy all the "boy things" he would hope to share with his son. Jane wonders what he will be able to learn. Her closest friend in the condo is an elementary school teacher. The friend called the state department of education who referred her to the local Early Childhood Direction Center.

Since Robert's birth, Jane and Paul have consulted with a neurologist and geneticist. They wonder if this condition could recur in future pregnancies. The geneticist gave them material on a local parent network and a national organization for more information. The parents in this

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network have children with a variety of disabilities. An IHAP (an infant health assessment program of the local health department) nurse contacted Jane and Paul on referral from the hospital. She provided an introduction to early intervention possibilities and service coordination opportunities. She offered to either share their name with the local service coordinators or give the number to Jane and Paul who could initiate the contact. The parents chose to make the contact themselves. With this contact, the service coordinator arranged to meet with Jane, Paul, and Robert at their home. During the home visit, the service coordinator provided verbal and written information (brochures) about a variety of services. She noted that the first step to acquire services is an assessment process which involves collection of information about Robert and themselves. The intent is to develop a picture along with them of what kind of services best suit their interests and concerns at this point in time. Jane and Paul spoke about their concerns that were mentioned above. The service coordinator also asked the parents who they might want to participate in the assessment and planning process that will lead to matching concerns with services.

What resources has the family already accessed?

___

Who might the parents identify as the contributing members in the IFSP process?

___

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THE EVALUATION/ASSESSMENT PROCESS

The parents chose an evaluation team that provided a variety of disciplinary input.

Simultaneous to the weeks of appointments, Jane and Paul investigated some options and resources:

- a home based program in which professionals, selected according to the IFSP, would visit their home;
- a family day care home in which the provider is willing to discuss accepting Robert if she is given help with any special needs he may have;
- the day care center at Mom's job with support services that will be defined in the IFSP;
- private insurance coverage with services and limitations.

During this time, what has the service coordinator been doing in preparation for the development of the IFSP?

She has:

- followed up to determine that the assessment appointments were scheduled at a mutually convenient time to the parents and Robert;
- established with the family who would be responsible for different activities, e.g., investigating private insurance coverage;

- ensured that all the needed information was accessible to each person,
- will facilitate the meeting at which the team members will discuss the information collected during the assessment process.
- arranged the meeting of all the people who participated in the assessment process. It was originally scheduled at the service coordinators agency but two days prior to the meeting Jane called because Robert was sick. The meeting was rescheduled for Jane and Paul's home.

The following is the report that the group of discipline representatives prepared. This **integrated report** includes the information collected by each of the disciplines represented on the team in a cohesive manner. Such a report should provide the same information that individually prepared discipline specific reports usually generate. The intent of an **integrated report** is to present the assessment information in a collaborative, understandable, and meaningful format that supplies the IFSP team with the necessary information on which to develop a plan. **By using an integrated report, duplication of shared information is eliminated. The intent of such a report is to provide a picture of the whole infant or toddler.** The person generating the **integrated report** represents a member designated by the evaluation team. In some instances, it may be necessary to also submit discipline specific reports, such as one from a geneticist or neurologist to document medical conditions.

AN EXAMPLE OF AN *INTEGRATED REPORT*:

ROBERT'S CURRENT LEVEL OF FUNCTIONING

CHILD: Robert Smith DATE OF REPORT 4/15//92

DOB: 1/1/92

SOURCES OF INFORMATION FOR THIS **INTEGRATED REPORT**:

Person	Date(s)	Type	Agency
Jane and Paul	4/10 &12/92	Home visit	Parents
Dr. Neurologist	2/1/92	Report	Hospital
Dr. Geneticist	2/10/92	Report	Hospital
Infant Specialist	4/10/92	Home visit	CEC
Nurse	4/10/92	Home visit	CEC
Service Coor	4/1/92	Home visits	DOH
Physical therapist	4/12/92	Home visit	Rehab

ASSESSMENT TOOLS

The Bayley Scales of Infant Development was used to define the observations of the ed evaluator/infant specialist and the nurse.

Robert is a three and one half month old infant. His parents requested an evaluation to determine what early intervention services would be most helpful in their situation.

Robert is the first child born to Jane and Paul. They moved here from the midwest one year ago when Jane was transferred from her local office to the main branch of the company for which she works. Jane's employment provides the family's medical insurance. Paul has begun to develop his own local business. Jane and Paul's family do not live locally but have kept in close contact since Robert's birth. Paul's family is large and close knit. Jane

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has one brother living in California. The rest of her family lives near Paul's in the same small town.

Robert was born after a full term pregnancy with no unusual circumstances. He weighed 8 lbs. 8 ozs. The morning after his birth the pediatrician came to Jane's room and told her he suspected that Robert had a congenital abnormality. He made this judgment based on his observations of Robert's facial make-up and body composition. There were no tests that could verify the diagnosis but he would be available to explain what he knew about the condition as soon as Jane and Paul wanted more information. He would also refer them to a geneticist who would help them collect more information. Within his first day of life, Robert began to have seizures that required medication to control. A neurologist was brought in who related the seizures to the congenital condition. The seizures remained controlled for Robert's one week stay in the hospital. He was sent home with his parents at the end of one week with recommendation for follow up with the neurologist and geneticist.

Jane and Paul discouraged their respective family members from coming to help out at this point. Robert seemed to be doing all right, i.e., no more seizures, and they wanted to adjust to having their son at home. Jane and Paul's neighbors were helpful and supportive with their time and prepared dinners. During Robert's first three months, the seizure medication continued to control any activity. Robert quiets to his parents' voices, startles with loud sounds, and is beginning to gaze into his parents face for a few seconds at a time. He rests quietly wherever his parents place him. He has no set routine yet. On a rare occasion, he may sleep at night up to five hours at a time. During the day he generally cat naps with no prolonged sleep period longer than a half hour. He will cry if he is hungry

but takes no more than three ounces of milk at any one time. Jane and Paul feed him whenever he seems to need it which they judge by his cry. Some days he seems to want to drink all day while other days Jane and Paul may have to encourage Robert to take more than a few ounces in a 24 hour period. Robert's weight gain during the first three months has not been consistent. He gains and loses. At his last visit with the pediatrician at two and one half months he weighed 10 lbs. and 11 ozs.

Robert will quietly focus his eyes for a few moments on the people and things in his environment, e.g., the brightly colored mobile over his crib, the black and white picture of a face in his playpen, or his parents. He follows his mother's or father's face with his eyes when they move out of range. His body remains quiet most of the time. He prefers to lay on his back or side and will fuss and eventually cry loudly if he is left on his stomach.

The neurologist and geneticist identify the same congenital condition for Robert. They both report that children with this condition show a wide range of developmental patterns and delays. No consensus in the literature or research supports a prognosis in any direction. Some of the children do eventually experience significant developmental delays and mental retardation. Jane and Paul have not been able to identify any relatives in either of their families that might reflect a similar picture of Robert's concerns.

The parents' immediate concerns focus on Jane's need to return to work within three months. Prior to Robert's birth they had investigated local family day care situations and the on-site day care available through Jane's company. They wonder if this is still a possibility for them and Robert. Jane's boss advised her that the day care slot was still available but if Robert had unique needs it was not clear if the day care was set up to meet

them. The day care director did note that she would be interested in meeting with Jane and Paul with Robert to discuss the possibilities.

SUMMARY AND RECOMMEMDATIONS

The consensus of the sources of information, parents and professionals, indicated that Robert's limited ability to reach out to his environment by using sounds or his body also significantly limit his opportunity to learn about and from the people and things around him. His scores on the Bayley were within the borderline to low normal range for psychomotor and mental abilities. The existence of a congenital abnormality that could lead to developmental delays warrants monitoring. Robert's inconsistent weight gain and erratic sleep patterns also worried his parents. Robert's inconsistent weight gain raised differences of opinion concerning the next steps to take in order to address this concern. A pressing issue for Robert's parents is the need for child care services to begin with Jane's return to work.

Report prepared by: Date:
Infant Specialist, M.S. 4/15/92
Nurse Specialist, B.S., R.N.

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NOTES ON THE TEAM MEETING

Date: 4/16/92 Time: 5:30 - 6:30

Place: Jane and Paul's living room

Participants: Jane and Paul, parents, Service Coordinator, Infant Specialist, Nurse

Agenda

What do we know about Robert?

What do we know about the family?

What issues and concerns are important to this family?

What resources and services within and beyond the family are available to address these concerns?

How can they be put into place?

How will we be able to tell down the road if the planned services accomplished the goals set at this meeting?

MEETING SUMMARY

Discussions followed the questions listed in the agenda. Major points are documented on the IFSP form. The most effective way to address the group's concerns about Robert's weight gain was a point of dispute but the group did agree that not enough information was yet available to determine what might be most effective. The parents chose to continue to work with Ms. Banerjee as the service coordinator.

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How would you answer the questions listed in the agenda? Are the answers similar to those on the attached IFSP form? ______________________________

____

If not, why? ____

____

If so, why? ____

____

MEETING PROCESS

During the meeting the group considered the **resources** and **concerns** expressed by the participants. Then, these were listed on the IFSP documentation form (See example). Following this, the participants worked together to develop **goals/outcomes** that they listed on the goal sheet. The following forms note how the mutually agreed upon goals were broken into **objectives/activities** to clarify how the goals would be achieved.

The information you need to answer these questions would be drawn from the content of the team meeting. The outcomes (goals) possible in this situation are variable. Those presented in the IFSP form serve as examples. There could be others.

It is important to appreciate that outcome of the IFSP process will rely on:

* how the members communicate;
* the priorities of the parents;
* the sensitivity of the group to the parents' perspective;
* the priorities of the professionals;
* what resources are available.

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At the team meeting during the development of the IFSP, one of the team members should be assigned the job of completing the form tc document the process. Most, if not all the information needed to complete the process should be available from the team members during the meeting. The writing of the IFSP is the way to keep a record of the information, discussions, and decisions made by the team at the point in time that is noted in the IFSP. **The IFSP is an ongoing, continuous document that will change as often as the situation of the infant/toddler and family changes.**

Transition has not been raised as part of this IFSP yet. Once Robert is settled in child care and early intervention services have begun, the team will continue to discuss the outcomes for future planning. For example, do Robert's parents anticipate continuing to live in their present community? Do they look toward a nursery school setting as Robert gets older?

These questions only suggest the direction the discussion could turn. The parents, service coordinator, and other team members who are invited to participate in the discussion would form the content of discussion.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

Background Information

Child: Robert	**Family member:** Jane	**Relationship:** mother
Family name: Smith	**Family member:** Paul	**Relationship:** father
Birthday: 3/1/92 **Age:** 3 mos. 15 days	**Address:**	**Insurance Co:** **Number:**
Gender:	**Home Phone:**	**Medicaid #:**
SS #:	**Work Phone:**	

Planning Team

Name/signature	Title	Agency	Date
Jane Smith	mother	family	4/16/92
Paul Smith	father	family	4/16/92
Maureen Olsen	Infant Specialist	CEC	4/16/92
Amita Banerjee	Service Coordinator	Early Intervention Unit DOH	4/16/92
Mary Lou Delamater	Nurse	CEC	4/16/92

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EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

*STAR PRIORITIES

RESOURCES
Robert has the support of his parents.
Seizure activity in presently controlled by medication.
Robert has a beginning awareness of people and things.
Around him he reacts facially to his parents, objects and sounds.
Robert shows preference for laying on his back.
He cries loudly when uncomfortable.
When he is fussy, he settles down to his parents' touch or voice.
Jane and Paul are actively seeking information from a variety of sources.
The family has the help of other family and friends.
Jane's health insurance policy with PPP covers X,Y, and Z.

CONCERNS
Robert's weight gain in inconsistent.
He sleeps 5 hours at night on occasion.
Robert's body remains quiet most of the time.
When Robert shows a reaction to something, he does not accompany this with any sounds.
*Jane and Paul need child care to begin when Jane returns to work 7/1/92.
*Jane and Paul are concerned about future medical costs, child care and early intervention fees.
The long term effects of the congenital condition are unknown.
*Jane and Paul wonder what Robert will be like as he grows up. What is his future?

EXAMPLE OF A DOCUMENTATION FORM FOR THE ...

GOAL: Day care with support services will begin July 1, 1992.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Investigate day care options that will include support services.	Service coordinator Jane and Paul Prospective day care providers	4/16 - 6/16 Collect information 6/16 Evaluate choices and make a decision	Service coordinator and parents will consult directly with support service staff re: schedule for direct and consultation services.

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION [illegible]

GOAL: Robert shows his reactions to familiar people and objects by moving his arms and legs in a typical fashion (symmetrical movements) as recorded by the participants.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Typical daily routines with family and child care person(s).	Robert Parents Day care providers Physical Therapist	Review 9/1/92	Team to develop recording method to be coordinated by PT and shared with service coordinator.
			Review to determine use of consultation vs. direct service time.

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL: Robert coos and babbles when reacting to people and objects in his environment.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Typical routines with family and child care.	Robert Parents Special Educator Child care person(s)	Review 9/1/92	Team develops method of recording sounds. Special Educator will coordinate this and share with service coordinator.

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL: Jane and Paul report that Robert sleeps at least 5 hour stretches most nights.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Consultation with suggestions for intervention.	Robert Parents Neurologist Pediatrician	Review 9/1/92	Parents will report results of consult to service coordinator.

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL: Jane and Paul report that Robert's weight gain in inconsistent.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Consultation with suggestions for intervention.	Robert Parents Pediatrician Nurse	Review 9/1/92	Parents will share information with service coordinator.

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE

GOAL: Jane and Paul collect information from parent-to-parent network.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Phone calls/meetings.	Jane and Paul Service Coordinator Parent-to-parent network	Review 9/1/92	

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL: Further funding needs will be clarified.

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS
Consultation with PPP Insurance DOH.	Parents Service Coordinator	Review 9/1/92	

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EARLY INTERVENTION SERVICE PROVISION

CHILD: Robert Smith **BIRTH DATE:** 1/1/92

Service Type	Provider	Frequency/ Duration	Time frames	Location	Funding Source/ Approval*	Family Signature/ Date
PT consultation	Rehab Center	up to 120 min/mo	7/1/92 - 1/1/93	Day care/ Home	PPP Insurance DOH	
PT direct service	Rehab Center	1x wk for 30 min	7/1/92 - 1/1/93	Day care/ Home	PPP Insurance DOH	
Special Ed. consultant	CEC	up to 120 min/mo	7/1/92 - 1/1/93	Day care/ Home	DOH	
Special Ed. direct	CEC	1x wk for 30 min	7/1/92 - 1/1/93	Day care/ Home	DOH	
Transportation	Parents	5 days/wk	7/1/92 - 1/1/93	Day care/ home	Parents	
Service Coord.	DOH		7/1/92 - 1/1/93	as needed	DOH	

*Initialed by Service Coordinator on receipt of approval by appropriate payment source.

EARLY INTERVENTION SERVICE PROVISION

PURPOSE of this document:

to maintain a running record of the services provided that actualize the decisions made based on the Individualized Family Service Plan within the guidelines of the most recent regulations. Approval for funding is not considered final until the Early Intervention Official (EIO) or the appropriate insurance payer submits approval.

WHO completes it:

the **service coordinator** at the time of first planning and whoever takes on this role as planning proceeds.

WHY would you need to change it?

The IFSP is an ongoing, flexible process that will change as the priorities, resources, and concerns of the infant/toddler and family change. Parental rights and due process based on federal and state law provide a means to resolve problems that can not be handled within the usual team process.

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MARIA: A CASE STUDY

Maria is a two year old girl who lives at home with her mom and dad, and two of her five brothers and sisters. The pediatrician at the Neighborhood Health Care Center expressed concern to Maria's mom. Maria communicates with the people around her by grunting and gesturing. Maria's family is bilingual and speak their native language at home. Her older brother and sister, 11 and 12 years old, live with their grandparents in the home country. Her baby sister, 4 months old, and 7 year old brother live at with Maria and their parents. The 7 year old brother is being evaluated now for possible special education placement. The pediatrician who also knows the 7 year old expressed concerns about Maria in relation to learning about the referral for special education for the 7 year old.

Maria is a reasonably healthy child. The present pediatrician has had continuous contact with this family for the last six months. Prior to that, at least two other pediatricians were involved through the center. Mom reported to the pediatrician that Maria does not make eye contact easily or often. At home she watches TV endlessly and does not play with her brother or notice the baby much. She can't let you know what she wants and will either tantrum or give up when she does try to communicate.

Maria's Mom wants to go back to work now that the baby is 4 months old. Before the baby was born, Mom's sister took care of the kids while Mom worked. The sister just had a baby also and has moved to her own apartment. She no longer is available to baby-sit. Maria's father is at home but is disabled. He was hurt at work and receives disability monthly that just about covers rent. The family receives supplementary public assistance including Medicaid, food stamps, and WIC.

Maria's Mom returned to the center the day after the pediatrician mentioned her concerns. She was bringing the baby in because of continued colic. Mom noted that she wondered why the pediatrician had asked about Maria's use of language. Mom added that other family members had expressed similar concerns. The pediatrician called the center social worker into her office. The bilingual social worker who already had helped Mom with public assistance offered to visit the Mom at home with information about what they could do to investigate the concerns about Maria's language development.

During the home visit the following week, the social work introduced information about early intervention services for infants and toddlers. The social worker gave an overview of the process to go through. How could we tell if Maria needed early intervention services (assessment and eligibility)? How would we go about getting services for Maria (developing and implementing an Individualized Family Service Plan)? Mom said she was interested in getting some answers to these questions.

The social worker shared information about where and how an assessment could take place. Since the Mom was already familiar with the Neighborhood Health Care Center she chose to have it take place there where a speech therapist is available to participate on the team.

What resources has the family already accessed?

Who might the mom identity to participate in the IFSP process?

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Who might be involved in the assessment process?

Who might be at the IFSP development meeting?

Who might act as the service coordinator?

What will this role involve?

This case study can be used as an opportunity to work through the IFSP process. Additional information can be added to develop a picture complete enough to support the development of an IFSP.

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EXAMPLE OF A DOCUMENT FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

Background Information

Child:	Family:	Relationship:
Family name:	Family:	Relationship:
Birthday: Age:	Address:	Insurance Co: Number:
Gender:	Home Phone:	Medicaid #:
SS #:	Work Phone:	

Planning Team

Name/signature	Title	Agency	Date

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EXAMPLE OF A DOCUMENT FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

***STAR PRIORITIES**

RESOURCES

CONCERNS

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EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL:

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED

GOAL:

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED FAMILY SERVICE PLAN

GOAL:

ACTIVITY	PARTICIPANTS/ RESOURCES	TIMELINES	COMMENTS

THIS CHART SHOULD BE COMPLETED AT THE IFSP TEAM MEETING.

EXAMPLE OF A DOCUMENTATION FORM FOR THE INDIVIDUALIZED

EARLY INTERVENTION SERVICE PROVISION

CHILD: Maria ______________________ BIRTH DATE: ______________________

Service Type	Provider	Frequency/ Duration	Time frames	Location	Funding Source/ Approval*	Family Signature/ Date

EARLY INTERVENTION SERVICE PROVISION

PURPOSE of this document:

to maintain a running record of the services provided that actualize the decisions made based on the Individualized Family Service Plan within the guidelines of the most recent regulations. Approval for funding is not considered final until the Early Intervention Official (EIO) or the appropriate insurance payer submits approval.

WHO completes it:

the **service coordinator** at the time of first planning and whoever takes on this role as planning proceeds.

WHY would you need to change it?

The IFSP is an ongoing, flexible process that will change as the priorities, resources, and concerns of the infant/toddler and family change. Parental rights and due process based on federal and state law provide a means to resolve problems that can not be handled within the usual team process.

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7. GLOSSARY OF TERMS

Assessment Planning - the gathering and exchange of information between family members and providers that shape the assessment process.

Best Practice for the IFSP - a judgment, based on the consensus of providers, family members, policy-makers, and advocates, that this IFSP process if effective and meets the highest standards of clinical excellence and family-centered principles.

Empowerment - the interaction of professionals with families in such a say that families maintain or acquire a sense of control over their family lives and attribute positive changes that result from early intervention of their own strengths, abilities and actions.

Enabling - creating opportunities and means for families to display their present abilities and competencies and to acquire new ones that are necessary to meet the needs of their children and themselves.

Family Concerns - areas that family members identify as needs, issues, or problems that want to address as part of the IFSP process.

Family Priorities - a family's agenda and choices for how early intervention will be involved in family life.

Family Resources - the strengths, abilities, and formal and informal supports that can be mobilized to meet family concerns, needs, or outcomes.

Family Strengths - characteristics that family members identify as contributing to the growth and development of the child and family. Among the areas of family life that many families identify as strengths are coping strategies, nurturing relationships, communication, religious or personal beliefs, family competence, and family/community interconnectedness.

Family-Centered - 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 strength and competence of the family.

IFSP Evaluation - the determination of the appropriateness and effectiveness of the IFSP process, outcomes and services.

IFSP Outcomes - statements of the changes families want to see for their children or themselves.

IFSP Team - the family members and professionals who meet together to asses the child, identify family concerns, priorities and resources, develop and carry out outcomes and strategies and evaluate the effectiveness of the IFSP.

Normalization Principle - the principle that children and families should have access to services provided in as usual a fashion and environment as possible.

Service Coordination - an active process for implementing the IFSP that promotes and supports a family's capacities and competencies to identify, obtain, coordinate, monitor, and evaluate resources and services to meet its needs.

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ACRONYMS

- A -

AAA	Area Agency on Aging
AA/HRC	Affirmative Action/Human Relations Committee
AAMR	American Association on Mental Retardation
AAUAP	American Association of University Affiliated Programs
ACD	Alternate Care Determination
ACDD	Accreditation Council on Developmental Disabilities
ADA	American with Disabilities Act
ADL	Activities of Daily Living
AHRC	Association for the Help of Retarded Children
AFDC	Aid for Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
AIP	Annual Implementation Plan
AOD	Administrator on Duty
ARC	Association for Retarded Children/Citizens
ASFC	Agency Sponsored Family Care

- B -

BMAC	Behavior Management for the Aggressive Client
BOCES	Board of Cooperative Educational Services
BOE	Board of Education
BOV	Board of Visitors

- C -

CAB	Consumer Advisory Board
CADC	Comprehensive Assessment and Diagnostic Clinic
CADD	Computer Assisted Design Development
CAH	Care At Home
CAPA	Child Abuse Prevention Act
CARF	Commission on Accreditation of Rehabilitation Facilities

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ACRONYMS (CONT'D.)

CCF	Council on Children & Families
CCL	Consolidated Clinical Laboratories
CDC	Centers for Disease Control
CETA	Comprehensive Employment & Training Act
CFR	Consolidated Fiscal Report
CHAS	Comprehensive Housing Affordable Strategy
CHHA	Certified Home Health Agency
CLMHD	Conference of Local Mental Hygiene Directors
CM	Case Management
CMCM	Comprehensive Medicaid Case Management
CMEDD	Consortium for Medical Education in Developmental Disabilities
CMHC	Community Mental Health Center
COBRA	Consolidated Omnibus Budget Reconciliation Act
CON	Certificate of Need
COP	Conditions of Participation
COPREP	Career Opportunity Professional Recruitment Education Program
CP	Cerebral Palsy
CPSE	Committee on Preschool Special Education
CQC	Commission on Quality of Care for the Mentally Disabled
CR	Community Residence
CRA	Community Residence Aide
CRD	Community Residence Director
CSE	Committee on Special Education
CSEA	Civil Service Employees Association
CSLA	Community Supported Living Arrangements
CSW	Certified Social Worker
CWA	Child Welfare Administration (NYC)

- D -

DAAA	Division of Alcoholism & Alcohol Abuse
DARM	Division of Administration & Revenue Management
DC	Developmental Center
DD	Developmental Disabilities
DDP	Developmental Disabilities Profile
DDP4	Developmental Disabilities Profile (Needs Assessment Form)
DDPC	Developmental Disabilities Planning Council
DDSO	Developmental Disabilities Services Office
DFTA	Department of the Aging (NYC)
DFY	Division for Youth
DHCR	Division of Housing & Community Renewal
DMHMRAS	Department of Mental Health, Mental Retardation & Alcoholism Services (NYC)
DMR	Discrete Mental Retardation Unit
DNR	Do Not Resuscitate
DOB	Division of the Budget
DOH	Department of Health
DQA	Division of Quality Assurance
DRC	Diagnostic and Research Clinic
DRG	Diagnostic Research Group
DSAS	Division of Substance Abuse Services
DSS	Department of Social Services
DVA	Division of Veterans' Affairs

- E -

EAF	Environmental Assessment Form
EAO	Employee Assistance Office

ERIC

ACRONYMS (CONT'D.)

ECAP	Energy Conservation Action Program
EEOC	Equal Employment Opportunity Commission
EIS	Environmental Impact Statement
E'SEP	Expanded In-Home Services for Elderly Persons
EPSDT	Early Periodic Screening & Diagnostic Treatment Program
ESO	Employee Services Office

- F -

FAS	Fetal Alcohol Syndrome
FC	Family Care
FCH	Family Care Home
FDC	Facilities Development Corporation
FFC	Foster Family Care
FLSA	Fair Labor Standards Act
FOIL	Freedom of Information Law
FSS	Family Support Services
FSS	Federal Salary Sharing
FTE	Full Time Equivalent
FFY	Federal Fiscal Year
FY	Fiscal Year

- G -

GOER	Governor's Office of Employee Relations

- H -

HCBS	Home & Community Based Services Medicaid Waiver
HCFA	Health Care Financing Administration
HHS	Health and Human Services
HMO	Health Maintenance Organization
HRA	Human Resources Administration (NYC)
HSA	Health Systems Agency

ACRONYMS (CONT'D.)

HUD	Housing and Urban Development

- I -

IAC	InterAgency Council of Mental Retardation and Developmental Disabilities Agencies, Inc. (NYC)
IBR	Institute for Basic Research in Developmental Disabilities
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDA	Industrial Development Agency
IEP	Individual Education Plan
IFSP	Individualized Family Service Plan
IHP	Individual Habilitation Plan
ILC	Independent Living Center
IOCC	Inter-Office Coordinating Council
IPP	Individual Program Plan
IPR	Independent Professional Review
IRA	Individualized Residential Alternative
IRC	Integrated Residential Community
ISE	Individual Service Environment
ISG	Information Services Group
IT	Interdisciplinary Team (also IDT)
ITT	Interdisciplinary Treatment Team
IUR	Independent Utilization Review
IWRP	Individual Written Rehabilitation Plan

- J -

JCAH	Joint Commission on the Accreditation of Hospitals

- L -

LCED	Level of Care Eligibility Determination

ACRONYMS (CONT'D.)

LD	Learning Disability
LGU	Local Government Unit
LHCSA	Licensed Home Care Services Agency
LOC	Level of Care
LSC	Life Safety Code
LTCPCC	Long Term Care Planning Coordinating Committee
LTHHC	Long Term Home Health Care
LTSE	Long Term Sheltered Employment

- M -

M/WBE	Minority/Women Owned Business Enterprise
MA	Medicaid
MC	Management/Confidential
MCFFA	Medical Care Facilities Finance Agency
MDU	Multiple Disability Unit
MHL	Mental Hygiene Law
MHLS	Mental Hygiene Legal Service
MMIS	Medicaid Management Information System
MPDI	Minority Professional Development Institute
MRDDAC	Mental Retardation & Developmental Disabilities Advisory Council
MRU	Mental Retardation Unit

- N -

NARR	National Association of Residential Resources
NASMRPD	National Association of State Mental Retardation Program Directors, Inc.
NASPRFMR	National Association of Superintendent Public Residential Facilities for the Mentally Retarded
NBI	Neighborhood Based Initiative
NFPA	National Fire Protection Association

ERIC

ACRONYMS (CONT'D.)

NH	Nursing Home
NI	Neurological Impairment
NIA	National Institute on Aging
NICU	Neonatal Intensive Care Unit
NIDRR	National Institute of Disability & Rehabilitation Research
NIE	National Institute of Education
NIH	National Institutes of Health
NIMBY	Not In My Back Yard
NIMH	National Institute of Mental Health
NPS	Non-Personal Services
NYALD	New York Association of Learning Disabilities
NYCRO	New York City Regional Office
NYCRR	New York Codes, Rules and Regulations
NYSACRA	New York State Association of Community and Residential Agencies
NYSARC	New York State Association for Retarded Children
NYSARF	New York State Association of Rehabilitation Facilities
NYSSAC	New York State Society for Autistic Citizens

- O -

OAD	Office of Advocate for the Disabled
OFA	Office for Aging (County)
OGS	Office of General Services
OHSM	Office of Health Systems Management
OMH	Office of Mental Health
OMRDD	Office of Mental Retardation & Developmental Disabilities
OSC	Office of the State Comptroller
OSES	Office of Special Education Services
OSM	Office of Special Master (Willowbrook Consent Decree)
OT	Occupational Therapy

ERIC

ACRONYMS (CONT'D.)

OTPS	Other Than Personal Service
OVR	Office of Vocational Rehabilitation (now called VESID)

- P -

PA	Physician's Assistant
PA	Provider Agreement
PAC	Products of Ambulatory Care
PAT	Personal Adjustment Training
P/PM	Policy & Procedures Manual
PC	Personal Care
PDG	Program Development Grant
PEF	Public Employees Federation
POCA	Plan of Corrective Action
POS	Purchase of Service
PPA	Prior Property Approval
PPAC	Preferred Physicians and Children
PPSD	Policy, Planning, & Service Design
PS	Personal Service
PT	Physical Therapy
PWS	Prader-Willi Syndrome

- Q -

QA	Quality Assurance
QMRP	Qualified Mental Retardation Professional

- R -

RBTU	Regional Behavioral Treatment Unit
RFA	Request for Application
RFP	Request for Proposal
RMFO	Revenue Management Field Office
RRTC	Rehabilitation Research & Training Center

ACRONYMS (CONT'D.)

RUGS	Resource Utilization Group System

- S -

SAPA	State Administrative Procedure Act
SCA	Standards Compliance Analyst
SCIP	Strategies for Crisis Intervention Prevention
SED	State Education Department
SEQRA	State Environmental Quality Review Act
SHPDA	State Health Planning Development Agency
SHSC	State Health Services Corps
SMP	Strategic Management Plan
SPM	Strategic Planning Model
SNF	Skilled Nursing Facility
SOCR	State Operated Community Residence
SOD	Statement of Deficiency
SOFA	State Office for the Aging
SOICF	State Operated Intermediate Care Facility
SRU	Small Residential Unit
SSA	Social Security Administration
SSDI	Supplemental Security Disability Income
SSI	Supplemental Security Income
SUIT	Secure Unit for Intensive Treatment

- T -

TABS	Tracking And Billing System
TASH	The Association for Persons with Severe Handicaps
TBI	Traumatic Brain Injury
TDD	Telephone Device for the Deaf
TRAID	Technology-Related Assistance for Individuals with Disabilities
TLM	Transitional Living Model

TRO	Temporary Restraining Order
TTL	Treatment Team Leader
TUBS	Temporary Use Beds

- U -

UAP/DD	University Affiliated Programs in Developmental Disabilities
UCPA	United Cerebral Palsy Association
UR	Utilization Review

- V -

VA	Veterans Administration
VESID	Vocational & Educational Services for Individuals with Disabilities (formerly OVR)
VOCR	Voluntary Operated Community Residence
VOICF	Voluntary Operated Intermediate Care Facility

- W -

WAT	Work Adjustment Training
WMS	Welfare Management System

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	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
	Edelman, L. (1991). Getting on Board: Training activities to promote the practice of family-centered care. Bethesda, MD: Association for the Care of Children's Health.	Association for the Care of Children's Health 7910 Woodmont Avenue Bethesda, MD 20814 (301) 654-6549 ask for publications	$21.50 includes shipping and handling	
	National Center for Clinical Infant Programs (1985). Equals in this Partnership: Parents of disabled and at-risk infants and toddlers speak to professionals. Washington, DC: Author.	The National Maternal and Child Health Clearing House 38th and R Streets NW Washington, DC 20057 (202) 625-8410	Free	
Assessment of Family Situation	Bailey, D.B. (1991). Issues and perspectives in family assessment. Infants and Young Children, 4(1), 26-34.	Infants and Young Children: An interdisciplinary Journal of Special Care Practices. Aspen Publishers, Inc., 7201 McKinney Circle Frederick, MD 21701 1-800-638-8427	$55.00 1 yr. subscription or $19.00 per copy	

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	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
	Bricker, D., & Slentz, K. (1992). Family guided assessment for IFSP development: Jumping off the family assessment bandwagon. Journal of Early Intervention, 16(1), 11-19.	Division for Early Childhood of the Council for Exceptional Children Division Manager CEC 1920 Association Drive Reston, VA 22091 (703) 620-3660 Publications X467	$28.00 1 yr. subscription or $10.00 per issue	This article expresses concern with prevailing family assessment models that suggest comprehensive assessment across all areas of family functioning. Issues of instrument development and use, the types and nature of early intervention services provided, and the role of interventionists are discussed in light of feedback from practitioners.

	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
	Hanson, M.J., & Lynch, E.W. (1992). Developing cross-cultural competence. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.	Paul H. Brookes Publishing Co., Inc., P.O. Box 10624 Baltimore, MD 21285 (410) 337-9580	$31.00 plus shipping and handling	This book is written by several authors. It is based upon literature that describes best practices in early intervention, literature on inter-cultural effectiveness and information and insights from the authors who are bi-cultural and often bilingual. The book is organized into 3 sections: Part 1, provides the reader with an introduction to issues concerning working with families from diverse cultural backgrounds; Part 2 introduces the reader to a number of the major cultural and ethnic groups that make up the population of the United States; Part 3 provides recommendations for interventionists working in service delivery systems.

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RESOURCES FOR TRAINING

	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
Assessment of the Child	Campbell, P. (1991). Evaluation and assessment in early intervention for infants and toddlers. Journal of Early Intervention, 15(1), 36-45.	Division for Early Childhood of the Council for Exceptional Children Division Manager CEC 1920 Association Drive Reston, VA 22091	$28.00 1 yr subscription or $10.00 per issue	This article examines assessment as it relates to the development of IFSP's. The article draws attention to determining eligibility, purposes of assessment, difference between evaluation and assessment and where in the IFSP process, assessment data can be collected. A model of the top down and bottom up approaches to goals setting are diagrammed and discussed.
	Cultural competencies in screening and assessment: Implications for services to young children with disabilities. (1992). Prepared by PACER Center, Inc., for NEC*TAS.	PACER Center 4826 Chicago Avenue S Minneapolis, MD 55417-1098 (612) 827-2966	$4.00	This booklet examines issues related to the screening and assessment of infants, toddlers and pre-schoolers from families with various cultural and linguistic backgrounds. This is accomplished through interviews with five individuals discussing their experiences and perspectives on cultural competence. Strategies and a selected resource list are included.

RESOURCES FOR TRAINING

	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
Team Process	Bennett, T., Lingerfelt, B., & Nelson, D. (1990). Developing individualized family support plans. A training manual. Cambridge, MA: Brookline Books.	Brookline Books P.O. Box 1047 Cambridge, MA 02238 (617) 868-0360	$24.95 plus shipping and handling	This training manual is for anyone training early interventionists to design functional and useful IFSP's. The material presented on IFSP's in this manual is early to understand and practical to use. Everything a trainer needs is included.
	Woodruff, G., & McGonigel, M.J. (1988). Early intervention team approaches: The transdisciplinary model. In J.B. Jordan, J.J. Gallagher, P.L. Hutinger & M.B. Karnes (Eds.), Early childhood special education: Birth to three (pp. 163-183). Reston, VA: Council for Exceptional Children.	Council for Exceptional Children 1920 Association Drive Reston, VA 22091 (703) 620-3660 Publications X467	$28.60 plus shipping and handling	This chapter defines the concept of team as it relates to early intervention and describes three team approaches commonly used with infants with special needs and their families. These three approaches are the multidisciplinary, interdisciplinary, and transdisciplinary models. The article explores the transdisciplinary in great detail and recommends it as a way to offer coordinated and comprehensive services to infants and their families.

RESOURCES OF TRAINING

	SOURCE	ADDRESS & PHONE NUMBER OF PUBLISHER	COST	ANNOTATION
	Nash, James K. (1990). Public Law 99-457: Facilitating family participation on the multidisciplinary team. Journal of Early Intervention, 14(4), 318-326.	Division for Early Childhood of the Council for Exceptional Children Division Manager CEC 1920 Association Drive Reston, VA 22091 (703) 620-3660 Publications X467	$28.00 1 yr subscription or $10.00 per issue	This article, briefly outlines the characteristics of teams and team work and the requirements for family participation under P.L. 99-457. Strategies for facilitating family participation are also discussed.
Collaborative Goal Setting	Bailey, D.B. (1987). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7(2), 59-71.	Family Child Learning Center 90 West Overdale Drive Tallmadge, OH 44278 (216) 633-2055	$5.00	This book is designed to familiarize parents with the IFSP process. It was written by a group of mothers of children with disabilities as a part of an educational and support workshop called Building Family Strengths. The book focuses on skill building techniques and strategies as well as important information about the law and the IFSP process.

APPENDIX V

ERIC

A PARENTS GUIDE TO SERVICE COORDINATION IN EARLY INTERVENTION

Barbara Gibbs Levitz

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A PARENTS GUIDE TO SERVICE COORDINATION IN EARLY INTERVENTION

This booklet is to assist you and other families who have infants and toddlers with special challenges in looking closely at the process of Service Coordination in Early Intervention. The information will help you to think about and determine what **you** would like the Service Coordination to be and may guide you in selecting your Early Intervention Service Coordinator.

The role of a Service Coordinator is to assist and enable an eligible infant or toddler and his or her family to receive the rights, procedural safeguards and services that are authorized under the state's Part H legislation (Public Law 99-457, retitled the Individuals with Disabilities Education Act in 1990). The Service Coordinator starts, facilitates, and maintains the Early Intervention process.

The ways the Service Coordinator will offer assistance should include:

1. Developing a **support** system
2. Understanding **the process** of getting help with the things you want help with
3. Developing a good **working relationship** with the people who will have the information or services you want
4. Making sure that **information is shared** between and among all the people involved
5. Selecting and guiding the **evaluation** process
6. Developing the **Individualized Family Service Plan**
7. **Facilitating** and **coordinating** the many pieces and people involved with you and your child

1. DEVELOPING A SUPPORT SYSTEM

Through the experience of having a child with special challenges, you are probably discovering that the concerns you have about your young child are having an impact on your family in some emotional, social, physical or financial ways. What affects one member of your family will affect all the members of your family.

The support that you receive from others should be sensitive to **your** feelings. People need to be responsive to the issues that confront you every day and with your concerns as they change over time. This support may come from your extended family, friends, co workers, church or synagogue, community groups, or the many new professionals you encounter, especially your Service Coordinator. Sometimes, the most important and meaningful support can come from other parents who have had experiences similar to yours. Your Service Coordinator should be able to offer you a link to other families.

It is important for a Service Coordinator to be aware of the people whom **you** feel give you support either informally or formally. In order to feel comfortable about letting other people help and support you, it is helpful to find ways to give something in return. Perhaps the Service Coordinator can suggest some simple ways in which you can reciprocate the help you receive from others, if you like.

A Service Coordinator should also help you to identify individuals, agencies and organizations in your community that you may wish to contact as resources. Areas of information may include medical services, health insurance, child care, entitlement programs, respite, recreation, counseling, transportation, products and equipment, assistive technology, household adaptations, parent education and any other types of support services that may be available for your infant or toddler and your family. Do not overlook the opportunity to use the same programs that you would use if your child did not have special challenges.

2. UNDERSTANDING THE PROCESS OF GETTING HELP

Your initial contact with a Service Coordinator should begin shortly after you have learned that your infant or toddler may have special needs or may be at risk for disabilities. The first step in introducing you to the Early Intervention System should be an explanation of the purpose of Early Intervention.

The Service Coordinator must inform you of your rights, the procedures, safeguards and services. Since this may be complex, be sure that the information can also be provided to you in print or audio visual form.

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The way that the Service Coordinator works with you from the very beginning will definitely influence how useful and effective the Early Intervention system will be for your family. Early Intervention should be a process over time, not just an activity that involves filling out papers and forms.

One of the first roles of a Service Coordinator is to assist you through the process of obtaining an evaluation to determine if your child is eligible for Early Intervention Services. All infants and toddlers believed to be eligible for Early Intervention Services are entitled to a free evaluation. Be sure that your Service Coordinator clarifies for you any issues or concerns you may have about the cost for services, the use of funding sources and any impact this may have on your health insurance policy.

The Service Coordinator should assist you in identifying and accessing resources that should help you in reaching the goals, aspirations and dreams you have for your child and family. To receive Early Intervention Services, each infant or toddler with a disability, and sometimes infants or toddlers at risk for a disability, will have an Individualized Family Service Plan (IFSP). The IFSP is a working document that outlines the types of services and goals for your child and your family. The Service Coordinator is responsible for working together with you to develop this plan and to see that it is implemented, monitored, and periodically revised.

The Early Intervention process must be centered on the needs of your family. The Service Coordinator should consider your choices of when and where you prefer appointments and meetings to take place and any particular people **you** would like to participate.

This planning process will be useful and effective if it takes into account how the various members of your family naturally interact with one another, the usual roles and responsibilities they have within your family, and how they choose to go about their daily lives. It must also be compatible with the values, customs, and traditions that are part of your family's culture and ethnicity. A Service Coordinator must understand that there are many factors in your life that influence your decisions as well as your sources of support. Be sure that there is a role in this process for your infant or toddler's brothers, sisters, grandparents and other important family members to the extent they desire.

3. DEVELOPING GOOD WORKING RELATIONSHIPS

The relationship between you and your Service Coordinator should be built upon a sound foundation of mutual trust and respect, a shared interest and concern in your child and family, and effective communication.

Interactions with the Service Coordinator should enable you to talk about issues that concern you, to get information that will help you set goals and determine which are most important to you. You and your service coordinator must be able to work collaboratively with others, as a team, in making choices, decisions and addressing concerns to achieve good results for your child and family. It takes time in all new relationships to establish a good rapport and gain a sense of trust. Naturally, it is much easier to respond to a Service Coordinator who approaches your family with a positive attitude.

It is most helpful when the Service Coordinator responds quickly to your requests, is consistent in his or her actions and allows sufficient time for telephone conversations and face to face discussions. Remember, however, that the Service Coordinator is also working with other families and may have many responsibilities. Try to be reasonable in what you expect, but do not feel that you must settle for less than what you or your child may need.

Sometimes a Service Coordinator may offer to go to an appointment or meeting with you. Whether you go with your Service Coordinator, by yourself or with someone else, it is good to be prepared. The Service Coordinator can help by explaining what will take place and anything you can do in advance to make things go more smoothly such as completing forms, bringing along certain information or documentation, writing down questions, being equipped for a certain waiting period and any other suggestions.

Personal qualities most families like to see in a Service Coordinator include the ability to be warm, friendly, patient, understanding, open, honest, sincere, nonjudgemental and nonpatronizing.

The Service Coordinator should help you to feel that you are not alone and encourage you to keep a positive outlook. Your opinions and suggestions should be valued as important. A Service Coordinator should make you feel competent by focusing on your strengths, abilities, resources and contributions. When there is a focus on your successes and accomplishments, your self confidence will grow in this experience that is new to you.

Early Intervention for your infant or toddler and your family will have the best outcomes when bas upon good communication. It is important to express your feelings, thoughts and ideas clearly. It is equally important to be sure that you understand exactly what is being said to you. Without effective communication between you and your Service Coordinator, the working relationship could be confusing, unpleasant, uncomfortable and unproductive.

It is important for you and your Service Coordinator to set up a good communication system from the very beginning of your relationship. It is helpful when people listen and respond to what is being said, not just what they **want** to hear. A good way to improve communication is to restate or rephrase what is said to confirm that the information exchanged is being correctly understood by both parties. For example, you might say "so what you are saying is ......".

A role of the Service Coordinator should be to ensure that information is in language that everyone is able to understand. During conversations with the Service Coordinator or other professionals, as well as at appointments and meetings, information is too often stated in technical terms, initials or abbreviations. This can be confusing and intimidating because you must either interrupt to ask what something means, or be put in the position of feeling uninformed. This certainly limits a parent's ability to fully participate. You have the right to be given information in words that you can understand.

A Service Coordinator has the responsibility to facilitate good communication and information sharing. A Service Coordinator should also find ways to overcome any barriers to good communication because of differences in spoken or written language, and methods of communicating such as using sign language, Braille, assistive communication devises, and others.

A Service Coordinator should communicate a basic respect for the dignity of your child and family, regardless of the challenges of the disability. It is helpful to have a Service Coordinator that shows a genuine acceptance and appreciation for your child's quality of life and is relaxed and comfortable with your family. Parents have a right to be considered as individuals within a unique family and not be subjected to labels and stereotypical statements. Your comfort level with a Service Coordinator will depend on how he or she communicates and interacts with all the members of your family.

4. INFORMATION SHARING

Information is a basic requirement for decision making. How information is gathered, shared and used will shape the planning process for Early Intervention. For example, information compiled during the IFSP process will help determine appropriate intervention strategies.

Every family has the right to choose the extent to which they feel comfortable participating in the process. It is helpful for the Service Coordinator to encourage you to take as active a role as you wish, and to act on your own behalf when possible. This will enable you to build some

independence and put **you** in control of setting priorities and making choices and decisions.

In order to do this, you must have complete and unbiased information. The Service Coordinator or any other professional, should share **all** information with you pertaining to evaluation and planning, not just selective information. Having complete information will enable and empower you to make good choices and sound decisions.

Remember that you **are** the expert on your child and family. Trust your instincts and keep in mind that you have a great deal of information to contribute. Any decisions must take into account what is most natural for your child in his or her home, family and community. The caring professionals that work with your child will change over time, but you are the most important influence and constant person in your child's life.

In working with a Service Coordinator and any other professionals, it is your right to have your privacy respected and to have the interactions with your child and your family be as nonintrusive as possible. Be sure that the Service Coordinator discusses with you, the reasons why certain information may be needed, how it will be used and with whom it may be shared. This should help you determine what information you may or may not wish to share. The Service Coordinator must explain your right to confidentiality and the procedures to ensure this.

After information is gathered and assessed with your input, insist that it be put together in a format that will be useful to you as well as any other individuals with whom you wish to share it. In doing so, this may eliminate your need to repeat the same information every time another professional becomes involved with your family.

5. THE EVALUATION PROCESS

Eligibility for Early Intervention is determined by a screening and/or evaluation of your infant or toddler. With the parent's written consent, all children thought to be eligible are entitled to a multidisciplinary evaluation.

Such an evaluation must include assessments conducted by trained professionals from **at least** two fields appropriately related to your child's special needs.

For example, speech pathology, audiology, occupational therapy, physical therapy, psychology, physicians and others. Parents have a right to select an evaluation team from a list of all such evaluation teams in your locality. The Service Coordinator should provide you with such a list at the very beginning of the referral process, to assist you in selecting an

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appropriate evaluation team. Be sure that you are given complete information on all of your options.

To help you in selecting an evaluation team, you may want to ask how you can find out about the different types of assessments that are used by the evaluators. Also, ask the Service Coordinator to explain the differences between a screening and a multidisciplinary evaluation. Remember that your child is entitled to an evaluation, not just a screening. You are also entitled to request additional assessments and evaluations that you feel are important but may not have been part of the multidisciplinary evaluation. A Service Coordinator should encourage your input in gathering information about your infant or toddler as part of the evaluation process.

In addition to an evaluation for your infant or toddler, a family assessment may be conducted as a tool to help you identify your resources, concerns and priorities. There are various types of family assessments that focus on what you see as your needs as a family of a child with special challenges. Such family assessments are completely **voluntary** in nature. You have a right to refuse to participate in this type of assessment or to participate but only share certain information, and be assured that this will **not** impact on your child receiving services.

The Service Coordinator should also explain the methods to resolve any disagreements related to evaluation results. In addition to your Service Coordinator, there may be other information and referral sources in your region to help you with information on evaluations and other Early Childhood Services.

6. DEVELOPING AN INDIVIDUALIZED FAMILY SERVICE PLAN

The assessments and information that are part of the evaluation should be the basis for the goals/outcomes that you set for your child and family. You will develop an Individualized Family Service Plan (IFSP) with your Service Coordinator, the Evaluation Team or a representative of the Evaluation Team, and any other people you invite to participate.

Parents should be encouraged to have the opportunity to suggest issues to be discussed and addressed during the planning process. For example, parents may suggest an agenda or agenda items for the planning meetings.

The IFSP is the result of a collaborative process in which your family makes informed choices based on your child's present and future needs. It is the result of the review of your concerns, resources and priorities. A Service Coordinator should not go ahead with any actions until confirming that you are in agreement on issues and decisions. The ultimate goal is to foster your child's development.

The Service Coordinator should help you resolve immediate concerns and prioritize what goals/outcomes to work on first and what can wait. The Service Coordinator should also help you to set goals/outcomes that are achievable, that you value as important and that can be measured by observable change. These goals/outcomes should foster your child's independence and inclusion in regular everyday activities at home and in your community. In addition, family goals/outcomes may also be part of the Individualized Family Service Plan.

An array of services may be recommended to help in achieving these goals/outcomes. Such services may include special instruction, speech pathology and audiology, occupational therapy, physical therapy, psychological services, family training, counseling, home visits, parent support groups, related health services, nursing services, nutrition services, social work services, vision services, assistive technology devices and services, transportation, respite and others. These services should be provided, to the maximum extent possible, in natural settings including the home and community, where children without disabilities would participate.

Various individuals, including your family members, may agree to be involved in particular functions and activities to help in achieving the goals/outcomes that are part of the Individualized Family Service Plan. The IFSP should be an ongoing and continually changing plan of action that reflects the priorities and concerns of your family. Working as a part of the planning team, the Service Coordinator is responsible for periodically updating the IFSP and following up with the individuals who are working with you and your child to attain the goals/outcomes that have been identified. At any time, as parents, you may call for an update meeting to be scheduled.

In addition, as part of the IFSP for a toddler, a Service Coordinator is responsible for planning a process to help your child smoothly transition from Early Intervention for infants and toddlers to an appropriate preschool setting and services for your child at age three.

7. FACILITATING AND COORDINATING

Service Coordination is a key component of Early Intervention, a system that is based on a family centered philosophy of parent participation and parent choice. Feel free to exercise these rights as you advocate for your family and on behalf of the rights of your child.

When selecting a Service Coordinator, take into consideration the many roles and responsibilities in facilitating and coordinating this Early Intervention process.

In some localities, an initial Service Coordinator may be assigned to you and you subsequently have an opportunity, at the time of the IFSP meeting or at another time in the process, to either maintain the same Service Coordinator that was assigned to you, or designate a new Service Coordinator.

A Service Coordinator may be a trained professional in a related field or another parent who is trained and experienced in Service Coordination. It is important that the Service Coordinator either has or will be able to acquire a good understanding of the multiple needs of your family. Sometimes it may be advantageous to select as your Service Coordinator, an individual or agency that is familiar to you or is currently providing this type of service to your family.

To help ensure quality Early Intervention for not only your family but also other families of infants and toddlers with special challenges, you might also consider finding out about how to participate in your State or local Early Intervention Coordinating Council.[1]

---

[1] This project was sponsored in part by Grant H024D10052 from the Office of Special Education and Rehabilitation Services, U.S. Department of Education, Early Childhood Program for Young Children with Disabilities. The Grant, the Birth to Three Inservice Outreach Project, was directed by Mary Beth Bruder, Ph.D at the Westchester Institute for Human Development.

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APPENDIX W

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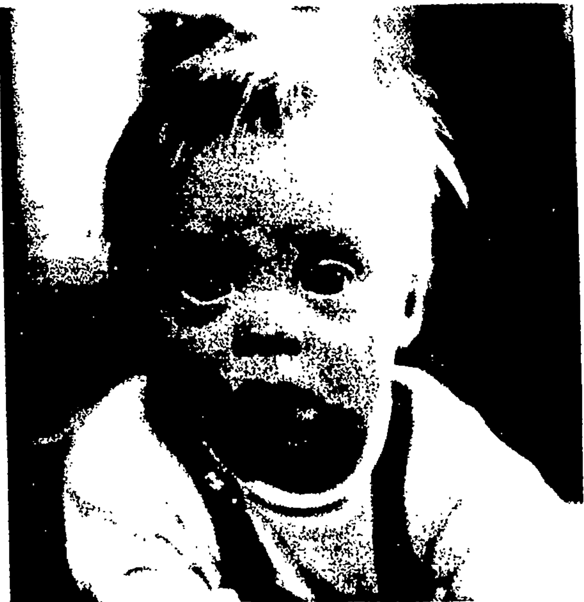

THE BIRTH TO THREE INSERVICE OUTREACH TRAINING PROJECT

APPENDIX X

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VITA

MARY ELIZABETH BRUDER, Ph.D.

Professional Experience:

1988-Pres.	Associate Professor, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1990-Pres.	Director, Family Support/Early Intervention, Westchester Institute for Human Development, New York Medical College, Valhalla, NY
1988-1989	Director, Pediatric Research and Training Center, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1988	Associate Director, Pediatric Research and Training Center, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1986-1987	Training Director, Pediatric Research and Training Center, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1985-1986	Early Intervention Co-coordinator, Virginia Institute on Developmental Disabilities, Virginia Commonwealth University, Richmond, VA
1983-1986	Assistant Professor of Special Education, Coordinator of Early Childhood Special Education, Virginia Commonwealth University, Richmond, VA
1983	Instructor, Special Education, Severely Handicapped, University of Oregon, Eugene, Oregon
1981-1983	Coordinator, Parent Education Program, Infant Monitoring Project, University of Oregon, Eugene, Oregon
1980-1981	Coordinator, Parent Education Program, Infant Monitoring Project, University of Oregon, Eugene, Oregon
1980-1981	Coordinator, Early Intervention Demonstration Program, University of Oregon, Eugene, Oregon
1980-1982	Training Supervisor, Early Childhood-Special Education/Severely Handicapped Masters Program, University of Oregon, Eugene, Oregon
1979-1980	Research Assistant, Center on Human Development, University of Oregon, Eugene, Oregon
1976-1979	Classroom Teacher, Ira Allen Essential Early Education Center, Burlington Public Schools, Burlington, Vermont
1878	Intern, Bureau of Education of the Handicapped, United States Department of Health, Education and Welfare

Selected Professional Activities:

1991	Testified before the U.S. House of Representatives Subcommittee on Select Education of the reauthorization of Part H of the Individuals with Disabilities Act
1989-1990	Promotions Committee, Department of Pediatrics, University of Connecticut School of Medicine
1988-1989	Residency Curriculum Committee, Department of Pediatrics, University of Connecticut School of Medicine
1985-1986	Chair, Research Committee, School of Education, Virginia Commonwealth University
1979	Testified before U.S. Senate Subcommittee on Labor and Education on the reauthorization of P.L. 94-142, The Education of All Handicapped Children Act

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Education:

University of Oregon Eugene, Oregon	Ph.D.	1983	Developmental Disabilities Early Childhood
University of Oregon Eugene, Oregon	M.S.	1981	Developmental Disabilities Early Childhood
Trinity College Burlington, Vermont	B.A.	1976	Psychology-Special Education

Publications:

Bricker, D., Bailey, E., & Bruder, M. (1984). The efficacy of early intervention and the handicapped infant: A wise or wasted resource? In M. Wolraich & D. Roth (Eds.), **Advances in developmental and behavioral pediatrics, (Vol. 5)**. Greenwich, CT: JAI press.

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Goodall, P., & Bruder, M. (1986). Parents and the transition process. **The Exceptional Parent, 16**(2), 22-28.

Lazarri, A., & Bruder, M. (1988). Teacher evaluation practices in early childhood special education. **Journal of the Division of Early Childhood, 12**(3), 238-245.

McLean, M., Bruder, M., Baird, S., & Dunst, C. (1991). Techniques for infants with multiple or severe disabilities. In S. Raver-Lampman (Ed.), **Strategies for Teaching At-Risk and Handicapped Infants: A Transdisciplinary Approach.** Columbus, OH: Merrill Publishing Co.

McLean, M., Burdge, N., Bruder, M., & McCormick, K. (1987). An investigation of the validity and reliability of the Battelle Development Inventory with a population of children younger than 30 months of age with identified handicapped conditions. **Journal of the Division for Early Childhood, 11**(3), 238-246.

Professional Organizations:

Chair, Connecticut Higher Education council for Infant Intervention, 1988-1990

Personnel Preparation Task Force, Connecticut Birth to Three Interagency Coordinating Council, 1989-Present

Advisory Board, Least Restrictive Environment Training Standards, Connecticut State Department of Education, 1988-1989

Co-Chair, Connecticut Council for Exceptional Children, Division of Early Childhood 1987-1988

Chair, Virginia Early Childhood Special Education, Higher Education Council, 1984-1986

Chair, Virginia Early Intervention Network, 1984-1986

Grant Experiences:

Director, Physicians Model Training Project, U.S. Department of Education, 1992-1995

Director, Social Competency Experimental Project, U.S. Department of Education, 1992-1995

Co-Director, Higher Education Faculty Inservice Project, U.S. Department of Education, 1992-1995

Director, M.P.H. Program for Nurses focusing on Early Intervention, U.S. Department of Education, 1991-1994

Director, Faculty and Related Services Inservice Project, U.S. Department of Education, 1990-1993

Director, Birth to Three Inservice Outreach Project, U.S. Department of Education, 1990-1993

Director, Niños Especiales Outreach Project, U.S. Department of Education, 1990-1993

Director, Interdisciplinary Masters Degree Program for Infant Specialists, U.S. Department of Education, 1990-1993

Director, Masters Degree Program for OT/PT in the Schools, U.S. Department of Education, 1990-1993

Director, Standards for Community-Based Services for Children with Complex Medical Needs, U.S. Department of Education, 1989-1991

Director, Partners for Policymaking, Connecticut Developmental Disabilities Council, 1990-1991

Director, Policy Institute for Examining Barriers to Home Care, U.S. Department of Education, 1989-1991

Director, Birth to Three Integrated Service Delivery Project, U.S. Department of Education, 1989-1992

Director, Multidisciplinary Inservice Training for Day Care Providers, U.S. Department of Education, 1989-1992

Director, Personnel Preparation Project for Infant Specialists, U.S. Department of Education, 1989-1992

Director, Integrated Preschool Service Delivery Project, U.S. Department of Education, 1988-1991

Director, Day Care Training Project, Connecticut Department of Human Resources, 1987-1990

Director, Birth to Three Inservice Demonstration Project, U.S. Department of Education, 1987-1990

Director, Personnel Preparation Institute for Interdisciplinary Infant Specialists, U.S. Department of Education, 1987-1990

Director, Niños Especiales Outreach Project, U.S. Department of Education, 1986-1989

Director, Personnel Preparation Project for Early Childhood and Infant Special Educators, U.S. Department of Education, 1984-1986

Director, Developmentally Disabled Parent-to-Parent Project, Virginia Developmental Disabilities Program, 1984-1986

Director, Parent-to-Parent Monitoring Program, U.S. Department of Education, 1984-1987

Awards:

First Lady's Research Grant, Virginia Commonwealth University, 1983[1]

[1] Vita Updated, December, 1992

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VITA

Marie Brand, M.S.
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PROFESSIONAL EXPERIENCE:

1991 - Present: New York Medical College, Family Support/Early Intervention Program, Valhalla, NY
- 10/92-Pres.: Coordinator, Birth to Three Inservice Training Outreach Project
- 8/91-10/92: Co-coordinator, Day Care Inservice Training Project

1988 - 1991: Sullivan Diagnostic Treatment Cntr., Harris, NY
- 1990 - 1991: Coordinator, Infant and Family Services Early Intervention Program
- 1988 - 1989: Teacher/Supervisor, Preschool Program

1988 - 1989: Teacher/GED, BOCES, Monticello, New York

1984 - 1988: Manager, Retail Chain, Liberty, New York

1981 - 1984: Teacher, Elementary School, Grades 2 and 3, Paterson Public Schools, Paterson, New Jersey

1977 - 1981: Private Tutoring, Medically Fragile Children Ages 5 - 10, Bergen County, New Jersey

1975 - 1977: Teacher, Grades 1 and 2, Sacred Heart School, Haworth, New Jersey

EDUCATION:

Institution	Dates	Degree
New York Medical College, Valhalla, New York	6/91 - Pres.	M.S. Develop. Disab. in Infants (in progress - 9/93)
Mount St. Mary College, Newburgh, New York	9/89 - 8/92	M.Ed. Spec. Education
Univ. of Utah, Salt Lake City, UT	3/73 - 12/74	B.S. Early Childhood/ Elementary Ed.
Ladycliff College, Highland Falls, NY	9/71 - 12/72	

CERTIFICATION:

New York Perm.- Nursery, and K - 6
New York Perm. - Special Education (K-12)

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Marie Brand

PROFESSIONAL ACTIVITIES:

3/92 - 8/92: State Technical Assistance Resource Network (STARN) - Daycare curriculum compilation and training

1990 - 1991: New York State Regional Planning Group

PROFESSIONAL ORGANIZATIONS:

The Council for Exceptional Children
National Association for the Education of Young Children
Orange County Child Abuse Task Force
New York State Infant/Toddler Coalition
Child Care Council of Westchester, Inc.

PRESENTATIONS:

11/92 - Child Care and Parenting Council of Greenwich, CT "Development of High Self-Esteem and Positive Self-Concept in Young Children"

10/92 - United States Military Academy - Exceptional Family Member Program "Inclusive Education: Children Belong Together"

9/92 - Rockland Council for Young Children "Inclusion: Linking Early Intervention With Child Care"

5/92 - State Technical Assistance Resource Network (STARN) Day Care Training

4/92 - Westchester Child Care Consortium Day "Inclusion: Mainstreaming in Day Care"

11/91 - Westchester Co. Day Care Directors "The Americans With Disabilities Act: Impact on Day Care"

ATHENA (TINA) M. NIKITAS
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EDUCATION AND TRAINING:

6-83	M. Ed. Early Childhood Special Education University of Oregon Eugene, Oregon
6-79	B.A. Speech Pathology/Audiology University of Vermont Burlington, Vermont
2-87 to 6-88	Participant, Oregon's federally funded Statewide In-service Project on Augmentative Alternative Communication

PROFESSIONAL EXPERIENCE:

6-88 to Present

Project Coordinator
Birth to Three Inservice Training Project
Division of Child and Family Studies
Department of Pediatrics
University of Connecticut Health Center
Farmington, Connecticut

Under a grant from the federal Handicapped Children's Early Education Program (HCEEP), the project is to develop, implement and evaluate a model of training for staff in the State of Connecticut who work with children ages birth to three years with developmental disabilities and their families.

The project is piloting a model of intensive institute training with a follow up component. The five institute training topics are:

- Programming for Infants, Toddlers and Their Families (25 hours)
- Individualized Family Service Plans (18 hours)
- Infant Curricula (21 hours)
- Case Coordination (15 hours)
- Transdisciplinary Teaming (12 hours)

After the training sessions, participants undertake program tasks to attain the competency goals established for each institute. Follow up includes meeting with participants to provide consultation and feedback on the attainment of the specific program tasks. Institutes are limited to ten participants.

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PROFESSIONAL EXPERIENCE: (continued)

6-88 to present (continued)

Project Coordinator
Birth to Three Inservice Training Project

As one of the two person team, duties include: develop training content by writing manuals for each institute topic; implement evaluation procedures by supervising and evaluating students. Additional duties include preparation and presentation of special workshops, of which examples are listed below.

11-86 to 6-88

Program Coordinator/Early Intervention Specialist
Morrison Center Early Intervention Program
Milwaukie, Oregon

50% Program Coordinator of Early Intervention Program in Clackamas and Multnomah Counties. Responsibilities: attain contract goals; maintain contractual standards; perform staff supervision, training and evaluation; develop program evaluation system; develop and implement parent/education support groups; coordinate with state and local agencies.

As co-chair of the tri-county Developmental Disabilities Preschool Committee, organized two state wide conferences: Early Intervention: A Functional Approach, February, 1987, and Bringing a Family Focus to Early Intervention: The Impact of 99-457, February, 1988.

50% Early Intervention Specialist. Responsibilities: caseload of 10 children with developmental disabilities (ages 0-3); interdisciplinary team member; develop individual program plans; consult with families; coordinate parent/toddler and parent/infant groups; liaison between family and other social service agencies.

11-84 to 11-86

Program Manager/Early Intervention Specialist
Morrison Center Early Intervention Program
Milwaukie, Oregon

Directed development and implementation of Morrison's expansion of early intervention services into Clackamas County. Designed a satellite program in rural county in close coordination with county authorities, advocacy groups and parents. Carried caseload of 20 children with developmental disabilities, ages birth-3.

ERIC

PROFESSIONAL EXPERIENCE: (continued)

9-83 to 11-84

Early Intervention Specialist
Morrison Center Early Intervention Program
Portland, Oregon

Staffed both home and center based early intervention services with caseload of 20-25 children with developmental disabilities (ages birth-5) and their families. Responsibilities included assessing children; developing and implementing IPP's; managing parent-toddler groups; and coordinating services with other local social service agencies.

1-83 to 6-83

Substitute Teacher
Lane Education Service District and 4J Public School District, Eugene, Oregon

Substituted in classrooms for persons with severe handicapped ; implemented classroom instructional and behavioral programs; collected program data.

6-79 to 6-80

Teacher Aide
Cambridge, Massachusetts

Classroom Assistant for eight language delayed children, ages 7-9.

6-79 to 9-79

Speech Aide
Moodus, Connecticut

Conducted individual and small group therapy sessions.

WORKSHOPS:

Early Communication Development. At Conference on Integrating Therapy Approaches, Cromwell, Connecticut, 1-89.

Cognitive Linguistic Curriculum. For Mental Retardation Institute staff, White Plains, New York, 3-89.

PROFESSIONAL WRITINGS:

Buchanen, M., Fritz, D., Nikitas, A., Sims, C., Takemoto, K., Trujillo, G., & Unhammer, E. (1982). Problem Solving Curriculum, Center on Human Development, Eugene, OR.

Burmeister, C., Eberhard, J., Miller, M., & Nikitas, A. (1982). Increasing the Quality of Life of Severely Handicapped Secondary Aged Students. Non-Instructional Strategies, Specialized Training Program, Eugene, OR.

Fritz, D., Nikitas, A., Takemoto, K., & Unhammer, E. (1982). Early Communication Assessment, Center on Human Development, Eugene, OR.

Nikitas, A. M. (1983). Effects of Integrating Severely Handicapped Elementary Students into Leisure Activities. Masters Research Project, University of Oregon, Eugene, OR.

PROFESSIONAL ORGANIZATIONS:

Member	Council for Exceptional Children
Member	National Center for Clinical Infant Programs

REFERENCES:

Will be gladly furnished upon request.

APPENDIX Y

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Journal of Early Intervention, 1992
Vol. 16, No. 2, 173-180
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INNOVATIVE PRACTICES

Changing the Professional Practice of Early Interventionists: An Inservice Model to Meet the Service Needs of Public Law 99-457

MARY BETH BRUDER
TINA NIKITAS
MRI/Institute on Human Development

This article presents information on a model demonstration project focused on the inservice training of early interventionists from a variety of backgrounds. The training, which was delivered in a multi-session institute format with a one-year follow-up component, addressed service delivery topics mandated by P.L. 99-457. A variety of outcome measures were used, including the completion of competency-based tasks.

P.L. 99-457 presents many challenges professionals in the field of early intervention. States in particular are charged with designing a multidisciplinary early intervention program that contains 14 key components, all described within the law. Two of these components ensure the availability of appropriately trained early intervention personnel, particularly those implementing services. These components are (a) state standards of practice for all early intervention personnel and (b) a comprehensive system of personnel development (CSPD) using both preservice and inservice strategies. Both service delivery components will broadly affect all other components of the law as states begin to implement early intervention services as regulated by P.L. 99-457.

Professional organizations (e.g., Campbell, Oetter, Hall, & Berger, 1989; McCollum, McLean, McCartan & Kaiser, 1989; Wilcox, et al., 1989) and recognized leaders in early intervention personnel preparation (Bailey, 1989; Fenichel & Eggbeer, 1990; Hanft & Humphrey, 1989; Hanson & Lunch, 1989; McCollum & Thorp, 1988; Thorp & McCollum, 1988) have recommended specific competencies for early intervention professionals. Unfortunately, these competencies have not yet been included in state licensure or certification standards for professionals within the ten disciplines included under P.L. 99-457 (Bruder, Daguio & Klowsowski, 1991). This absence of state standards has resulted in an increased dependency on states' CSPD to provide early interventionists with the competencies they need.

The need for expansion within preservice training programs for early interventionists has recently received attention (e.g., Bailey, Palsha

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& Huntington, 1990; Gallagher & Staples, 1990). However, the current shortage of early intervention personnel (Meisels, Harbin, Modigliani, & Olson, 1988) has prompted many leaders in the field to rely on inservice training as the method to provide staff with the skills necessary to implement the service delivery requirements described in P.L. 99-457. As states begin to plan these inservice training activities, it is imperative that they apply "best practice" principles of adult learning to ensure that early intervention staff are prepared for the service delivery challenges of P.L. 99-457.

MODEL DESCRIPTION

The Birth to Three Inservice Training Project was a model demonstration project funded for 3 years (October 1987–October 1990) by the Handicapped Children's Early Education Program. The project was administered by the Department of Pediatrics, Division of Child and Family Studies, University of Connecticut School of Medicine, Farmington, Connecticut. The purpose of the project was to develop, implement, and evaluate an inservice training model for early interventionists in Connecticut.

Philosophical Approach to Training

Inservice education has been defined as the process by which practicing professionals participate in experiences designed to improve or change professional practice (Bailey, 1989). Generally, the objectives of inservice training include the changing of attitudes, the acquisition of new knowledge, and the development and enhancement of technical skills (Bernstein & Zamick, 1982; Laird, 1985). The desired outcome of inservice training is that participants will internalize new knowledge, applying it to their specific professional needs (Barcus, Everson, & Hall, 1987).

Many of the principles used in effective inservice training are based on some universally accepted assumptions about the adult as a learner. Malcolm S. Knowles (1980), a leader in the field of adult learning theory, identified five principles about adults as learners. The Birth to Three Inservice Project adopted these principles and used them to guide the project design. The principles are briefly explained below.

The need to know. Adults will learn more effectively if they understand why they need to know certain information or why they must have the ability to perform particular skills. Adult learners must be able to see that the benefit of learning a skill outweighs the cost in time and effort it takes to learn it. The more benefit to learning adults see, the stronger they will feel the "need to know".

The need to be self directed. As people mature, they have a deep psychological need to be responsible for their own lives. Cultural conditions enhance or retard this process, but there comes a time in the psychological development of adults when they "feel like an adult." At this point, adults resent being told what to do and having decisions made for them. Adult learners are more successful if they can take responsibility for their own learning.

The importance of experience. Adults, by virtue of their age and life experiences, bring a vast amount of knowledge and a wide variety of experiences to the classroom. This wealth of life experience influences the training program in the following ways:

1. Groups of trainees have wide and varied backgrounds, therefore the training staff should individualize instruction.
2. Adults are a rich source of information for themselves and other trainees

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because of their experiences. The training staff should take advantage of these experiences by using techniques such as group discussion and brainstorming.

3. Adults may have some rigid ways of thinking that interfere with learning. The training staff may need to "unfreeze" these ways of thinking through activities such as sensitivity training or values clarification.

The readiness to learn. Adults will learn the things that they perceive will bring them greater satisfaction or success in life. As adults move through stages of psychological and social development, their readiness to learn is reflected accordingly. For example, adults are interested in learning job-specific skills when they acquire a job. Training staff should understand that learning opportunities should be offered in a timely fashion on topics of immediate value.

Orientation to learning. Adults see the reason for learning as acquiring competencies that will enable them to cope more effectively with life, perform life tasks, and solve real problems. Training staff need to organize training programs around real-world issues that confront adults from day to day.

Model Elements

Based on the principles of adult learning, the Birth to Three Inservice Training Model adopted model elements upon which they predicated inservice activities. These elements were also adapted from Knowles' (1980) work, and each is described below.

A conducive learning climate. Staff attended to both the physical and psychological training environments to maximize the benefits of training. For example, the most important feature of the physical environments is a room arrangement that encourages the trainees' active participation in the learning process. Rather than arranging the chairs theater style, the chairs were arranged in a circle around a table. Consideration was also given to the temperature, ventilation, lighting, and acoustics of the training rooms. Whenever possible, training occurred in a neutral location, away from the trainees' work site.

The training staff attempted to establish a psychological climate that was conducive to learning. They designed learning activities which required sharing and helping to foster collaboration between the trainer and the trainees. To establish a climate of support and mutual trust, they encouraged trainees' input in planning. Training staff always acted as facilitators rather than as trainers. Activities involving the learner as a doer through whatever learning style he or she most favored, encouraged active inquiry and openness. Strategies such as letting the group decide on the sequence or content of learning activities, or allowing the group members to serve as teachers to the training staff, encouraged mutual respect between facilitators and trainees.

Mutual planning. Beginning at the needs assessment phase and continuing through the design, implementation, and evaluation phases of training, trainees and training staff worked together to plan activities. For example, the content of the inservice model institutes reflected input from early intervention program supervisors throughout Connecticut. Prior to training, trainees and facilitators developed individual training contracts which were adjusted throughout the training sessions to meet changing trainees' needs.

Diagnosis of individual learning needs. One of the best ways to improve performance and change behavior is to ask trainees what they want to learn. Prior to training, the project used a written needs assessment as well as

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an interview to determine the specific training needs of each of the participants. This procedure not only assessed content needs, but also logistical needs (time and place for training) and learning style.

Joint formulation of learning objectives. Each trainee had a training contract that included specific objectives, activities, and evaluation criteria. These contracts provided the training staff with a framework for designing, implementing and evaluating the actual training and served as a guide for the trainees as they moved through the learning process.

A collaborative model to implementing techniques. The primary task of the trainer was to facilitate learning by encouraging trainees' participation in a variety of activities. Since adults place a high value on their experiences, the training activities allowed trainees to share or identify ways to apply new techniques and innovations based on their own experiences. In addition, trainees examined case studies that illustrated and reinforced the use of new practices.

Continuous evaluation of trainees' performance. A variety of techniques were used to assess skill acquisition. The evaluation design included measures of knowledge (pre/post indices), performance (practical activities), and products (competency tasks) that demonstrated competence within the training area. The trainees assisted in most of this evaluation. For example, self-rating scales were used to measure the trainees' perception of their own skills both prior to and after the training.

Follow-up to training. One method which may enhance long term behavior change is supervised follow-up of trainees as they transfer what they have learned to daily practice (Joyce & Showers, 1982). An integral component of the training model, individual and group follow-up activities, ensured that trainees mastered the training content and completed competency tasks. The follow-up also served as an additional and most important indice of the training effectiveness.

Model Procedures

Training took place during half-day workshops or, more often, during institutes consisting of multiple 3-hour sessions. Topics for the institutes were developed in response to needs assessments administered to infant interventionists throughout the state. During the three years of the project, five institute topics were developed: Individualized Family Service Plans (IFSP); case coordination; infant curricula; transdisciplinary teaming, and programming for infants, toddlers, and their families.

A maximum of 10 trainees recruited from early intervention programs and representing a variety of disciplines participated in each institute. All trainees were working with the birth to 3 population and chose to participate in the institute that interested them. The institutes consisted of two components: group training sessions and individual long-term follow-up.

Training Sessions. Each institute consisted of 4 to 10 group training sessions depending on the institute topic. Each session was approximately 3 hours long and consisted of a combination of lectures, discussions, films, practical activities, and feedback. In general, the sessions were held once a week in a central location. Table 1 contains the topical agenda for the IFSP institute.

Prior to each institute, trainees attended an orientation meeting. The primary purpose of the orientation meeting was to explain the format of the institute, the content, and the requirements for participation (attending weekly half-day sessions for 4 to 10 weeks, completing a set of tasks, and participating in fol-

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TABLE 1
Institute Agenda

Session	*Content*
Session 1:	P.L. 99–457
	Program Philosophy
	"Family Centered Care"
	Program Goals
Session 2:	Family Systems Theory
	Family Empowerment
	Early Intervention Roles
	Why We Assess Families
	Types & Methods of Family Assessment
Session 3:	Overview of Communication & Interview Skills
	Practice Interviews
	Review Family Assessments Instruments
Session 4:	Child Assessment Tools:
	Purposes and Characteristics
	Methods & Best Practices of Child Assessment
	Team Assessments
	Review Assessment
Session 5:	Team Meetings
	Sharing Assessment Results with Families
	Goal Setting with Families
	Collaborating with Families
Session 6:	Review Components of IFSP
	Family Outcomes
	Writing Family Outcomes
Session 7:	Choosing Child Outcomes
	Determining Functional Child Outcomes
	Developing Child Outcome & Objectives: Definition & Examples
	Case Studies
Session 8:	Overview of Teaching Principles
	Incidental Teaching
	Instructional Programs
	Case Study: Writing Instructional Programs
Session 9:	IFSP Implementation
	Transitions
	Post Measures

low-up evaluation and consultation for up to one year). The session topics and institute competency tasks were also reviewed at this time. A second purpose was to complete the pre-institute evaluation measures.

Each training session had a written outline, containing agendas, objectives, readings, and references for specific topics. A minimum of two graduate-level trainers from the Birth to Three Inservice staff, each having experience as an infant interventionist, served as instructors for each institute session. Flexibility within the agenda allowed adaptation to trainees' concerns, interests, and immediate issues. The post measures were conducted during the last session and dates for the follow-up sessions were scheduled at that time.

Follow-up. The purpose of follow-up was to guide and support the trainees while they implemented newly learned skills within their programs. During follow-up, trainees completed a series of six to ten competency based tasks that represented the application of each of the institute's objectives. Trainees were given written material on each task which included the general objective, the behavior or product to be performed or produced, and the specific criteria for meeting the objective. The tasks were operationalized to clarify the expected outcome, and they were adapted to each trainee's individual needs and situation. Every effort was made to reduce the amount of additional work the tasks required by fitting them into typical job responsibilities. Table 2 contains two sample tasks from the IFSP institute.

Follow-up activities consisted of meetings and observations conducted on-site at the trainee's program unless otherwise arranged. During the first follow-up session, the trainer, trainee, and the trainee's supervisor discussed the competency tasks and adapted them to correspond with the intervention program's structure and needs. A timeline was drawn to estimate dates for completion of each

TABLE 2
Sample IFSP Program Tasks

Description	*Program Task*	*Criteria*
Team Meeting	The trainee will facilitate two team meetings to discuss child and family assessment results. Parents and all service providers working with the families will participate in these meetings. Prior to the meeting, the trainee will (a) develop a written agenda, (b) delineate roles and responsibilities of participants, and (c) prepare families for their role in the meeting.	The instructor will observe the team meetings and provide written feedback. The trainee will submit a written summary of the results of the meetings and discuss them with the instructor.
Collaborative Goal Setting	In collaboration with the family and members of the intervention team, the trainee will develop individualized goals to meet the needs of both the family and child.	1. The family goals will reflect the needs identified by the family during the assessment process. The goals will be operationalized and non-intrusive to the family. Goals will be reviewed by the instructor. 2. The child goals will reflect the needs of the child as identified by the family and the team assessment process. Goals must be operationalized and reviewed by the instructor.

task and was incorporated into a follow-up contract. Follow-up site visits were scheduled approximately twice a month. During each visit, the trainer collected completed tasks and discussed tasks that the trainee was completing. When appropriate, the trainer also observed the trainee to provide consultation and feedback. Competency tasks were required to be completed within one year of the last institute session.

Model Implementation

During the 3 years of the project, 141 infant interventionists received training through 21 institutes. These interventionists responded to a general recruitment letter that went out every project year to all of Connecticut's early intervention programs. Evaluation measures were administer' prior to the beginning of the trainin, sessions, after the training sessions were completed, and again after the follow-up phase was completed. The measures included a program profile of each trainees' intervention program; pre/post knowledge questionnaires which consisted of multiple choice, true/false, and open-ended questions; self-rating scales which consisted of a checklist of skills related to the institute's learning objectives; consumer satisfaction questionnaires; and competency based program tasks. All measures of effectiveness

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documented positive changes within the trainees.

SUMMARY

In summary, The Birth to Three Inservice Model provided training within Connecticut on issues related to P.L. 99-457. The training appears to have improved the quality of early intervention in Connecticut. Evaluation measures demonstrated increased trainee knowledge about selected intervention topics and documented (through the use of competency tasks) changes in early intervention practice. These criteria are often overlooked by many providers of inservice training.

The Birth to Three Inservice Model fulfilled its objectives and completed all proposed activities during the 3-year project period. The model proved effective on a range of outcome measures implemented both at the completion of the training phase and at the completion of follow-up. The model adhered to principles of adult learning in both the design and implementation of the training. In particular, the trainees assisted in the development of the training agendas and individual training contracts. Individual follow-up was provided to each trainee as they implemented competency-based tasks at their program site. The trainees were also able to provide extensive feedback to project staff throughout the training process.

States that are developing a CSPD which includes inservice training may be able to use elements from the Birth to Three Inservice training Model. However, this model requires an extensive commitment to the training process. Results from the 3 years of project implementation strongly suggest that changing the professional practices of early interventionists requires collaborative training activities which include demonstration, feedback, long term support, and ongoing evaluation.

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