Journal of Early Intervention
2020, Vol. 42(3) 244–258
© 2019 SAGE Publications
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/1053815119886110
journals.sagepub.com/home/jei
SAGE

What Early Intervention Looks Like in Child Care Settings: Stories From Providers

Jenna M. Weglarz-Ward[1], Rosa Milagros Santos[2], and Loretta A. Hayslip[2]

Abstract

As more families enroll their infants and toddlers with disabilities in child care programs, early intervention (EI) services are being delivered in these natural environments. This article presents the findings of a study on infants and toddlers with disabilities in child care settings from the perspectives of professionals. Twenty-four child care and EI providers participated in eight focus groups across one state to discuss their experiences with EI services in child care settings. Using thematic analysis, major themes emerged, including *Participant Experiences With EI in Child Care* with six unique codes. Results suggest that the great variability of experiences across children, professionals, and programs contributed to an uncertainty of professional roles and responsibilities, challenges to communication among providers, and alignment to professional recommended practices. In addition, differences in specific location of services (i.e., in a separate room) and delivery model led to EI visits being viewed as disruptive and carrying over strategies into child care routines difficult. Recommendations for future research, policy, and practice are included.

Keywords

child care, inclusion, Part C services, teaming and collaboration with others, infants and toddlers, young children

Early intervention (EI) services for infants and toddlers with disabilities (e.g., occupational therapy, physical therapy, special instruction, speech-language therapy) should be provided in natural environments, meaning settings that same-aged infants or toddlers without disabilities experience and may include home or community settings (Division for Early Childhood/National Association for the Education of Young Children [DEC/NAEYC], 2009). Furthermore, the U.S. Department of Education, Office of Special Education Program, Workgroup on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings (2008) and Division for Early Childhood of the Council for Exceptional Children (2014) recommend that EI services are embedded into natural routines with familiar people, places, and activities. As many

---

[1]University of Nevada, Las Vegas, USA
[2]University of Illinois at Urbana–Champaign, USA

Corresponding Author:
Jenna M. Weglarz-Ward, Department of Early Childhood, Multilingual, and Special Education, University of Nevada, Las Vegas, 4505 S. Maryland Parkway MS3001, Las Vegas, NV 89154, USA.
Email: jenna.weglarz-ward@unlv.edu

young children with and without disabilities attend child care programs (e.g., center-based, home-based, university programs, faith-based), child care settings have become common natural environments for EI services through Part C of the Individuals With Disabilities Education Act (IDEA; Hebbeler, Spiker, Morrison, & Mallik, 2008; U.S. Census Bureau, 2013; U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, 2017). McWilliam (2015) indicates that intervention occurs within the context of adult–child relationships during daily routines and activities with parents, other caregivers, and children between visits from EI professionals. Indeed, child care providers and teachers who serve as primary caregivers in these settings are viable agents to facilitate intervention, support child outcomes, and share EI information with families. Ideally children receiving EI services in child care settings would have visits take place in typical settings (e.g., classroom, playgroup, family child care home), using regular routines and materials (e.g., snack, free play, group stories or songs, program toys, books), and incorporating primary caregivers and peers. However, children often receive their EI services in child care settings without capitalizing on the natural environment and child care providers as active team members.

Past researchers have highlighted the benefits, challenges, and potential of providing special education and EI services in child care settings. High-quality, coordinated early childhood programs promote positive child and family outcomes. Specifically, quality child care programs and EI services foster children's development across all domains of growth, including cognition, language, social, and emotional skills (Noggle & Stites, 2018). Moreover, high-quality programs for infants and toddlers with disabilities with well-trained staff increase families' choices for child care and protect families from risks of poverty and toxic stress (Division for Early Childhood of the Council for Exceptional Children, 2016; Shonkoff & Phillips, 2000; Wertlieb, 2018). Supporting families' access to child care is important as many families with children with disabilities report more irregular employment, lower incomes, higher levels of stress, and higher family expenses (e.g., health care, transportation, specialized equipment; Goudie, Havercamp, Rambon, & Jamieson, 2010; Knoche, Peterson, Edwards, & Jeon, 2006). Researchers have also reported that families of children with disabilities struggle in finding quality child care arrangements and providers who are willing to collaborate with child care and special education services (Child Care Aware, Division for Early Childhood, & The Ounce, 2017).

Supporting infants and toddlers with disabilities in child care settings also promotes the access and participation of children with disabilities in inclusive environments (DEC/NAEYC, 2009; U.S. Department of Health and Human Services & U.S. Department of Education, 2015). For children with disabilities, attending inclusive early care and education programs with the assistance to develop a sense of belonging for themselves and peers creates a long-term trajectory of positive educational experiences. Supporting professionals across child care and early childhood special education/EI and families through integrated services is necessary for positive inclusion.

Despite parents' reporting challenges to finding care, there are more young children with disabilities who attend child care than ever before (Child Care Aware et al., 2017). With the increasing number of children with disabilities in child care, more and more EI providers are delivering services in these settings (Hebbeler et al., 2008; U.S. Department of Education, 2017; Weglarz-Ward, Santos, & Timmer, 2019). Fortunately, child care providers have indicated a strong interest and willingness to participate in the EI process (Mohay & Reid, 2006; Weglarz-Ward et al., 2019). Yet, professionals in both child care and EI struggle to effectively communicate and collaborate with each other (DeVore & Hanley-Maxwell, 2000; Mohay & Reid, 2006; Wong & Cumming, 2010) making each one uncertain of his or her role in the EI process.

As reflected in the above review of the literature, there has been a significant lack of research in recent years focusing on understanding infants and toddlers with disabilities in child care settings and that include insights from EI providers (Weglarz-Ward & Santos, 2018). Therefore, focus groups were conducted across a large Midwestern state to gain understanding of what EI services in child care setting look like by listening to experiences and stories from professionals. These groups were conducted as part of a larger mixed-method study that included an online survey prior to focus groups. Primarily, we explored their experiences when EI services were provided in child care programs. We also sought to explore survey findings related to factors that supported and hindered inclusion of infants and toddlers with disabilities in child care settings and professional collaboration between child care and EI professionals, and possible solutions aimed to support infants and toddlers with disabilities in child care, their families, and professionals. In this article, we describe the portion of the findings from these focus groups with child care and EI providers specific to the following research questions:

Research Question 1: How do child care and EI providers describe typical visits from EI providers to child care settings?
Research Question 2: What are common characteristics of EI visits to child care settings?
Research Question 3: What are common challenges to EI visits to child care settings?

Method

Participants

Focus group participants were recruited from the survey portion of the larger study. For more information about survey recruitment procedures, participants, and findings, see Weglarz-Ward et al., 2019. Survey participants were recruited in cooperation with state partners and professional organizations in child care and EI (e.g., EI professional development agency, state child care resource and referral agency). Survey respondents included 620 child care participants and 371 EI participants. Upon completion of the survey, participants were invited to volunteer for one of eight face-to-face focus groups, four for each professional group; 186 child care providers and 89 EI providers who completed the survey volunteered to participate in the focus groups. Focus groups were held in each major region of the state. In regions that had an abundance of volunteers, participants were randomly selected. Participants were invited via email and phone to participate. Although over-invitation was used to ensure focus groups of at least four participants as recommended by Ryan, Gandha, Culbertson, and Carlson (2014), many participants did not show up to focus groups resulting in small group sizes with an average of three participants per focus group (range = 2-5 participants). By the end of the scheduled focus groups, new information was not being generated indicating that saturation of data had occurred and additional data collection would not be particularly beneficial (Fusch & Ness, 2015).

A total of 24 providers participated across eight focus groups (i.e., four focus groups with child care providers, four focus groups for EI providers; see Table 1). Particularly because a finding from the survey was that respect among professionals was a barrier to collaboration, focus groups were homogeneous by either child care or EI providers to allow each group to feel comfortable describing their experiences without perceived judgment from other groups. Across groups, all participants were women and primarily Caucasian. Child care provider focus groups included 12 participants representing teachers and directors of center-based and family-home programs. The average age of participants was 43.42 (*SD* = 9.57). On average, participants had 13.17 years (*SD* = 8.54) of experience in child care. The majority of child care participants held bachelor’s degrees. Three participants noted that they were currently seeking higher degrees.

In addition, 12 professionals participated in the EI providers’ focus groups, including professionals in speech-language pathology, developmental therapy, physical therapy, occupational therapy, and social work. All participants were credentialed providers in the state and held the appropriate licensure for their discipline. The average age of EI providers was 47.83 (*SD* = 14.51). The majority of participants held master’s degrees; however, three participants held

Table 1. Focus Group Characteristics.

Child care providers

Professional role n = 11	Program type	Highest education	Years of experience in child care (M = 13.17, SD = 8.54)	Age (M = 43.42, SD = 9.57)	Ethnicity	State region
Teacher	Center	Master's	5	39	African American	1
Director	Center	Associate's	11	50	African American	1
Owner	Family home	Bachelor's	13	53	African American	1
Teacher	Center	Bachelor's	25	41	African American	2[a]
Owner	Family home	Bachelor's	30	47	Caucasian	2[a]
Teacher	Family home	Bachelor's	3	31	Caucasian	3
Owner	Faith-based center	Bachelor's	8	38	Caucasian	3
Child care assistant	Family home	Associate's	8	36	Caucasian	3
Teacher	Center	Bachelor's	30	51	Latino	3
Teacher	Center	Bachelor's	8	58	Caucasian	4/5
Director	Center	Associate's	11	50	Caucasian	4/5
Teacher	Faith-based center	Bachelor's	6	27	Caucasian	4/5

EI providers

Professional role n = 12	Program type	Highest education attained	Years of experience in EI (M = 10, SD = 7.61)	Age (M = 47.83, SD = 14.51)	Ethnicity	State region
Speech pathologist	Agency	Master's	15	57	African American	1
Social worker	Independent	Master's	2	28	Asian	1
Developmental therapist	Independent	Master's	3	34	Caucasian	1
Developmental therapist	Independent	Master's	6	69	Caucasian	1
Developmental therapist	Agency	Bachelor's	—	42	Caucasian	2
Physical therapist	Agency	Bachelor's	5	67	Caucasian	2
Speech pathologist	Agency	Master's	1	25	Caucasian	3
Occupational therapist	Independent	Bachelor's	15	51	Caucasian	3
Social emotional consultant	Independent	Master's	23	45	Caucasian	4/5
Speech pathologist	Independent	Master's	20	52	Caucasian	4/5
Speech pathologist	Independent	Master's	9	35	Caucasian	4/5
Speech pathologist	Agency	Master's	20	59	Caucasian	4/5

Note. EI = early intervention.

[a] Audio was damaged, and data were not included in the analysis.

bachelor's degrees as their highest level of education. The average amount of experience in EI reported by participants was 10 years (SD = 7.61).

Focus Group Protocol and Procedure

This study was approved by the university's Institutional Review Board as well as child care and EI state offices. The focus group protocol was developed based on themes derived from the survey results and literature review. The protocol was pilot tested with separate groups of four child care and four EI providers not participating in the study. Feedback on topics, questions, and flow of protocol was used to develop final protocol for data collection (full scripted protocol is available by request to the first author). Specifically, questions were revised to provide clarity and common terminology across groups. Themes included what EI looks like in child care settings and what EI should look like in the child care settings, factors that supported and hindered professional collaboration, and training needs. Each of the eight focus groups engaged in discussions using the following questions:

1. Describe a recent visit you had to a child care to provide EI services (*for EI providers*).
   Describe a recent visit you have had from an EI provider to your program (*for child care providers*).
   For others in the group, is this similar to your visits? Or different (if different, have person describe his or her visit).
2. What do you think EI should look like in child care settings?
3. Is it different in center-based programs versus family-home child care?
4. From survey: "The intervention strategies and adaptations necessary to assist a child with a disability are easy to prepare and carry out" was an area the survey identified as a challenge for inclusion. How do you agree or disagree with this? Why/why not?
5. What do you think your role in these visits should be?
6. How do you build relationships and communicate with child care providers or EI providers?

Careful consideration was taken to create an environment that was supportive and productive as participants discussed survey results and offered suggestions for training and policy ideas to foster collaboration between professional groups. Focus groups took place in neutral locations (e.g., public libraries, community colleges, extension offices) and lasted on average 81.75 minutes (*SD* = 14.12). Upon arrival, participants were greeted by the facilitator and note taker, offered refreshments, and asked to complete informed consents, demographic surveys, and incentive agreements. Each participant received a US$50 gift card upon completion of the focus group meeting as well as copies of resources from state agencies on implementing EI services in child care settings. Participants were arranged in a circular fashion around a table with a recording device in the center area to capture audio of the discussion that was used later for analysis. The facilitator and note taker sat next to each other. Once all participants arrived, the facilitator began introductions, provided information about the study, and described how the focus group would proceed.

The first author and a research assistant conducted the focus groups. Training of the research assistant included observing the first author conduct a focus group, co-facilitating a focus group, and reviewing audio recordings of focus groups before independently conducting three of the eight groups. The first author reviewed recordings of each focus group conducted by the research assistant to ensure fidelity and provided feedback as needed. In addition, a note taker was present in all the focus group meetings and captured the main ideas and participants' interactions.

After each focus group meeting, the research team comprised of the first author, research assistants, and note takers met to discuss major themes and possible additions to the focus group protocol for future groups. Focus groups were audio recorded using a digital recorder and transcribed by an independent, professional transcription service. All transcripts were compared with audio recordings and researchers' notes to ensure accuracy. In addition, summaries were created for member checks. Data were entered into qualitative analysis software (e.g., NVivo®). The audio from one child care focus group was inaudible due to an unforeseen issue with the recording device and therefore was unusable (see *Note* on Table 1). Thus, specific data extracts or quotations from this one focus group meeting were not included in the final analysis.

Data Analysis

Qualitative data from focus group were analyzed using a six-phase thematic approach to identify patterns in the data (Braun & Clarke, 2006; Saldana, 2016) by the first author and a research assistant. Using an inductive approach, the first author and research assistant listened to recordings and read transcripts to familiarize themselves with the data. Then using the transcriptions, a list of 44 initial codes was generated from the entire data set. Using mapping to organize, from these initial codes, four major themes and 20 subthemes were identified across the data set. Next, the themes were reviewed, combined, or eliminated based on the research questions of the larger study, frequency, and intensity of extracts of each theme, and common themes across all focus groups. This resulted in three major themes across the entire data set (e.g., participant experiences with EI in child care settings, factors that support or hinder inclusion and collaboration, moving forward to successful collaboration) and 15 specific codes. The theme, *Participant Experiences With EI in Child Care Settings*, with six specific codes, was directly attributed to the research questions presented in this article. A codebook of initial themes and definitions, examples, and non-examples was developed to guide the review stages of coding. Portions of the data set were coded (e.g., two transcripts) to assess the accuracy of the final themes and codebook. Once the codebook was finalized, the entire data set was independently coded and the research team met to discuss their findings. To ensure reliability and prevent coder drift, the research team discussed each data extract and its corresponding code. When initial coding was not in agreement, team discussed each extract to reach consensus to include, exclude, or change code of extract. Representative quotations were selected by the team to provide a rich description of the data.

Trustworthiness of data. To meet quality standards of qualitative research, steps to ensure trustworthiness were used. To provide triangulation, a mixed-method design was used for methodological triangulation and multiple researchers collected and analyzed data for investigator triangulation (Brantlinger, Jiminez, Klingner, Pugach, & Richardson, 2005; Greene, 2007). Facilitators followed a discussion protocol, met with each other to debrief after each group, and listened to each other's audio recordings to ensure fidelity of implementation of protocol and revised the protocol as needed. To ensure accuracy of data collected, the focus group moderator summarized comments and assessed for accuracy throughout and at the end for each group. In addition, 11 participants volunteered to review summaries and confirm their accuracy or provide corrections via member check (Creswell, 2009). These participants agreed that the information as summarized were correct and offered additional comments to the importance of the discussions. Among the 11 volunteers who conducted a member check, eight participants provided feedback via email within 2 weeks of the conclusion of focus groups. Each member check respondent received a gift card as a token of appreciation for their time.

Results

In relation to the research questions related to providers' experiences with EI visits to child care, six main codes were identified: (a) roles and responsibilities of providers, (b) communication among providers, (c) location of EI services, (d) EI visits as a disruption, (e) carrying over strategies into child care routines, and (f) variability impacts collaboration. When appropriate, each code is described first in relation to the perspectives of child care providers, followed by the perspectives of EI providers. The results are organized starting with the most prominent code (i.e., most commonly discussed across groups), roles and responsibilities of providers followed by the code related to communication among providers. Next, the location of services is discussed followed by the remaining codes including the finding that services were distracting, and implementation of strategies into daily routines. The final code focused on how the variability among individuals and programs affected collaboration.

"I Don't Want to Overstep My Bounds": Roles and Responsibilities of Providers

Most prominently, participants discussed their role as child care and EI providers in relation to supporting children's development, interactions with families, and collaboration among providers. Both groups discussed that they were part of a team for a particular child and family. One child care provider said, "Part of that [success] is our classroom, part of it is the therapist. I've seen good come out of it." However, overall participants were uncertain of the role child care providers played in the EI process.

Child care providers, in general, viewed their roles as an extension of children's families and primary caregivers for children. They observed children's developmental gains and identified developmental concerns. Child care providers found it important to express concerns about children's development to families, assist families in making referrals to the EI system, and share what happens during EI visits at child care. One home-based provider said, "If you're concerned about the child, you would do whatever is necessary for the child to get the help that is needed." EI providers agreed with these ideas and added that child care providers also provided insights to how the children behaved with their peers.

EI providers viewed their roles when providing services in child care as teaching child care providers about EI and child development, and providing suggestions to support the child's goals. One speech-language pathologist said, "My role was general education for the child care providers and helping them understand their responsibilities." She also commented, "I'm going to have to invest a whole lot into the teachers before I can even really get to the kiddo." However, EI providers did not offer other examples of supporting child care providers outside of providing suggestions for activities at the end of each visit.

Across focus groups, both child care and EI providers felt that child care administrators or owners as well as EI service coordinators and administrators set the tone and procedures for collaboration. This affected EI providers' access to child care staff, communication, and location of services. More importantly, administrators affected the formal inclusion of child care providers in the EI process. Child care providers in the focus groups could not recall being asked to attend meetings. Only two EI participants recalled classroom teachers or family-home providers contributing to Individual Family Service Plans (IFSP). However, some of the EI providers recounted times when directors or parent educators attended those meetings. EI providers commented that service coordinators were essential to coordinating services between home and child care by asking parents to invite child care providers to attend IFSP meetings, scheduling meetings when parents and child care providers could be present, and conducting routines-based interviews, which were required for coordinators to complete, with primary caregivers at child care. However, most EI providers said that service coordinators varied greatly in how they approached services. Child care providers in the focus groups did not identify service coordinators as active participants in collaboration.

Overwhelmingly, all participants agreed it would be beneficial to formally include child care providers in the EI process. Participants felt this would help child care providers better understand EI and be able to carry over strategies into daily routines. Although participants agreed on the benefits of child care providers' participation, both child care and EI providers were unsure how they could become more involved and to what degree.

Both groups of providers continued to consider their uncertainty about specific roles. In particular, they shared they were unsure whose role it was to initiate or facilitate collaboration. Specifically, both child care and EI providers were unsure who was responsible for inviting child care providers to be part of the IFSP team. A home-based provider said, "It's [IFSP] not just to be shared with the parents but whose responsibility is that, I don't know. Is it the parents? Is it the specialist?" Both sets of providers discussed that parents and service coordinators were often in the role of facilitating teaming.

In summary, although providers had ideas about their role in supporting children's development as discussed above, articulating their role in specific to EI in child care settings was challenging. Uncertainty in relation to the child care providers' role, EI providers' ability to include child care providers in services, and administrators' control over information were conveyed as barriers to collaboration.

"Communication Is Key": Communication Among Providers

All the groups discussed how they communicated with each other, both verbally and through written correspondence. Although all participants expressed that communication was important, they agreed that most communications were brief and occurred primarily at either the beginning or the end of the EI visit. EI providers labeled this communication as "on the fly," "drive bys," and "doorknob questions." These communications were typically about what the child care provider had observed the child doing since the last visit, what the EI provider worked on during the visit, and ideas for carryover. Commonly, EI providers discussed difficulty in finding time to communicate with child care providers as they were often busy with daily tasks. An occupational therapist said, "It's a balancing act because sometimes they're occupied. You don't want to be someone that makes their job harder." Many of the EI providers also mentioned that they left contact notes after each visit in the child's cubby or backpack. A speech-language pathologist described this as, "They're [child care providers] welcome to read all the notes. Usually, once I'm used to the daycare and how it runs, I'll just stick it in their cubby. But the teacher is always aware that it's in there." However, none of the child care providers in the focus groups mentioned receiving or reading contact notes. Furthermore, it was also discussed that contact notes were confidential and should only be available to IFSP team members, which child care providers were not considered. In sum, both sets of providers struggled with finding time to communicate with each other. EI providers felt they made concerted efforts to communicate with child care providers; however, child care providers seemed largely unaware of these efforts.

"So When the Therapists Come, They Work Back There": The Location of EI Services

Overwhelmingly, participants indicated that EI providers delivered services to the child in a separate area of the classroom or family child care home away from peers and child care providers or, more commonly, in a separate room. They also expressed they were unsure as to the best practices related to where services should be conducted.

Child care providers described this practice as how they think EI visits should be and based their opinions on their past experiences with EI providers. Some of the child care providers were unsure where services should take place. Other child care providers discussed how they were not sure if providing services with other children was even appropriate. If services were delivered with other children, they were concerned that the target child would not receive the appropriate attention. On the contrary, some providers felt that separating the child from the group elicited feelings of being left out for that child. One home-based provider summed this up by saying, "When they [the child] get pulled out, they also feel like what did I do wrong? Why can't I go play with my friends? They're riding their bikes and I have to sit here and do this."

EI providers also struggled in deciding where to deliver services. Some preferred to do EI visits within the classrooms or programs; however, many experienced push back from child care providers who asked them to conduct visits outside of the room. A physical therapist recalled a center that asked her to do her sessions in a closet. Another provider described the challenge of transitioning from providing services in a separate room after 30 years to embedding it into the classroom. She shared that it was difficult to give up control of her goals for each session, “Going into the classroom, you have to wait for the opportunity because you can’t really change what is happening. It’s not time to request. It’s time to talk about pictures.” A new provider expressed her struggles about providing services within the classroom due to a lack of support and models from other seasoned therapists in her agency. Not all providers felt this way. One occupational therapist shared that she never left the room and incorporated peers into songs and games while embedding the target child’s occupational therapy goals into the activity.

In summary, most EI visits took place separately from the regular child care programs and peers. Although providers in both groups saw the value of delivering services within regular routines and with peers, they were unsure how to do this and whether it was an appropriate way to meet the children’s goals. The following codes further explain the impact of the location of services.

“It’s Chaotic”: EI Visits as a Disruption to Child Care Programs

Both groups discussed that the location of services and collaboration with child care providers around EI services was hindered by the fact that both child care and EI providers viewed EI visits as disruptive to the regular child care program. Statements related to distraction or disruption emerged in all of the focus groups. Most commonly, the presence of an EI provider was seen as a distraction to the other children in the program. This was frequently mentioned in relation to the EI provider bringing in a bag of toys that attracted the children. One child care provider described this as, “I’ve seen therapists come in and all of the kids attack them at once because they have really cool new toys in their bag.” Many of the EI providers understood that their visits could be a distraction to the regular routine. In addition, EI providers described that the classroom or home environment was noisy and chaotic and created difficult situations for the child and provider to focus on the targeted skills, particularly listening to speech sounds. In summary, the distraction of EI visits influenced the location for services.

“Show Us What We Can Do”: Carrying Over Intervention Strategies in Child Care Routines

Participants in all eight focus groups discussed their experiences implementing intervention strategies during the daily routines of child care programs. In general, child care providers felt the suggestions offered by EI providers were often vague, while EI providers felt frustrated when child care providers did not carry over strategies they recommended. Child care providers described that some EI providers observed the child at the beginning or at the end of their session in the regular routines of the day and provided suggestions for the child care providers to support the child’s development. Some child care providers shared examples of EI providers who observed their routines and understood their limited time and budget, and thus were able to provide very practical suggestions. In general, child care providers described this as EI providers, “telling us what they were working on.” However, child care providers felt that they were general ideas such as, “work on requesting” or “practice speech sounds” but not necessarily provided with information on how the suggestions connected to the child’s goal or how the child care provider could integrate specific strategies into existing routines. This left the child care providers to design their own strategies to implement, which many reported they did. One child care director described how she wrote the child’s goals into their weekly lesson plans. For example, she said, “For a student with speech, we try to get him to use more words and ask him more open-ended questions.” Child care providers, however, consistently described how implementing strategies was challenging. One issue that multiple providers discussed was the challenge to provide specific, individualized interventions such as sensory integration (e.g., deep pressure, brushing) while also managing a large group of children. One center-based provider said, "So we try to carry out as much as we can without hindering the other 15 kids in the classroom."

EI providers also realized the challenges of implementing strategies across daily routines and within large groups of children. Although most of the EI providers expressed some disappointment that child care providers did not often report carrying over strategies between visits, many EI providers described successful instances of carryover that included strategies that supported all children's development or could be implemented with peers. A developmental therapist shared, "Because if you just have to do it for only little Johnny, it's not going to happen but if you give that teacher a whole group activity then it's much more likely to carryover." Many of these providers also described strategies they have used to increase carryover. They suggested that EI providers needed to try different strategies and learn how to best communicate with the child care provider to provide meaningful suggestions. They also acknowledged that carryover may be challenging for child care providers due to their limited time to talk with EI providers, staffing limitations, and lack of motivation to carry over strategies.

Both groups noted that carrying over strategies into daily routines was important. Child care providers saw this value and wanted to take part but they did not feel that EI providers supplied suggestions that were explicit and sensitive to their routines and resources. EI providers felt they were providing suggestions but noted that it was challenging. Overall, both groups were unsatisfied with how carryover of intervention was implemented.

"It Depends": Variability Impacts Collaboration

All participants discussed that there was considerable variability in collaboration that existed between child care and EI providers. This variability occurred due to differences among and across child care providers, EI providers, children, and families as well as child care programs. Commonly, participants used words such as "varies," "different," and "depending" to describe collaboration with others. A physical therapist summarized this issue by saying, "Daycare is different from door to door to door just like EI is different from CFC [EI region] to CFC." EI providers also mentioned in particular that EI may be different by discipline (e.g., speech and language pathology, physical therapy, occupational therapy). A speech-language pathologist explained that there were differences among child care providers:

> I see more variation teacher to teacher. And some will go out of their way to help them and are really interested and ask a lot of questions. And others you can tell they don't get paid enough to care.

This variety made it difficult to create a one-size-fits-all model of inclusion that providers seemed to desire. Having these unique relationships increased the amount of time and energy needed to build successful collaborations.

Discussion

The findings about EI visits to child care settings provide insight into the factors that can make EI effective and challenging in child care settings. In relation to our research questions, participants concluded that it is difficult to identify common characteristics of EI visits to child care programs. The common characteristic was variability across programs and providers in providing individualized services to each child and family. In addition, it was common for child care providers to not be fully engaged in the EI process or visits to child care programs. In relation to the larger study conducted on this topic, these qualitative findings confirm and expand on major themes from quantitative data by providing examples of current practices from the voices of providers in the field. Participants' descriptions of uncertainty and chaos were strong themes that affected the roles of providers, the quality of communication among providers, and the location of services. These factors also influenced the ability of child care providers to use intervention strategies within daily routines to provide additional opportunities and supports for children's development and learning as well as facilitate family outcomes. This echoes McWilliam's (2015) conclusions that diversity of natural caregivers and how professionals engage with them contribute to child outcomes.

Both child care and EI providers were unsure on how to implement EI services in child care settings. Child care providers were not sure whether they should actively participate or give EI providers space to work individually with a child. EI providers often assumed that child care providers understood the purpose and process of EI and that they should use intervention strategies in their child care routines. However, because child care providers were not explicitly involved in the EI process, they did not always see this as their role. Furthermore, participants in this study were not sure how, what, or when to communicate with each other. These results aligned with survey data that EI providers tended to overestimate their communication efforts with child care providers. For example, EI providers mentioned that they put everything in contact notes in the children's cubbies or backpacks. Although this may serve as a good communication strategy, contact notes are confidential to only the IFSP team that of which the child care providers were not part of. While families can sign releases of information to share this information, contact notes alone do not help child care providers understand how to implement intervention strategies. These experiences highlight the challenge to implementing Division for Early Childhood of the Council for Exceptional Children (2014) Recommended Practices related to Teaming and Collaboration specifically systematically sharing knowledge, planning, and implementing services and using communication to facilitate team relationships.

Similar to DeVore and Hanley-Maxwell's (2000) findings, the variability among professionals, programs, and even children and families further confused child care providers on their role. They often took the lead from the EI providers who visited their programs. Therefore, if providers actively involved the child care provider in services, child care providers learn to expect that from EI services. However, if EI providers did not build a relationship with child care providers and consistently provided services outside the room, child care providers assumed that was what EI looked like. When a new EI provider comes to the child care program, the child care provider may expect and promote similar practices from the previous provider including suggesting that therapy can be done in a different room. This aligns with DeVore and Hanley-Maxwell's (2000) conclusions that as child care providers gain more experience with children with disabilities and working with other professionals, they shape their perceptions and practices of inclusion.

These factors greatly affect the ability to carry over strategies from EI visits into daily routines at child care and home. As intervention occurs during the time between EI visits (McWilliam, 2015), opportunity is lost when child care and EI providers do not interact during visits. With any EI services, services provided with outside materials (i.e., professional's toy bag), excluding natural caregivers, and in artificial environments, impedes child outcomes. In child care settings, consider if an 18-month-old child received his services in a separate room away from his child care providers, peers, and parents, no adult is available to embed the strategies used during the EI visit within daily routines. As recommended by Division for Early Childhood of the Council for Exceptional Children (2014) instruction and environment practices, if children are supported with familiar routines and materials with adults providing responsive interactions and using evidence-based strategies in natural environments, the opportunities for children to learn and grow increase. In many situations, EI providers may need to take the lead in supporting child care providers' understanding of EI as well as engage child care providers with adult learning strategies, collaborative consultation, and coaching (Cook Pletcher

& Younggren, 2013; McWilliam, 2011). In addition, as families may not see the EI provider, child care providers can in turn use these strategies for families to use at home. Following Trivette, Dunst, Hamby, and O'Herin's (2009) recommendations, providers can engage each other and families in learning through introduction of concepts, illustrating or modeling of strategies, practicing strategies together, and, independently, evaluating and reflecting on the learning process and skills. Coaching and consultation can provide specific guidance on how to implement specific strategies within the child care or home routines. For example, an EI provider and child care provider can identify a developmental skill to focus on such as making verbal requests. Working together, they can identify what activities this skill would naturally occur (e.g., snack time). The EI provider could model strategies for the child care provider during snack and provide opportunity for the child care provider to practice those strategies while the EI provides feedback. During the time between sessions, the child care provider uses these strategies and communicates with the EI provider on their successes with that strategy or remaining challenges. This process allows for teaming and collaboration to increase the learning opportunities for the child across settings, actively involves the child care provider in the EI process, and provides a learning process that can be shared with family members.

Implications for Practice, Policy, and Research

Within professional practice, both child care and EI providers should develop relationships with each other at individual, program, and community levels. By additionally partnering with families, professionals can help to strengthen communication; clarify roles, expectations, and responsibilities; and develop feasible strategies to maximize EI visits. Although each provider, program, family, and child will bring different ideas to the table, we should identify common characteristics of EI visits so that services are consistent across settings. Using recommendations from U.S. Department of Education, Office of Special Education Program, Workgroup on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings (2008) and Division for Early Childhood of the Council for Exceptional Children (2014) can support the use of evidence-based practices in IFSP development, service delivery, and teaming and collaboration.

To support quality EI services in child care settings, an examination of program procedures and state policies that support and hinder quality EI services in child care settings would be valuable. More specifically, assessing how child care providers are systematically included in the EI and IFSP process would be valuable in addressing roles, expectations, and any liability concerns. Integrated training and technical assistance to support child care providers' understanding of EI, EI providers' understanding of child care, and teaming strategies would be valuable.

To gain a better understanding of the prevalence and needs of children with disabilities and their families related to child care is needed. Researchers should explore how many children with disabilities receive services in child care programs, including center-based, family-home, after-school, and family, friends, and neighbor care. In addition, research across multiple states will provide a broader understanding of the needs of professionals to better support the inclusion of young children with disabilities and clarify common and challenging circumstances to providing services in these natural settings. In addition to continued survey and interview methods, case studies of successful collaborations between child care and early childhood special education/EI programs would provide insight into the key components for inclusion. Furthermore, researchers should include families of young children with disabilities in child care settings, administrators (e.g., child care directors/owners, service coordinators), and family-home providers to include experiences from the many individuals involved in the lives of young children. This greater understanding on these issues would allow for the development of intervention to support more coordinated services and positive outcomes for children and their families.

Limitations

Although data collected across groups, providers, and across the state including urban, suburban, and rural areas were robust and consistent across focus groups, the sample was smaller than anticipated. In addition, data were collected from one state system. As child care and EI systems vary by state, examining multiple areas of the country would provide greater insight. Therefore, caution is recommended when generalizing the results of this study to larger groups or different geographic areas.

Conclusion

While families interact with multiple early childhood programs to meet their families' needs (U.S. Census Bureau, 2013), EI visits to child care are becoming more common to implementing Part C services. For example, a child may attend an EI playgroup in the morning and a community child care or home-based program in the afternoon; or a family may arrange their schedule to have EI visits at their home, but their child attends a center-based child care program for 40 hr per week. If learning and development happen within the context of familiar people, places, and routines, it is important to consider how IDEA services maximize these opportunities to support children across settings and caregivers. This study indicates that how children receive services in child care programs is variable and far from ideal and the relationship child care providers have with EI may not be reaching its potential. Therefore, it is important to consider how this may affect the goals of IDEA and influence child and family outcomes. Both EI and child care providers in this study were clear that they are willing and interested in supporting infants and toddlers with disabilities and their families in child care setting; thus, with increased research, policy, and training, high-quality inclusive experiences will be possible.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The contents of this review were supported by funding from the U.S. Department of Health and Human Services Administration of Children and Families (90YE0163, Project Officer Ann Rivera) and U.S. Department of Education (H325D110037, Project Officer Dawn Ellis). However, those contents do not necessarily represent the policy of the U.S. Departments of Health and Human Services and Education, and one should not assume endorsement by the Federal Government.

ORCID iD

Jenna M. Weglarz-Ward https://orcid.org/0000-0001-7357-4724

References

Brantlinger, E., Jiminez, R., Klingner, J., Pugach, M., & Richardson, V. (2005). Qualitative studies in special education. *Exceptional Children*, *71*, 195-207.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101. doi:10.1191/1478088706qp063oa

Child Care Aware, Division for Early Childhood, & The Ounce. (2017). *Building inclusive state child care systems*. Retrieved from https://usa.childcareaware.org/wp-content/uploads/2017/09/CCDF-and-Inclusion-Final-Sept.-2017.pdf

Cook Pletcher, L., & Younggren, N. O. (2013). *The early intervention workbook: Essential practices for quality services*. Baltimore, MD: Brookes.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: SAGE.

DeVore, S., & Hanley-Maxwell, C. (2000). “I wanted to see if we could make it work”: Perspectives on inclusive childcare. *Exceptional Children*, *66*, 241-255.

Division for Early Childhood/National Association for the Education of Young Children. (2009). *Early childhood inclusion: A joint position statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC)*. Chapel Hill, NC: The University of North Carolina, FPG Child Development Institute.

Division for Early Childhood of the Council for Exceptional Children. (2014). *DEC recommended practices for early intervention/early childhood special education*. Retrieved from http://www.dec-sped.org/recommendedpractices

Division for Early Childhood of the Council for Exceptional Children. (2016). *Position statement on maltreatment*. Retrieved from https://www.decdocs.org/position-statement-child-maltreatme

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20*, 1408-1416.

Goudie, A., Havercamp, S., Rambon, L., & Jamieson, B. (2010). Caring for children with disabilities in Ohio: The impact of families. *Ohio Development Disability Council*. Retrieved from http://ddc.ohio.gov/Pub/OHFamImpStudyWhitePaper-FINAL.pdf

Greene, G. C. (2007). *Mixed methods in social inquiry*. San Francisco, CA: John Wiley & Sons.

Hebbeler, K., Spiker, D., Morrison, K., & Mallik, S. (2008). A national look at the characteristics of early intervention services [Young Exceptional Children Monograph Series No. 10]. *Early Intervention for Infants and Toddlers and Their Families: Practices and Outcomes*, 1-18.

Knoche, L., Peterson, C. A., Edwards, C. P., & Jeon, H. J. (2006). Child care for children with and without disabilities: The provider, observer, and parent perspectives. *Early Childhood Research Quarterly*, *21*, 93-109.

McWilliam, R. A. (2011). The top 10 mistakes in early intervention in natural environment and the solutions. *Zero to Three*, *31*, 11-16.

McWilliam, R. A. (2015). Future of early intervention with infants and toddlers for whom typical experiences are not effective. *Remedial and Special Education*, *36*, 33-38. doi:10.1177/0741932514554105

Mohay, H., & Reid, E. (2006). The inclusion of children with a disability in child care: The influences of experience, training and attitudes of child care staff. *Australian Journal of Early Childhood*, *31*, 35-42.

Noggle, A. K., & Stites, M. L. (2018). Inclusion and preschoolers who are typically developing: The lived experience. *Early Childhood Education Journal*, *46*, 511-522. doi:10.1007/s10643-017-0879-1

Ryan, K. E., Gandha, T., Culbertson, M. J., & Carlson, C. (2014). Focus group evidence: Implications for design and analysis. *American Journal of Evaluation*, *35*, 328-345. doi:10.1177/1098214013508300

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Thousand Oaks, CA: SAGE.

Shonkoff, J. P., & Phillips, D. A. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academies Press.

Trivette, C. M., Dunst, C. J., ’Hamby, D. W. O., & Herin, C. E. (2009). *Characteristics and consequences of adult learning method and strategies* (Winterberry Research Syntheses, Vol. 2, Number 2). Ashville, NC: Winterberry Press.

U.S. Census Bureau. (2013, April). *Who’s minding the kids? Child care arrangements: Spring 2011*. Retrieved from http://www.census.gov/prod/2013pubs/p70-135.pdf

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2017). *39th Annual Report to Congress on the Implementation of the Individuals With Disabilities Education Act*. Washington, DC: Author.

U.S. Department of Education, Office of Special Education Program, Workgroup on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings. (2008, March). *Agreed upon mission and key principles for providing early intervention services in natural environments*. Retrieved from http://ectacenter.org/~pdfs/topics/families/Finalmissionandprinciples3_11_08.pdf

U.S. Department of Health and Human Services, & U.S. Department of Education. (2015). *Policy statement on inclusion of children with disabilities in early childhood programs*. Retrieved from http://www2.ed.gov/policy/speced/guid/earlylearning/joint-statement-full-text.pdf

Weglarz-Ward, J. M., & Santos, R. M. (2018). Parent and professional perceptions of inclusion in child care: A literature review. *Infants & Young Children*, *31*, 128-143. doi:10.1097/IYC.0000000000000115

Weglarz-Ward, J. M., Santos, R. M., & Timmer, J. (2019). Factors that impact inclusion in child care settings: Perspectives from child care and early intervention providers. *Early Childhood Education Journal*, *47*(163), 163-173. doi:10.1007/s10643-018-0900-3

Wertlieb, D. (2018). Inclusive early childhood development: Ensuring the right and well-being of infants and toddlers with disabilities and their families. *Zero to Three*, *38*(4), 22-30.

Wong, S., & Cumming, T. (2010). Family day care is for normal kids: Facilitators and barriers to the inclusion of children with disabilities in family day care. *Australian Journal of Early Childhood*, *35*, 4-12.