MODULE 1 - HANDOUTS

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Handout 1.1
Differences Between Parts C and B of IDEA

Individuals with Disabilities Education Act

Part C (B-3)	Part B (3 to 21)
Services	
Provides services for children ages B to 3.	Provides services for children ages 3 to 21.
Service Coordination	
Service Coordination is a mandated service.	Uses and educational Case Manager.
Timelines	
Forty-five (45) calendar days from the referral to the initial IFSP team meeting.	Educational evaluation completed within thirty (30) school days from the date the parent signs the consent to evaluate.
Evaluation Components	
Evaluations in all areas of development (motor, cognition, communication, social/emotional, adaptive/functional). Each time a meeting is held, prior written notice is provided.	Evaluate only the areas of suspected delay/disability.
Eligibility Components	
Part C Categorical eligibility Developmental Delay - diagnosed condition with a high probability of developmental delay, or - a delay of 1.5 standard deviation below the mean in one or more areas of development, or - eligibility established through the use of informed clinical opinion.	Part B Categorical eligibility Developmental delay - diagnosed condition with a high probability of resulting in delay, or - a delay of 1.5 standard deviations below the mean in two or more areas of development, and - an identified education need.
Focus of Services	
Services and support provided to the family and child.	Special education and related services are provided to the child.
Goals	
Focus on supporting the family in meeting developmental needs of the child.	Focus on the child's educational needs.
Plan of Service	
Individual Family Service Plan (IFSP)	Individual Education Plan (IEP)
Delivery of Service	
Requires services and supports to be provided in natural environments.	Requires special education and related services to be provided in the least restrictive environment.
Year-Round Services	
Services and supports are required to be provided year-round to any child with an IFSP.	A child must meet Extended School Year (ESY) criteria to receive service through the summer. Required documentation is needed.
Progress Reporting	
IFSP is reviewed at least every six months.	Progress is reported at least as often as parents for children without disabilities are informed.

Individuals with Disabilities Education Act of 2004 (IDEA), Pub. L. No. 108-446
http://idea.ed.gov/

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 1.2
State Performance Plan (SPP) and Early Childhood (Part C) Indicators

How do the State Performance Plan (SPP) and Early Childhood Indicators relate to Service Coordination?

The Individuals with Disabilities Education Act (IDEA) is the Federal law that guarantees a free, appropriate public education to each child with a disability throughout the nation. The IDEA governs how states and public agencies provide early intervention and special education.

IDEA was reauthorized in 2004 and now requires each State develop a State Performance Plan (SPP). For Part C, the SPP includes baseline data, measurable and rigorous targets, and improvement activities for 14 indicators. For Part B, the SPP includes baseline data, measurable and rigorous targets and improvement activities for 20 indicators. The Part C indicators and two of the Part B indicators that relate to children birth through age 5 with IFSPs or IEPs are listed below. The SPP and the results of these indicators are used by the school districts and the state as a tool to improve education for children with disabilities. Service Coordinators need to be familiar with these targets as they relate directly to service coordination activities, timelines and child and family outcomes monitored by the MN Department of Education (MDE) and reported to Office of Special Education Programs (OSEP). The ultimate goal is that young children and their families receive early intervention and special education in accordance to the law (U.S. Office of Special Education Programs).

Part C SPP Indicators – for children birth to three

1. **Timely Service Delivery**- Percent of infants/toddlers with IFSPs receiving EI on their IFSPs in a timely manner.
2. **Settings-** Percent of infants/toddlers receiving EI in the home or programs for typically developing children.
3. **Child Outcomes-** Percent of infants/toddlers demonstrating improved: positive social-emotional skills; acquisition & use of knowledge & skills; use of appropriate behaviors.
4. **Family Outcomes-** Percent of families reporting EI services have helped the family: know their rights; effectively communicate child's needs; and help their children develop and learn.
5. **Child Find, Ages Birth to 1**- Percent of infants/toddlers birth-1 with IFSPs compared to: other states with similar eligibility definitions; and national data.
6. **Child Find, Ages Birth to 3-** Similar to indicator 5 for B-3.
7. **Timeliness of IFSP**- Percent of eligible infants/toddlers with IFSPs within 45-day Part C timeline.
8. **Early Childhood Transition**- Percent of all children exiting Part C who received timely transition planning by their 3rd birthday.
9. **Part C Monitoring System**- General supervision system identifies & corrects no later than one year from identification.
10. **Administrative Complaints-** Percent of signed written complaints with reports issued that were resolved within 60 day timeline.
11. **Due Process Hearings-** Percent of due process hearing requests that were fully adjudicated within applicable timeline.
12. **Resolution Agreements**- Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement.
13. **Mediations-** Percent of mediations held that resulted in mediation agreements.
14. **Data Accuracy-** State reported data are timely and accurate.

Handout 1.2
State Performance Plan (SPP) and Early Childhood (Part C) Indicators, cont.

Part B SPP Indicators – for children three to five

1. **Preschool Setting-** Percent of preschool children with IEPs who received special education and related services in settings with typically developing peers.
2. **Preschool Skills-** Percent of preschool children with improved positive social emotional skills including social relationships; acquisition & use of knowledge & skills including early language/communication and early literacy; and use of appropriate behaviors.
3. **Transition from Part C to Part B-** Percent of children referred by Part C prior to age 3, who are found eligible for Part B, and who have an IEP developed and implemented by their third birthdays. 20 U.S.C. 1416(b)(2)(ii)(II) and 142 of the Individuals with Disabilities Act of 2004 – Pub. L. No. 108-446

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 1.3
Outcomes of Effective Service Coordination Parent Checklist

Circle the frequency with which these outcomes occurred with your child and family because of being in the Early Intervention Program.

Outcomes	Always/Almost always	More than half the time	Less than half the time	Never/Almost never
By being in the program, my child & family had access to support, information & education that addressed our needs.	4	3	2	1
By being in the program, my family developed the ability to communicate our needs.	4	3	2	1
Be being in the program, my family developed the ability to make informed decisions.	4	3	2	1
The agencies and professionals with whom my family worked were coordinated.	4	3	2	1
Be being in the program, my child & family had access to quality service.	4	3	2	1
The services we received were individualized with effective supports and services.	4	3	2	1
By being in the program, my family had the ability to acquire and/or maintain a quality of life that enhanced our well-being.	4	3	2	1
By being in the program, my family developed the ability to meet the special needs of our child.	4	3	2	1
By being in the program, my child's health and development have been enhanced.	4	3	2	1

Program Analysis: Tally the responses from parents and determine where changes need to be made in your program. When working with families and children with disabilities, programs should be scoring mostly 4s, maybe some 3s. Make a commitment to target the areas that did not score a four. The program team can develop a plan of action and an evaluation for the target area(s). Work on one area at a time. .Begin work on the area that scored the lowest.

Adapted from: Bruder, M.B. (2010). Coordinating services with families. In R.A. McWilliam (Ed.), *Working with families of young children with special needs.* New York: The Guilford Press (pp. 93-126).

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

References

Blaska, J., Haak, J. & Schoepf, S. (2011). *Service coordination practices in Minnesota: Summary of survey findings.* Minnesota State Department of Education, Part C Early Learning Services: Roseville, MN

Bruder, M.B. (2005). Service coordination and integration in a developmental systems approach to early intervention. In M.J. Guralnick (Ed.), *A developmental systems approach to early intervention: National and international perspectives* (pp.29-58). Baltimore: Brookes.

Bruder, M.B. (2010). Coordinating services with families. In R.A. McWilliam (Ed.), *Working with families of young children with special needs* (pp.93-126). New York: The Guilford Press.

Dunst, C.J. & Bruder, M.B. (2006). Early intervention service coordination models and service coordinator practices. *Journal of Early Intervention,* 28(3), 155-165.

Federal IDEA Part C, 34 C.F.R. 303.34

Harbin, G. Bruder, M.B., Adams, C., Mazzarella, C., Whitbread, K., Gabbard, G., Staff, I. (2004). Early intervention service coordination policies: National policy infrastructure. *Topics in Early Childhood Special Education,* 24(2), 89-97.

Individuals with Disabilities Education Act of 2004 (IDEA), Pub. L., No. 108-446

McWilliam, R.A. (2006). What happened to service coordination? *Journal of Early Intervention,* 28(3), 166-68.

Minnesota Statue (2011), 123 A.33(a) and (b) Service Coordination;

Minnesota Statue (2011) 125.32
https://www.revisor.mn.gov/statutes

U.S. Office of Special Education, Ideas that Work. Learning More About Idea: State Performance Plans and Annual Performance Reports
http://spp-apr-calendar.rrfcnetwork.org/explorer/view/id/844

Resources

Differences Between Parts C and B of IDEA, Individuals with Disabilities Education Act (2004)
http://idea.ed.gov

Early Childhood Outcomes Center (ECO)
http://www.fpg.unc.edu/~eco/pages/outcomes.cfm
http://www.fpg.unc.edu/~eco/pages/fedreq.cfm

Minnesota Department of Education, (2010) Measuring what matters: Outcomes in early intervention and ECSE.
http://education.state.mn.us/search?q=Measuring+What+Matters&searchbutton=Go&output=xml_no_dtd&oe=UTF-8&ie=UTF-8&client=New_frontend&proxystylesheet=New_frontend&site=default_collection

Minnesota Department of Education, Family Outcomes Survey
http://projects.fpg.unc.edu/~eco/pages/tools.cfm#SurveyVersions

Minnesota Help Me Grow
http://www.mnparentsknow.info

Office of Special Education Programs' (OSEP's) Part C of the IDEA website. Website lists all information that goes out to Part C Coordinators
http://idea.ed.gov/part-c/search/new

State Performance Plan (SPP)
20 U.S.C. 1416(b)(2)(C)(ii)(11) and 1442 of the Individuals with Disabilities Education Act (IDEA) of 2004 P.L. No. 108-446
20 U.S.C. 1416(a)(3)(A) and 1442- Child Outcomes Summary Form and Family Survey

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MINNESOTA SERVICE COORDINATION MODULES

MODULE 2 - HANDOUTS

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Handout 2.1
Understanding Families who have Children with Disabilities

In order to work successfully with families who have children with disabilities, it is necessary that professionals understand the emotional impact on the family. Parents who have children with disabilities experience the emotions of grief as they cope with the loss of the child they had dreamed about and anticipated. Their dream has been shattered. The severe loss they experience is the loss of their dream child. Grieving helps parents let go of their dream and eventually become able to refocus and dream new dreams for the child that they do have. Emotions appear and reappear with a parent experiencing one, two or more emotions simultaneously.

The Cyclical Grieving Model specifically describes the grief that parents of children with disabilities experience. Cyclical grieving is the intermittent reoccurrence of one or more emotions. It occurs throughout the life cycle of the family and is triggered by a variety of events. Parents have reported that significant events such as a child needing surgery in order to walk, as well as seemingly insignificant events, seeing a child at the grocery store, who is developing typically, act as triggers for grieving. The seemingly insignificant events were in fact significant to some parents based on their perception of the event. It is difficult if not impossible to predict which events or developmental changes will act as catalysts to grieving. The reoccurrence is unique to each parent.

The frequency of the occurrence of cyclical grieving and the intensity of the feelings diminish with the passage of time. During the days, weeks and months when grieving is not occurring, parents report being free of the feelings of grief. The occurrence of cyclical grieving does not preclude parents from loving their child and deriving joy from their child's development and achievements. Parents are busy working toward understanding and accepting their child who has the disability, reorganizing their lives to cope with whatever demands are placed on them, celebrating accomplishments and dreaming new dreams.

To validate the Cyclical Grieving Model, Blaska conducted a study using face-to-face interviews to determine if parents of children with disabilities did experience cyclical grieving. The findings of the study clearly supported the concept of cyclical grieving. The participants of the study indicated this model depicted a true picture of the emotions and behaviors they experienced as they grieved the loss of their dream child and began the journey of developing new dreams for their children with disabilities.

Blaska, J.K. (1998). Cyclical grieving: Reoccurring emotions experienced by parents who have children with disabilities. (ERIC Document Reproduction Service No. ED 419-349).

Handout 2.2
Cyclical Grieving: Guidelines for Professionals – Checklist

Respond to each of the statements by circling a number to indicate how often you do or do not do what is described in the statements.

	Always, almost always	More than half the time	Less than half the time	Never, almost never
Be sensitive to the on-going emotional challenges parents face with cyclical grieving.	4	3	2	1
Provide on-going support as one cannot grieve alone.	4	3	2	1
Support parents by being a good listener.	4	3	2	1
Provide adequate and accurate information through open and honest communication.	4	3	2	1
Validate the parent's feelings (eg. "I can understand why you'd be angry.").	4	3	2	1
Help parents remain positive and hopeful (Look at all Joey has accomplished.")	4	3	2	1
Demonstrate respect for families, recognizing their strengths and needs, without judging.	4	3	2	1
Help parents maintain a commitment to the entire family by recognizing the needs of each family member.	4	3	2	1
Recognize that all families are unique and react to having a child with a disability in their own way with their own timeline.	4	3	2	1
Be realistic with families, but give them hope; sometimes it is the hope that allows parents to get up in the morning.	4	3	2	1

Adapted from: Blaska, J.K. (1997). Does grief reoccur for families who have children with disabilities? Practical Update, (1)3 2-5.

Handout 2.2
Cyclical Grieving: Guidelines for Professionals – Checklist, cont.

Goal Setting – Personal Reflection

Read through your responses and choose where to make changes.

When working with families with children with disabilities, professionals should be scoring mostly 4s, maybe some 3s. Make a commitment to work on behaviors that do not score a four. First, work on behaviors scored 1s and 2s. Then move to 3s.

A goal may be a behavior that you would like to increase or decrease. It is important to remember, we can change behavior if we are willing to work for change.

Select one to three behaviors to work on throughout a specific period of time, eg. six months, or a year.

Don't choose more than three goals, as it needs to be realistic or you will become discouraged.

When you have met a goal, you can always add another new goal.

Remember to pat yourself on the back for all that you or the team are doing well!!

Handout 2.3
Key Elements of Family-Centered Care: Checklist for Professionals

Respond to each of the statements by circling a number to indicate how often you do or do not do what is described.

	Always, almost always	More than half the time	Less than half the time	Never, almost never
Recognize that the family is the constant in a child's life.	4	3	2	1
Facilitate parent / professional collaboration in all activities.	4	3	2	1
Honor racial, ethnic, cultural & socioeconomic diversity of families.	4	3	2	1
Recognize family strengths, individuality and respect different methods of coping.	4	3	2	1
Share with parents, complete and unbiased information.	4	3	2	1
Encourage and facilitate family-to-family support and networking.	4	3	2	1
Incorporate the developmental needs of infants, children and their families into all service.	4	3	2	1
Implement policies and programs that provide emotional and financial support to meet the needs of families.	4	3	2	1
Design accessible services that are flexible, culturally competent, and responsive to family-identified needs.	4	3	2	1

National Center for Family-Centered Care (1990). What is family-centered care? Bethesda, MD: ACCH

Goal Setting – Personal or Program Reflection:

Read through your responses and choose where to make changes **or** have the team analyze where the group would choose to make changes.

When working with families with children with disabilities, professionals should be scoring mostly 4s, maybe some 3s. Make a commitment to work on behaviors that do not score a four. First, work on behaviors scored 1s and 2s. Then move to 3s.

A goal may be a behavior that you would like to increase or decrease. It is important to remember that we can change behavior if we are willing to work for change.

Select one to three behaviors to work on throughout a specific period of time, i.e. a semester, a year.

Don't choose more than three goals, as they need to be realistic or you and your team members will become discouraged.

When you have met a goal, you can always add another new goal.

Remember to pat yourself or each other on the back for all that you or the team are doing well!!

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Handout 2.4
Family Strengths with Examples

Families with children with disabilities may have many needs and concerns, but they also have strengths. The challenge is that professionals have not always recognized the child's and family's strengths. Often the families themselves have not recognized their own strengths.

Professionals working with the family can talk about strengths with the family. The professional can point out strengths of the child or family. For example, at a home visit the visitor says to the mom,

> ***"I have noticed how often Maggie smiles at me when I arrive. I see her smiling at you too. This is really something special to get these beautiful smiles from her. I see it as one of her strengths!"***

Compliments about the child should be part of every home visit. Equally as important is to compliment the parent. Examples:

> ***"You are so patient with her."***
>
> ***"You are really good at figuring out what he wants!"***
>
> ***"You have been working so hard and now, look how well he is doing."***

Another example of strengths: The professionals working with this family know that dad works three jobs to take care of his family and they wonder if he ever has time with his family. By taking time to talk to the family and **listen** to their story, they would find out that dad **initiated** movie time every Saturday night with his children. The children choose the movie, dad makes popcorn and together they have a fun evening watching a movie together. An important strength of this family is that they set aside time to be together.

Families and professionals need to acknowledge the strengths as an avenue to working with the child. It is important to develop a strength-based philosophy, i.e. everyone has some strengths.

When you believe and think like this, strengths will "jump out" at you!

Share these strengths with the family.

Handout 2.5
Are You Building a Trusting Relationship? - Checklist

This is a self-evaluation. Read each statement made by a mother as she described what she feels builds trust with her Primary Care Provider. *Circle the response that best describes your behavior*.

	Always, almost always	More than half the time	Less than half the time	Never, almost never
You are prompt.	4	3	2	1
You are open and honest with me.	4	3	2	1
You listen to me, I mean really listen.	4	3	2	1
You try to understand what it is like to parent a child with a disability.	4	3	2	1
When I am upset or cry, you acknowledge and respond to my feelings.	4	3	2	1
You give me information I can use.	4	3	2	1
You demonstrate a deep caring for all members of my family.	4	3	2	1
You ask about my other children & my husband [significant other].	4	3	2	1
You get back to me when you say you will.	4	3	2	1
I can depend on you.	4	3	2	1

When working with families with children with disabilities, professionals should be scoring mostly 4s – Make a commitment to work on behaviors that do not score a four. Building trust is a critical part of developing strong, successful working relationships with families.

Blaska, J.K. (2011). Families: Relationships and boundaries, Paper presented at Part C: Service Coordination Training, St Paul, MN

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 2.6
Examples of Effective Questions

A few leading questions to assist in discovery:

- Tell me about...
- What would you like to change or do differently…?
- What does that mean for you…?
- What else can you tell me about…?
- How are you feeling about…?
- Help me understand...
- I'm curious about how/what…?
- What are your thoughts about...?
- What might that look like for you?
- It seems like_____, is that right?
- What might you want to know more about?

Questions that create forward movement in discussion:

- What would it take to create change on this issue?
- What could happen that would enable you/us to feel fully engaged and energized about…?
- What's possible here and who cares? (rather than "What's wrong here and who's responsible?")
- What needs our immediate attention going forward?
- If our success was completely guaranteed, what bold steps might we choose?
- What conversation, if begun today, could ripple out in a way that created new possibilities for the future of …?
- What seed might we plant together today that could make the most difference to the future of …? (Vogt, et al., 2003)

Asking reflective questions:

- What did you want to have happen?
- What's happening now?
- What have you tried?
- When does the behavior occur?
- Who is involved?
- How does this compare to what we know…?
- Tell me about a time when….
- Based on what you know now, what would you do differently next time?
- What does it mean when he…?
- What would you do if…?
- When are you going to…? (Hanft, et al., 2004)

Vogt, E., Brown, J., & Issacs, D. (2003). The art of powerful questions: Catalyzing insight, innovation and action. Daily Good: News That Inspires, p. 18.
Hanft, B.E., Rush, D.D. & Sheldon, M.L. (2004). Coaching families and colleagues in early childhood. Baltimore: Paul H. Brookes.

Handout 2.7
The Power of Language: Speak and Write Using "Person First"

The use of words or expressions when referring to persons with disabilities is very subtle and might seem unimportant. However, "when one considers that language is a primary means of communicating attitudes, thoughts, and feelings…the elimination of words and expressions that stereotype becomes an essential part of creating an inclusive environment" (Froschle, et al., 1984, p.20)

Use: child has a disability	**Instead of: disabled child**
Use: the boy with autism	**Instead of: the autistic boy**

A group of young children on a school outing entered the zoo with great excitement. One little boy worked his way through some people standing in a group enjoying the antics of the gorilla. He was moving slowly and made it near the front so he could see the gorilla too. His teacher gave him a "high-five" for his accomplishments of maneuvering his wheelchair. This student had a successful outing with his classmates.

The language used in this scenario promotes a positive image of a young man who is on an outing with classmates. Oh yes, he happens to have a disability! Compare this to the following scene:

A group of handicapped children *on a field trip with their* normal classmates *entered the zoo with excitement. One* wheelchair-bound *young man who* suffers *from cerebral palsy maneuvered his wheelchair through the group of people. His teacher praised the* disabled boy *for his efforts.*

The language describing this scenario produces an immediate image of a little boy in a wheelchair with a disability. By using the word handicapped early in the narrative to describe the children, the reader conjures up an image, based on his or her past experience of someone who is "handicapped," a term that is no longer used today. With this choice of language, it is difficult to get past the disability and recognize the abilities that are evident and create a negative image.

Avoid words such as these because they perpetuate negative stereotypes of people with disabilities:

handicapped	suffers from	confined
crippled	victim	drain or burden
stricken	disease	unfortunate

"We have a choice to continue to send negative messages which will be harmful to persons with and without disabilities or we can accept the challenge and **CHANGE OUR LANGUAGE**, which has the potential and power to positively impact society" (p. 31).

Blaska, J. K. (1993). The power of language: Speak and write using "person first." In M. Nagler (Ed.), Perspectives on disability (pp. 25-32). Palo Alto, CA: Health Markets Research.

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 2.8
Cross Cultural Communication

> ***"All facets of human life are influenced by culture, including child-rearing practices, food preferences, help-seeking behavior, and communication styles."***
>
> ***-Castro et al., 2011, p.27***

How to find out about a family's communication preferences:

- Listen to what the family says and watch for cues.
- Do not assume that you understand nonverbal cues; ask questions.
- Observe interactions between family members.
- Ask permission to address sensitive topics.
- Read information about the family's ethnic or cultural group to understand its history in the community.
- Be aware of differences in perceived power relationships.
- It is the ultimate responsibility of the professional to establish and maintain effective communication.
- Because first impressions are lasting, good communication begins with the first telephone call, or the first knock on the door.

Reflecting on your own communication style:

- Am I comfortable with direct eye contact?
- When I am in a conversation with someone, how much physical space do I need between me and the other person. How much if the person is a friend or relative?
- How do I react to people who are learning English or have accents different than my own?
- Do I talk more than I listen? How long do I wait for the other person to answer or respond to a question?
- Do I practice Active listening techniques?
- What messages do I communicate with my facial expression, posture, or tone of voice?
- Work with a colleague to increase comfort in communicating cross-culturally.

Important things to remember:

- Your cultural beliefs affect the way you serve children and families that are from cultures different from your own.
- Teachers and providers should be aware of the cultural and linguistic backgrounds of the children and families they serve in order to provide effective services.
- Understanding families' cultural perspectives is an integral part of family-centered Early Intervention services and is essential for early education programs to build partnerships with families.
- Everyone has the capacity to develop skills to work effectively with children and families who have diverse cultures, languages and abilities.
- It is important to participate in activities for learning about other cultures (e.g., take courses, read books, visit community centers, attend cultural activities).
- When you meet new people, be committed to getting to know them through your conversations and interactions with them, pushing away any bias or stereotypes.

Castro, D.C., Ayankoya, B.A., &Kasprzak, C. (2011). The new voices, nuevas voces: Guide to cultural & linguistic diversity in early childhood. Baltimore: Paul H. Brookes.

Handout 2.9
Cross Cultural Communication and Use of Interpreters

Use of Interpreters

Consecutive interpretation is the method generally used at home visits and meetings with families. This involves the interpreter changing the message from one language to another after the speaker's pauses (Castro et al., 2011).

Choosing an interpreter- Ideally the person:

- has had formal interpreter training
- knows the language of both parties
- is experienced in cross-cultural communication
- has excellent interpersonal skills
- has the ability to be sensitive to the feelings of all participants
- has the ability to understand the nuances of each participant's intended message
- has the ability to set aside emotions and opinions while interpreting
- has the basic understanding of the services and terminology that is used within the field

Cheatham (2010) has indicated when working with parents with cultural linguistic diversity, "Spoken parent-education interactions through language interpreters for parents who do not speak English can challenge early intervention/early childhood special education professionals." Research suggests that language interpretation is often inadequate to ensure that parental participation, informed parental consent, and interpretation mandates of IDEA (PL. 108-446) Parts B and C are met (p. 78).

Given the importance and complexities of the requirements of IDEA regarding parent participation, language interpretation and informed consent, EI/ECSE programs can work toward improving language interpretation for families by providing interpreters who have a high level of training in **four critical interpretation skills:**

- linguistic and cultural knowledge
- Early Intervention and Early Childhood Special Education knowledge
- interpretation practice, i.e. uses specific high quality interpretation practices
- explication and implementation of interpreter role, i.e. discuss intended role of interpreter prior to the meeting.
  (Cheatham, 2010, p. 82)

Handout 2.9
Cross Cultural Communication and Use of Interpreters, cont.

Guidelines for good interpreting

Service provider	Interpreter	Family
Use jargon free communication.	Address & respect the family's feelings about sharing personal information.	Use simple statements & questions.
Explain acronyms and avoid colloquialisms.	Maintain neutrality and confidentiality.	Speak slowly and clearly.
Use simple statements and questions.	Ask for explanations of jargon or acronyms.	Ask questions to clarify points if you don't understand or feel that you are not being understood.
Speak slowly and clearly but not loudly.	If needed, ask participants to speak or sign more slowly and to stop side conversations.	If you do not understand the interpreter, stop the meeting and request another interpreter.
Listen without judgment.		
Be aware of nonverbal behaviors		
Address family members directly, do not only look at interpreter.		

Moore, S., Perez-Mendez, C. Beatty, J., & Eiserman, W. (1999). A three-way conversation: Effective use of cultural mediators, interpreters and translators. Denver, CO: Western Media Productions.

Castro, D.C., Ayankoya, B.A., & Kasprzak, C. (2011). The new voices, nuevas voces: Guide to cultural & linguistic diversity in early childhood. Baltimore: Paul H. Brookes.

Cheatam, G.A., (2010). Language interpretation, parent participation, and young children with disabilities. Topics in Early Childhood Special Education, 31(2), 78-88.

Handout 2.10
Diffusing Tension and Preventing Conflict: What to Do and What Not to Do

Occasionally you will have a parent be angry, frustrated or aggressive for a number of reasons. It may be difficult to know how to handle this type of behavior.

If you have a plan for resolving conflict, it will give you the confidence to move forward.

Do the following:	Don't do the following:
Listen	Argue
Write down what the parent says.	Defend or become defensive
When the parent slows down, ask what else is bothering him or her.	Promise things you can't produce
Exhaust the parent's list of complaints.	Own problems that belong to others
Ask the parent to clarify any specific complaints that are too general	Raise your voice
Show your list and ask if it is complete.	Belittle or minimize the problem
Ask for suggestions for solving any of the problems listed.	
Write down the suggestions.	
As much as possible, mirror the person's body language.	
As the person speaks louder, speak softer.	

Taking these steps does not guarantee you can resolve the conflict, but gives you positive steps to take. You may need to each go home and consider the results of this meeting and have a second opportunity to talk and resolve what is happening.

Make a plan, with the parent, to check in and follow-up within the next week.

Kroth, R.L., & Edge, D. (1997). Strategies for communicating with parents and families of exceptional children (3rd Ed.). Denver, CO: Love Publishing Co.

Handout 2.11
Understanding the Need for Boundaries

"The term boundary is a metaphor for rules or limits, which can lead to a sense of safety. Generally, this sense of safety evolves from having an appropriate balance of closeness or distance in the relationship" (Nelson, et al., 2004, p. 153). "Boundaries are the limits that allow for a safe connection based on family needs" (Peterson, 1992).

The fields of social work and counseling have codes of ethics that provide guidelines for creating boundaries in working relationships. Education does not have these so each professional must be aware of developing appropriate boundaries.

In Part C programs, closeness develops when the primary care provider is working in the home. This is an intimate environment and the fact that babies are held and cradled creates close relationships. This provider is asked to identify family routines where outcomes can be embedded, which requires openness on the part of the parent. Practices such as these can increase the likelihood of boundary issues occurring.

Nelson, et al. (2004) suggest that it is important for parents and their primary care provider discuss expectations that each has of the parent-professional relationship. But Nelson emphasizes that prior to this discussion, professionals must, "think through their own preferences about relationship boundaries and also the feasibility of their going beyond the call of duty" eg. giving out a home phone number, making visits at nontraditional times of day (p. 163).

Providers who consistently "go the extra mile" (eg. sending birthday cards, going to doctor appointments) and spend time at home worrying about the family need to examine their boundaries as this pattern of involvement can lead to burn-out. It is important to understand the provider role is a helping role but does not replace or usurp the parenting role. The goal is to empower parents so they can be effective in parenting.

Being courteous, thoughtful and realistically available is necessary to establish trusting relationships with the families, yet remains within the scope of being an effective teacher without crossing boundaries.

Nelson, L.G., Summers, J.A., & Turnbull, A.P. (2004). Boundaries in family-professional relationships. Remedial and Special Education, 25(3), 153-165.

Handout 2.12
Maintaining Confidentiality - Checklist

Respond to each of the statements by circling a number to indicate how often you do or do not do what is described.

	Always, almost always	More than half the time	Less than half the time	Never, almost never
All records, including results of evaluations are kept confidential.	4	3	2	1
File drawers containing records of children with disabilities are locked when the Service Coordinator and Specialists leave the building.	4	3	2	1
After making home visits, staff only share information with colleagues who are members of the team.	4	3	2	1
If anyone outside the education team asks about one of your families, you indicate that the information is confidential.	4	3	2	1
Service Coordinators and Specialists are prepared to deflect questions seeking inappropriate personal information.	4	3	2	1
Service Coordinators and Specialists do not discuss Information about a child in a public place, i.e. faculty lounge, hallway.	4	3	2	1
School's confidentiality policies and procedures are reviewed annually and consistently followed.	4	3	2	1
If Service Coordinator or Specialists realize they made a breach, they would know to talk to their supervisor as soon as possible.	4	3	2	1

Adapted from: Doyle, M.B. (2008). The paraprofessionals guide to the inclusive classroom. Baltimore: Paul H. Brookes.

Handout 2.12
Maintaining Confidentiality – Checklist, cont.

Goal Setting – Personal or Group:

Read through your responses and choose where to make changes or have the team analyze where the group would choose to make changes.

When working with families with children with disabilities, professionals should be scoring mostly 4s, maybe some 3s. Make a commitment to work on behaviors that do not score a four. First, work on behaviors scored 1s and 2s. Then move to 3s.

A goal may be a behavior that you would like to increase or decrease. It is important to remember, we can change behavior if we are willing to work for change.

Select one to three behaviors to work on throughout a specific period of time, e.g. Six months, or a year.

Don't choose more than three goals, as it needs to be realistic or team members will become discouraged.

When you have made a change, you can always add another new goal.

Remember to pat yourself or each other on the back for all that you or the team are doing well!!

Handout 2.13
Self-Evaluation for Clear and Respectful Communication - Checklist

Respond to each of the statements by circling a number to indicate how often you do or do not do what is described in the statement.

	Always, almost always	More than half the time	Less than half the time	Never, almost never
Avoid making assumptions.	4	3	2	1
Avoid jargon and explain technical terms.	4	3	2	1
Share complete, honest and unbiased information.	4	3	2	1
Offer opinions and specify that these are suggestions and they are not the only options.	4	3	2	1
Respond to questions directly and specify when the answer is not known.	4	3	2	1
Avoid patronizing language and tone.	4	3	2	1
Recognize individuals' differing abilities to understand.	4	3	2	1
Clarify mutual expectations.	4	3	2	1
Realign the power. Partnerships will grow when families are treated as equals.	4	3	2	1
Respect different cultural perspectives.	4	3	2	1
Respect constraints in families' time and resources.	4	3	2	1
Nod and respond to nonverbal cues.	4	3	2	1
Create opportunities for open communication (p. 223).	4	3	2	1

Adapted from Hanson, M.S. & Lynch, (2004). Understanding families: Approaches to diversity, disability, and risk. Baltimore: Paul H. Brookes.

Handout 2.13
Self-Evaluation for Clear and Respectful Communication - Checklist, cont.

Personal Goal Setting

Read through your responses and choose where to make changes. When working with families with children with disabilities, professionals should be scoring mostly 4s, maybe some 3s. Make a commitment to work on behaviors that do not score a four. First, work on behaviors scored 1s and 2s. Then move to 3s.

A goal may be a behavior that you would like to increase or decrease. It is important to remember, we can change behavior if we are willing to work for change.

Select one to three behaviors to work on throughout a specific period of time, eg. six months, a year.

Don't choose more than three goals, as it needs to be realistic or you will become discouraged.

When you have made a change, you can always add another new goal.

Remember to pat yourself or each other on the back for all that you or the team are doing well!!

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

References

Blaska, J.K. (2011). Families: Relationships and boundaries. Paper presented at Part C: Service Coordination Training, St. Paul, MN

Blaska, J.K. (1998). Cyclical Grieving: Reoccurring emotions experienced by parents who have children with disabilities. (ERIC Document Reproduction Service No. ED 419 349)

Blaska, J.K. (1997). Does grief reoccur for families who have children with disabilities? Practical Update, 1(3), 2-5.

Blaska, J.K. (1993). The power of language: Speak and write using "person first." In M. Nagler (Ed.), Perspectives on disability (pp. 25-32). Palo Alto, CA: Health Markets Research.

Castro, D.C., Ayankoya, B. & Kasprzak, C. (2011). The new voices, Nuevas Voces: Guide to cultural and linguistic diversity in Early Childhood. Baltimore, MA: Paul H. Brookes Publishing.

Cheatham, G. A. (2010). Language interpretation, parent participation, and young children with disabilities. *Topics in Early Childhood Special Education,* 31(2) 78-88.

Doyle, M. B. (2008). *The paraprofessional's guide to the inclusive classroom.* Baltimore: Paul H. Brookes.

Dunst, C. J. (1999). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA, Brookline Books.

Hanft, B.E., Rush, D.D., & Sheldon, M.L. (2004). Coaching families and colleagues in early childhood. Baltimore: Paul H. Brookes.

Hanson, M.J. & Lynch, E.W. (2004). *Understanding families: Approaches to diversity, disability, and risk.* Baltimore, MA: Paul H. Brookes Publishing.

Individuals with Disabilities Education Act (2004), Pub.L. No. 108-446

Kroth, R.L. & Edge, D. (1997). *Strategies for communicating with parents and families of exceptional children* (3rd Ed.). Denver, CO: Love Publishing Co.

McWilliam, P.J. (2010). Talking to Families. In McWilliam, R.A. (Ed.), *Working with families of young children with special needs* (pp. 127-146). New York: The Guilford Press.

McWilliam, R.A. (2010a). *Routines-Based Early Intervention.* Baltimore: Paul H. Brookes.

Moore, S., Perez-Mendez, C., Beatty, J., & Eiserman, W. (1999). A three-way conversation: Effective use of cultural mediators, interpreters and translators. Denver, Co: Western Media Products.

National Center for Family-Centered Care. (1990). *What is family-centered care?* Bethesda, MD: ACCH.

Nelson, L. G., Summers, J. A., & Turnbull, A. P. (2004). Boundaries in family- professional relationships. *Remedial and Special Education,* (25)3, 153-165..

Parlakian, R. (2001a). *Look, listen, and learn: Reflective supervision and relationship-based work.* Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families.

Parlakian, R. (2001b). *The power of questions: Building quality relationships with families.* Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families.

Vogt, E., Brown, J., & Issacs, D. (2003). The art of powerful questions: Catalyzing insight, innovation and action. *Daily Good: News That Inspires,* p.18.

Resources

The Core of a Good Life: Guided Conversations with Parents on Raising Young Children with Disabilities. Waisman Center, University of Wisconsin-Madison

http://www.waisman.wisc.edu/naturalsupports/

Family-Professional Partnership Scale (Family version) – a checklist indicating how satisfied parent is with their teacher.

http://community.fpg.unc.edu/connect-modules

Zero to Three: National Center for Infants, Toddlers, and Families

http://zerotothree.org/bookstore

Booklets:

The power of questions: Building quality relationships with families

Look, listen, and learn: Reflective supervision and relationship-based work

"Talking to Families Checklist"

McWilliam, P.J. (2010). Talking to Families. In McWilliam, R.A. (Ed.). *Working with families of young children with special needs* (pp.144-146). New York: The Guilford Press.

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MINNESOTA SERVICE COORDINATION MODULES

MODULE 3 - HANDOUTS

Table of Contents

Handout 3.1
Family-Guided Routines Based Intervention (FGRBI)

Considerations for Planning Routines Based Intervention

Routines are an appropriate context for teaching and learning because they offer a familiar framework for caregivers to support the child to develop more sophisticated skills. The overall goal of FGRBI is to provide coaching to the family.

Routines based intervention is a systematic approach that is individualized to accommodate the child's skills and preferences with the caregiver's sequence and steps of daily routines. Outcomes for the child are based on child and family routines and activities.

The IFSP outcomes targeted within the routine must be:

* relevant to the needs of the child
* developmentally appropriate
* easily integrated within the routine
* organized to increase the child's
* observable and measurable
* functional use of the skill

Opportunities for teaching and learning on each target should be:

* embedded logically not to interfere with the routine,
* provided by the care provider with appropriate instruction or support,
* sufficient for acquisition of the skill to occur but dispersed naturally throughout the routine, as appropriate.
* repeated in a predictable framework, and
* varied for generalization to occur

Family-guided routine based intervention uses what the child and family does and embeds intervention; not the reverse. The family's preferences provide the foundation. Intervention is added when and where it is more comfortable and compatible. Our purpose is not to train parents to be interventionists – to do what we do. Our purpose is to include what will help the child learn and gain independence in typical activities as they occur within the life of the child and family.

References

Cripe, J.W. & Venn, M.L. (1997). *Family-guided routines for early intervention services.* Young Exceptional Children, 18-26.

Synder-McLean, L.K., Solomonson, B., McLean, J. & Sack, S. (1984). *Structuring joint action routines: A strategy for facilitating communication and language development in the classroom.* Seminars in Speech and Language, 5, 213-228.

Florida State University regarding Family Guided Routines Based Intervention (FGRBI) http://fgrbi.fsu.edu/

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 3.2
Support-Based Home Visits

The majority of children served under Part C of the Individuals with Disability Education Act (IDEA) are reported as receiving services in the home. Yet, there is limited literature providing data on effective home visiting.

McWilliams (2010b) recognized the need for a home visit approach and developed the Support-Based Home Visiting Model based on related research, which is outlined in his book.

McWilliam's (2010b) model is based on five key principles:

1. **It's the family that influences the child, and we can influence the family**. Families have greater influence over children than do home visitors who might only see the child for one hour a week.

2. **Children learn throughout the day**. Children do not learn in clumps of instruction or therapy that requires the processing of multiple rapid-fire inputs.

3. **Early intervention is not about providing weekly lessons**. In addition to the fact that young children learn through distributed trials, they have difficulty transferring from a structured "lesson" to regular routines.

4. **All the intervention for the child occurs between visits.** The function of the home visit needs to shift from direct intervention with the child to support of the caregivers.

5. **It's maximal intervention the child needs, not maximal services.** If the first four principles above are followed, the child's many learning opportunities are maximized and optimized. Regular caregivers' interventions with children are not affected by having more professionals providing more services (p. 208).

There are four problems with the clinic-based approach used today:

* It suggests that child change occurs as a result of home visits, rather than as a result of all the family-child and other adult-child interactions that occur between visits.

* It oversimplifies the needs that should be addressed in home visits, as though they were simply to provide developmental interventions to the child, which leads to the next problem.

* It promotes the "got a need, get a service" mentality, requiring a specialist for every need.

* It falls victim to the "model and pray" notion of how home visits work; that is, that the home visitor models & then prays the family was attending and imitates later (p. 208).

The antidote to the "model and pray" approach is the eight steps to modeling:

1. Talk to the parent about your suggestion.
2. If the parent appears not to understand, ask if he or she would like to be shown.
3. Tell the parent what you're going to do.
4. Do it.
5. Tell the parent what you did and point out the consequence.

Handout 3.2
Support-Based Home Visits, cont.

6. Ask the parent if he or she would like to try it.
7. If the answer is "yes," watch the parent trying it; if the answer is "no," leave it alone.
8. If yes, praise the parent and give limited amount of corrective feedback (p. 216).

McWilliams, R.A. (Ed.). (2010b). Working with families of young children with special needs. New York: The Guilford Press.

References

Cripe, J. W. & Venn, M. L. (1997). Family-guided routines for early intervention services. *Young Exceptional Children*, 1(1), p. 18-26.

Dunst, C., Bruder, M. B., Trivett, C. M., Raab, M., & McLean, B. (2001). Natural learning opportunities for infants, toddlers and preschoolers. *Young Exceptional Children*, 4(3), 18-25.

Edleman, L. (1999). A guidebook: Early childhood supports and services in everyday routines, activities, and places. *Early Childhood Connections*. Colorado Department of Education.

Florida State University regarding Family Guided Routines Based Intervention.

(FGRBI). http://www.fgrbi.fsu.edu/

Individual with Disabilities Act of 2004 (IDEA), Pub.L., No. 108-446

McWilliam, R. A. (2000). It's only natural…to have early intervention environments where it's needed. In S. Sandall & M. Ostrosky (Eds.), *Young Exceptional Children Monograph Series No. 2* (pp. 17-26). Denver, CO: Division for Early Childhood of the Council of Exceptional Children.

McWilliam, R. A, (2010a). Routines-based early intervention: *Supporting young children and their families.* Baltimore: Brookes Publishing.

McWilliam, R. A. (Ed.). (2010b). *Working with families of young children with special needs.* Baltimore: Brookes Publishing.

Minnesota Statute 2010, 125A.33 and 125A.27.

National Workgroup on Principles and Practices in Natural Environments (November, 2007). *Mission and principles for providing services in natural environments.* OSEP TA Community of Practice- Part C Settings.

http://www.nectac.org/topics/families/families.asp

Part C of IDIEA, 2004, 34 C.F.R 303.18.

Snyder-McLean, L. K., Solomonson, B., McLean, J. & Sack, S. (1984). *Structuring joint action routines: A strategy for facilitating communication and language development in the classroom.* Seminars in Speech and Language, 5, 213-228.

Resources

National Workgroup on Principles and Practices in Natural Environments (February, 2006). *Seven key principles: Looks like/doesn't look like.* OSEP TA Community of Practice – Part C Settings.

http://www.nectac.org/topics/families/families.asp

Sandall, S. & Ostrosky (Eds.). (2000). *Young exceptional children monograph series No. 2: Natural environments and inclusion.* Denver, CO: The Division for Early Childhood of the Council for Exceptional Children.

http://www.cec.sped.org/scriptcontent/orders/ProductDetailcfm?pc=s5420

Technical Assistance Center on Social Emotional Intervention for Young Children.

(TACSEI) http://www.challengingbehavior.org

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MODULE 4 - HANDOUTS

Table of Contents

Handout 4.1
Native Language (34 C.F.R. 303.25)

Definition of Native Language

"(a) *Native language,* when used with respect to an individual who is limited English proficient or LEP (as that term is defined in section 602(18) of the Act), means—

(1) The language normally used by that individual, or, in the case of a child, the language normally used by the parents of the child, except as provided in paragraph (a)(2) of this section; and

(2) For evaluations and assessments conducted pursuant to §303.321(a)(5) and (a)(6), the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.

(b) *Native language,* when used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, means the mode of communication that is normally used by the individual (such as sign language, braille, or oral communication).

(34 C.F.R. 303.25)

Identifying the Native Language

- Districts and charter schools must determine the primary home language of ALL students.
- A home language questionnaire (HLQ) is completed for all students who enroll in a school district. How the student sounds in English should not determine whether or not an HLQ is completed.
- When identifying the native language of a child, three key questions need to be asked of the parent/caregiver.

1. Which language did your child learn first?
2. Which language is spoken (used) most often in your home?
3. Which language does your child usually speak (use)?

Resource for Identifying the Native Language

The Home Language Questionnaire is a tool to assist in identifying the native language of children and parents. This tool is available on the Minnesota Department of Education website.at http://education.state.mn.us/MDE/JustParent/EngLearn/.

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.2
Defining Parent (34 C.F.R. 303.27

"(a) *Parent* means—

(1) A biological or adoptive parent of a child;

(2) A foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;

(3) A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);

(4) An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or

(5) A surrogate parent who has been appointed in accordance with §303.422 or section 639(a)(5) of the Act.

(b)(1) Except as provided in paragraph (b)(2) of this section, the biological or adoptive parent, when attempting to act as the parent under this part and when more than one party is qualified under paragraph (a) of this section to act as a parent, must be presumed to be the parent for purposes of this section unless the biological or adoptive parent does not have legal authority to make educational or early intervention service decisions for the child.

(2) If a judicial decree or order identifies a specific person or persons under paragraphs (a)(1) through (a)(4) of this section to act as the "parent" of a child or to make educational or early intervention service decisions on behalf of a child, then the person or persons must be determined to be the "parent" for purposes of part C of the Act, except that if an EIS provider or a public agency provides any services to a child or any family member of that child, that EIS provider or public agency may not act as the parent for that child." (34 C.F.R. 303.27)

Identifying the Parent

The school district must identify the legal parent in order to determine who has the legal right to sign consent for the district to proceed with screening, evaluation, program placement and other IFSP or legal documents requiring authorized signatures.

(34 C.F.R. 303.27)

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.3

45 Day Timeline (34 C.F.R. 303.9; MN Rule 3525.3790)

In an effort to determine the 45 day timeline, an important step is to define a "day". Section 303.9 defines a "day" as a calendar day, unless otherwise indicated.

MN Rule 3525.3790 clarifies that in computing any period of time prescribed by this chapter, the day of the event from which the designated period of time begins to run shall not be included. The last day of the time period shall be included, unless it is a Saturday, Sunday or a legal holiday, in which case the time period ends on the next day which is not a Saturday, Sunday or legal holiday.

Federal law assures that an IFSP meeting must take place within 45 days from the date the lead agency or Early Intervention Service (EIS) provider receives a referral. It also establishes two circumstances in which the 45 day timeline would not apply:

1. When the child or parent is unavailable due to exceptional family circumstances and
2. When the parent has not provided written consent despite documented requested attempts

Both of these exceptions must be documented in the child's early intervention record. The initial evaluation and initial assessment activities must be completed as soon as possible after the documented circumstance no longer exists. In addition, the initial family-directed assessment must be completed within the 45 day timeline, if the parent concurs.

The following are examples of **exceptional family circumstances** that may result in the 45 day timeline not applying:

*Illness of child or parent

*Family scheduling conflicts such as vacation or moving

*Other parent requested considerations

Some examples of **systems-related reasons** for not meeting timelines include:

*Inadequate capacity with existing providers (i.e. district decision not to contract for additional provider time, or district decision not to post for additional providers or inability to hire necessary qualified staff)

*Delay in securing services of an interpreter

*Referral received outside of the provider contract year

*Difficulty coordinating schedules of evaluation team members

*Referral received just prior to scheduled break in instruction

*Unanticipated absence of evaluation team member

*Delayed communication between central point of entry and evaluation team

*Inadequate documentation of reasons for untimeliness

****When the timeline is not met for systems-related reasons, it will result in a finding of non-compliance**.

Handout 4.3
45 Day Timeline (34 C.F.R. 303.9; MN Rule 3525.3790), cont.

Minnesota Department of Education

MN Rule 3525.3790 Time Computation

- In computing any period of time prescribed by this chapter, the day of the event from which the designated period of time begins to run shall not be included

- The last day of the time period shall be included, unless it is a Saturday, Sunday, or a legal holiday, in which case the time period ends on the next day which is not a Saturday, Sunday, or a legal holiday

45-Day Timeline: Application

A referral is faxed to your program from the local clinic. It is date stamped at 11:30 AM on Saturday May 12. You read the referral for the first time on Monday, May 14. What is the last possible date that an IFSP team meeting can be held and still meet Part C's 45-day timeline?

May 2012

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June 2012

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Tuesday, June 26=Answer

Handout 4.3

45 Day Timeline (34 C.F.R. 303.9; MN Rule 3525.3790), cont.

A referral arrives in your office on April 11, 2012 at 4:30. When is the LAST possible date you could hold an initial IFSP meeting for this eligible child within the 45 day time line?

April 2012

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 2012

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Tuesday, May 29= Answer

(34 C.F.R. 303.9; MN Rule 3525.3790)

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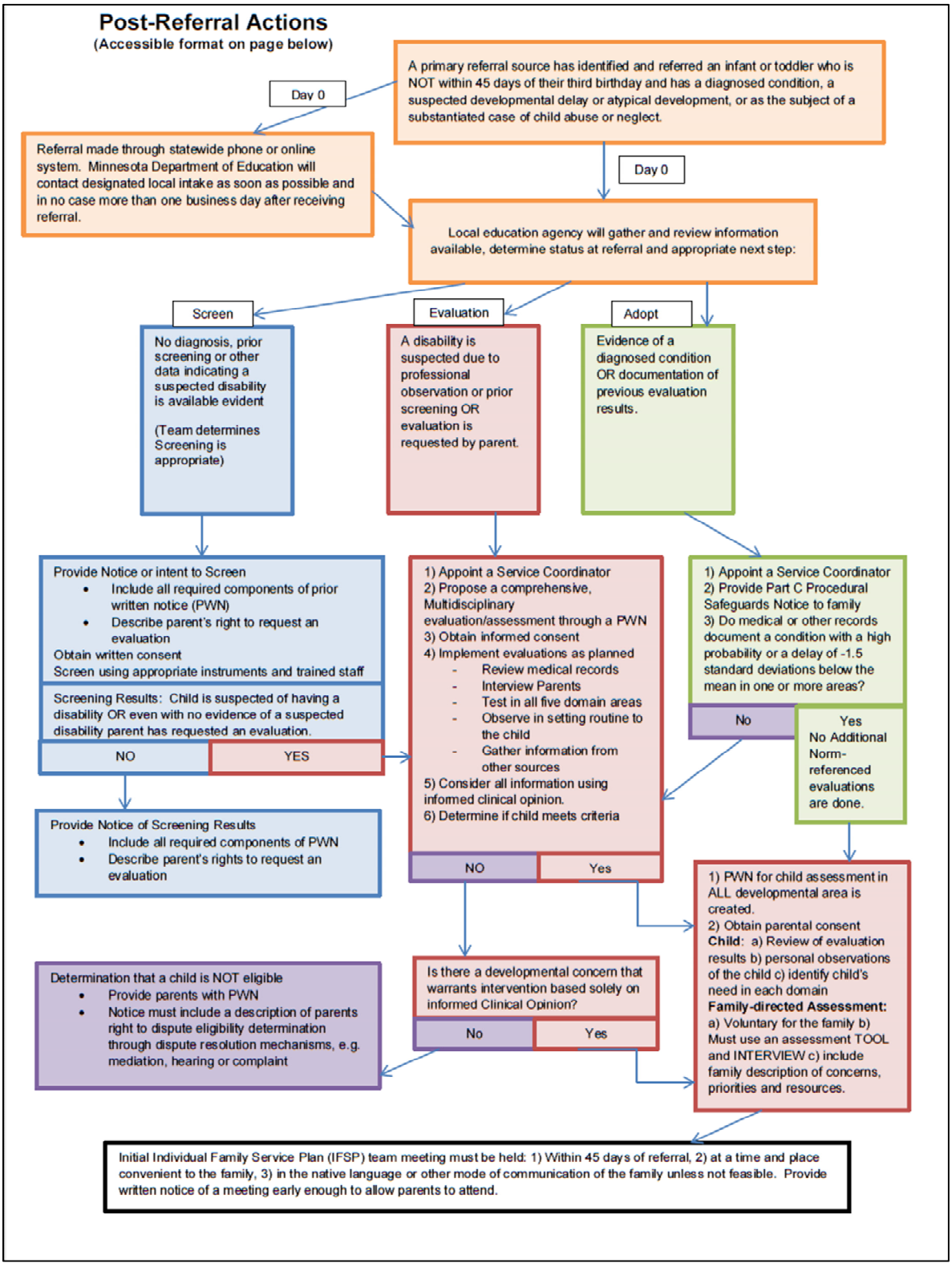
Handout 4.4
Post-Referral Actions

http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/index.html



Handout 4.4
Post-Referral Actions, cont.

Minnesota Department of Education
1500 Highway 36 West
Roseville, MN 55113-4266
651-582-8200

Receiving a referral

1) A primary referral source has identified and referred an infant or toddler who is NOT within 45 days of their third birthday and has a diagnosed condition, a suspected developmental delay or atypical development, or as the subject of a substantiated case of child abuse or neglect.

2) Referral made through statewide phone or online system. Minnesota Department of Education will contact designated local intake ASAP and in no case more than one business day after receiving referral or local education agency will receive referral and determine the appropriate next step.

Acting on a referral: Screen

1) No diagnosis, prior screening or other data indicating a suspected disability is available so the team determines screening is appropriate.

2) Provide prior written notice or intent to screen and make sure to include all required components of prior written notice and describe parent's right to request an evaluation at any point during screening.

3) Obtain written consent.

4) Screen the child using appropriate instruments and trained staff.

5) If the screening results indicate that the child is suspected of having a disability OR even with no evidence of a suspected disability the parent has requested an evaluation, begin the evaluation and assessment process described below.

6) If the screening results indicate that the child is NOT suspected of having a disability and parents have not requested an evaluation, provide prior written notice containing screening results. Include all required components of the prior written notice and make sure to describe parent's rights to request an evaluation.

Handout 4.4
Post-Referral Actions, cont.

Acting on a referral: Evaluation and Assessment

1) A disability is suspected due to professional observation or prior screening OR
2) evaluation is requested by parent. The team determines evaluation is appropriate.
3) Team will appoint a Service Coordinator for the family. The Service Coordinator will propose a comprehensive, multidisciplinary evaluation/assessment through a prior written notice.

4) Obtain informed consent from the parents.

5) Implement evaluations as planned. Make sure to review medical records that are available and interview parents regarding their concerns and observations. Make sure the evaluation includes evaluations of all five domain areas, observations in settings routine to the child and contains information from other sources as appropriate.

6) Consider all information using informed clinical opinion.

7) Determine if child meets criteria.

8) If child does meet eligibility criteria parents must have also given written consent on a prior written notice for the child assessment in ALL developmental areas. (This consent could have been obtained on the original prior written notice for evaluation.)

9) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child's need's in each domain. A criterion referenced tool may be used.

10) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

11) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date.
    a. Make sure that the meeting is at a time and place convenient to the family. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough to allow parents and other required team members to attend.

Handout 4.4
Post-Referral Actions, cont.

Acting on a referral: Informed Clinical Opinion

1) AFTER formal evaluation procedures have been conducted as described above the team determines that the child does not meet eligibility criteria based upon standardized evaluation measures. The team may choose to use informed clinical opinion to establish eligibility for Developmental Delay under Part C.

2) If the team believes the child does meet eligibility standards under this decision the parents must also give written consent on a prior written notice for the child assessment in ALL developmental areas.

3) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child need in each domain. A criterion referenced tool may be used.

4) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

5) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date.
    a. Make sure that the meeting is at a time and place convenient to the family. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough to allow parents and other required team members to attend.

Acting on a referral: Independent Evaluation will be adopted

1) Evidence of a diagnosed condition OR documentation of previous evaluation results have been given to the educational team. Review of this data indicates that child has met the eligibility criteria for an infant or toddler with a disability under Part C criteria.

2) The team will appoint a Service Coordinator. The Service Coordinator will provide Part C procedural safeguards notice to family.

3) The parents must give written consent on a prior written notice for the child assessment in ALL developmental areas.

4) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child need in each domain. A criterion referenced tool may be used.

Handout 4.4
Post-Referral Actions, cont.

5) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

6) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date. Make sure that the meeting is at a time and place convenient to the family.
   a. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough
   b. to allow parents and other required team members to attend.

Acting on a referral: Evaluation and application of Informed Clinical Opinion results in NO eligibility

1) Formal evaluation and applied use of informed clinical opinion has determined that the child is NOT eligible; does not have a disability.

2) Provide parents with prior written notice describing outcome of the evaluation process. This notice must include a description of parent's right to dispute eligibility determination through dispute resolution mechanisms, e.g. mediation, hearing or complaint.

3) If available, provide information about community programs, resources and services.

education.state.mn.us

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.5
Prior Written Notice (PWN) (34 C.F.R. 303.403; 303.41)

A Prior Written Notice (PWN) is required by Federal Law (34 C.F.R. 303.403 (a) at several points throughout the screening, evaluation and implementation of services in Part C. A Prior Written Notice (PWN) is a written document that must be given to parents within a reasonable timeframe before each time a school district proposes to initiate or change, or refuses to initiate or change, the identification, evaluation and education placement of a child or the provision of appropriate early intervention services to a child and family. 34 C.F.R. 303.403 (a)

A PWN is required:

*Prior to screening—intent to screen

*After screening when results indicate no suspicion of a disability or need to evaluate

*Initial evaluation and assessment for Part C

*Determination that a child is not eligible for Part C

*Initiating early intervention services

*Ongoing assessment

*Changing placement or provision of early intervention services

There are some general components of a Part C Prior Written Notice (PWN). They include:

1. The **action** that is being proposed or refused
2. The **reasons** for taking the action
3. All **procedural safeguards** that are available under this subpart, including a description of mediation, how to file a complaint and a due process complaint….and any applicable timelines

Written in **language understandable** to the general public and provided in the native language…or other mode of communication of the parent, unless clearly not feasible to do so. If the native language or other mode of communication of the parent is not a written language, the local education agency (LEA) must take steps to ensure that a) the notice is translated orally or by other means to the parent in the parent's native language or other mode of communication; b) the parent understands the notice; and, c) there is written evidence that the requirements of this paragraph have been met.

Some specific examples of a Prior Written Notice (PWN) for Part C:

Example 1: Screening

1. Description of what the district will do: *the district will conduct a developmental screening of Tyler using the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social Emotional (ASQ-SE).*
2. Explanation of why: *Tyler's parents are concerned that Tyler is developing more slowly than his cousins. The information obtained through screening will be used to determine whether or not Tyler is suspected of being a toddler with a disability.*
3. *You have the right to request an evaluation at any time during the screening process.*

Handout 4.5
Prior Written Notice (PWN) (34 C.F.R. 303.403; 303.41), cont.

Example 2: Evaluation and Assessment

1. Description of what the district will do: *The district will conduct an initial evaluation of your child. More specific information about the evaluation tools and procedures is documented below. If the scores on one or more of the five developmental domains on the Battelle Developmental Inventory-2 indicate that your child is eligible for early intervention, the district also proposes to conduct an assessment of your child in each of the five domains in order to identify your child's unique strengths and needs and the early intervention services appropriate to meet those needs. We also ask you to participate in a family-directed assessment to learn more about the concerns, priorities and resources of your family related to enhancing your child's development. The specific assessment activities are described below.*
2. Explanation of why: *The district is proposing this evaluation because the results of the screening conducted on 5/1/2012 indicate that your child is suspected of being a child with a disability. The district is proposing the child assessment if your child is determined eligible to provide information needed to develop an Individual Family Service Plan (IFSP) that will address any identified developmental needs and build upon your child's strengths.*

Example 3: Screening results indicate no suspected disability

1. Description of what the district will NOT do: *The district will not conduct an evaluation of your child at this time.*
2. Explanation of why: *The scores obtained from the Ages and Stages Questionnaire and the Ages and Stages Questionnaire Social Emotional were well above the cut-off for concern in the areas of Gross Motor, Fine Motor and Communication. The scores were above the cut-off in the areas of Problem-Solving and Personal-Social.*
3. *Even though the screening indicates that your child is not suspected of having a disability, you may still request an evaluation.*

Example 4: Initial assessment when eligibility is determined through a review of records

1. Description of what the district will do: *The district will conduct an initial assessment of your child. More specific information about the assessment tools and procedures is documented below.*
2. Explanation of why: *The district is proposing an initial assessment of your child to gather information needed to develop an Individual Family Service Plan (IFSP) that will address any identified developmental needs for your child and build upon your child's strengths.*

Handout 4.5
Prior Written Notice (PWN) (34 C.F.R. 303.403; 303.41), cont.

Example 5: Determination that a child is NOT eligible following a comprehensive evaluation

1. Description of what the district will NOT do: *The district will not provide early intervention services to your child and family at this time.*
2. Explanation of why: *The comprehensive initial evaluation conducted between May 10th and May 21st indicates that your child is meeting age-expectations in the developmental areas of communication, cognition, social skills, self-help and physical development.*
3. *You have a right to dispute this eligibility determination through alternative dispute resolution options, such as mediation, filing a state complaint or requesting a due process hearing. Basic information about these options is included in this notice. Information about these options can be found in the attached Procedural Safeguards Notice.*

Example 6: Initiation of services and ongoing assessment

1. Description of what the district will do: *The district will implement the initial Individual Family Service Plan (IFSP) for early intervention services as discussed at the IFSP Team meeting held on May 21. Please see the attached IFSP. The district will also assess your child's emerging development throughout the period covered by this IFSP using the Carolina Curriculum for Infants and Toddlers with Special Needs. The Carolina Curriculum will be completed during June and updated at least monthly thereafter.*
2. Explanation of why: *Your child has been found to be eligible for early intervention services. The IFSP addresses your child's unique needs and your priorities for your child and family. Ongoing assessment will provide information that will allow your child's IFSP team to monitor your child's Developmental progress across domains and promptly act upon any future developmental concerns.*

Example 7: Revision to IFSP following periodic or annual review

1. Description of what the district will do: *The district will implement the attached Individual Family Service Plan (IFSP). This IFSP was revised during the periodic review conducted on May 21. The revised plan increases the frequency of Family Training visits made by the ECSE teacher from 40 visits to 50 visits. The revised plan also includes a new outcome that focused on increasing Tyler's independent play with toys.*
2. Explanation of why: *Ongoing assessment and family concerns have identified a delay in Tyler's emerging play skills. The revised IFSP provides greater support for Tyler's family and emphasis on this newly identified need.*

(34 C.F.R. 303.403; 303.41)

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.6
Connecting Families to Community Resources

A. Building Relationships

- Building a relationship with the parent is essential and starts with the initial phone call.
- Be sensitive as this phone call is a reminder to the parent that there is a concern about their child.
- Explain who you are, where you got their name and ask if the parent has time right now for a short conversation.
- Explain the first step in the process and what is expected of the parent. If mailing questionnaires, let them know that.
- Let the parent know that you are gathering information from them because they know their child so well and can provide the beginning of the road map to meeting family needs.

At the initial visit it will be important to get a broad look at family needs by engaging the parent around what they perceive the developmental or behavioral issue is. Review whatever written information the parent is providing, such as an Ages and Stages Questionnaire, before asking other questions.

Key questions about birth and medical history, as well as developmental milestones will help the service coordinator begin to see patterns in either the child's development or in family needs

B. Strategies to Connect Families to Community Resources:

1. Map the community
   - Use success stories from current families to identify helpful community resources.
   - Meet with medical staff (pediatricians, family practice doctors or nurse case managers) to determine common practices such as developmental or hearing screening and work together to determine best practice in your community for identifying children who are delayed or at high risk for delay.
   - Meet with county nursing and social work staff to determine what services your county provides. If you work across counties, services will likely differ between counties.

Sources of Information
-Information will be gathered from the initial visit, during subsequent visits and, if the child qualifies, during the child and family directed assessment.
-This information will assist the team to determine the families concerns, needs, resources and priorities.

2. Map the family

   Gather information about informal and formal resources that the family is already utilizing.

   - An eco-map is a graphical representation that shows all of the systems at play in an individual's life and is a tool used to depict relationships between family members and other people in their environment. (A sample and instructions for how to draw an eco-map are attached)

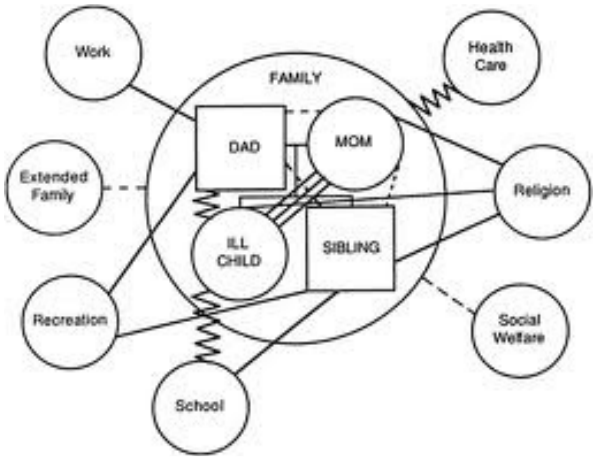
Miller, C., (2012) *Connecting Families to Community Resources* and *Service Coordination: It's all about Relationships*.

Handout 4.6
Connecting Families to Community Resources, cont.

C. Eco-Mapping

Instructions on how to draw an eco-map

1. Draw a large circle in the middle of the map. This represents the members of the household. Inside this circle draw figures representing your family: circles for females and squares for males. Inside these circles write names and ages. Place the parents above the children, like a family tree. Place an "X" through those members no longer living.
2. Connect the parental figures with a horizontal line representing their relationship. Draw a solid line for a healthy relationship, a line with one slash through it for a separated couple and a line with two slashes through it for a divorced couple. For an intense relationship, draw three connecting lines between them and for a strained relationship draw a squiggly line between them.
3. Connect the children to the parents with vertical lines, using the same lines to indicate the type of relationship they have. For example, if Johnny has an intense relationship with his father, you would connect them with three lines. You may also connect the siblings as well to make it more clear how the family interacts.
4. Draw smaller circles outside the family circle to represent outside forces and label them. These forces may include church, extended family, school, friends, health care, neighbors, employment and other significant relationships.
5. Connect these outside forces to individuals in the family or to the household as a whole. Again, use the corresponding lines to indicate the health and strength of the relationship. To make this more explicit, add arrows to indicate the flow of relationship. For example, if Johnny feels negatively toward his friends, draw a squiggly line with an arrow from Johnny pointing to the friends.



Read more: How to Draw an Ecomap | eHow.com http://www.ehow.com/how_6772859_draw-ecomap.html#ixzz1lXVrKZIL

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.7
Service Coordination: It's all about Relationships

It is important to build community relationships based on mutual clients and on shared concerns across family systems. Develop a relationship with at least one person in each community agency who;

- ❖ will listen to the family needs (possibly still in story form)
- ❖ has a good understanding of agency services
- ❖ can provide a connection to available resources

Key tools to use in Building Relationships with Community Partners:

1. **Release of Information**

   - ✓ Ensure you obtain a written release of information from the parent for each agency you will be requesting information from or sharing information with. Utilize the school districts release of information form unless the Early Intervention Program has a release specific to their program. Please note: releases to multiple agencies can no longer be used. There needs to be one release per community partner or agency. Individual medical records can only be accessed by using a formal medical release that has been approved by the specific medical clinic.

2. **Referral follow-up**

   - ✓ To maintain effective communication, follow up on all referrals with a 'referral summary' system. A referral summary gives written information back to the referral source. This summary indicates what action has followed the referral and gives a name and contact information for future concerns and questions.

   - ✓ To keep the lines of communication open and work in harmony with the best interests of the family.

Referral Follow-Up Case Study

Two year old Lydia was referred by her primary doctor to out-patient medical speech therapy due to concerns about expressive language. Lydia's mother, Rachel, asked if there was a school program available since Lydia is very shy and may do better at home. The doctor told her Lydia was too young for a school program. Since Lydia was put on a waiting list for medical therapy, Rachel looked for other options. When she found out about the Infant and Toddler Intervention system from a friend she contacted the local program. The intake and evaluation process was completed. A referral summary was completed and - mailed to her primary doctor. Since this doctor did not know about the Infant and Toddler Intervention Program, the Service Coordinator also called and talked with the doctor about the program, how to make referrals and let the doctor know the referral summary was in the mail.

3. **Personal connections**
   - ✓ Connect in person, if at all possible, with support staff in agencies/clinics. Having an 'anchor' contact helps navigate the system.
   - ✓ Share information, offer brochures and begin to build reciprocity in a relationship.

Handout 4.7
Service Coordination: It's all about Relationships, cont.

Personal connections case study

Eighteen month old Joshua has recently been identified as having developmental delays, but the service coordinator believes more medical assessment, specifically related to hearing and vision would be helpful in determining learning strategies. Joshua's mother is not sure who the primary doctor is at the large pediatric clinic, since they have recently moved to the area. This pediatric clinic has identified their referral nurse to be available to all Service Coordinators to assist in connecting primary physicians back to the Early Intervention System. With a release, the referral nurse can identify the primary doctor and request the provider call the Service Coordinator so that needed medical interventions can be discussed.

Some larger clinics have referral nurses who handle all the referrals to outside agencies. It is important for these nurses to be aware of the local Infant and Toddler Intervention Program. Making contact with them is valuable. Not only will this increase the nurse's and physician's awareness of community preschool options. it will also give the Infant and Toddler program a stronger connection to the clinic

4. **Begin your own list of 'favorites'**
   - ✓ Develop and maintain a list of people who may be 'go to' resources as you work with families and the needs that surface.
   - ✓ Build on successful connections. As you find and develop relationships with community partners, build on these connections by expanding within the agency/clinic. Start small, grow with time.
   - ✓ Celebrate the creative and novel solutions that surface to address issues and concerns. Keep track of informal and unique ways problems have been addressed and expand on options.

As you work in your community, remember some of the important and helpful community partners who are available. The list must be customized to your area, but some possible partners would include:

Early Childhood Family Education

- Minnesota is unique in the nation because we have Licensed Parent Educators who are available through ECFE to work with parents in groups and, in some programs, individually during home visits. Parent/child classes are available in all Minnesota school districts.

Child Care Resource and Referral

- Assist families in identifying available child care providers and knowing what to ask when locating high quality child care. Assist child care providers with training and food support programs.

County Human Services

- Provide case management in the areas of developmental delay, child protection and welfare and child and adult mental health. Eligibility criteria may differ between counties.

Handout 4.7
Service Coordination: It's all about Relationships, cont.

County Public Health
Provide Follow Along and Family Home Visiting programs in some Minnesota counties. Eligibility criteria may differ between counties.

Medical Clinics

- Pediatric medical clinics often provide developmental screening as part of well child visits and some also provide "Health Care Home" services to families who have children with special medical needs. The Minnesota Department of Health has more information about medical homes at this website: www.health.state.mn.us/healthreform/**home**s/index.html

Catholic Charities, Lutheran Social Services or other social service agency
Provide in-home family services such as therapy or skill building. Often is hired with public dollars through a county case manager. Some communities will not have these resources. The Service Coordinator will need to do some research to find out what agencies and services are available in the community where the parent lives.

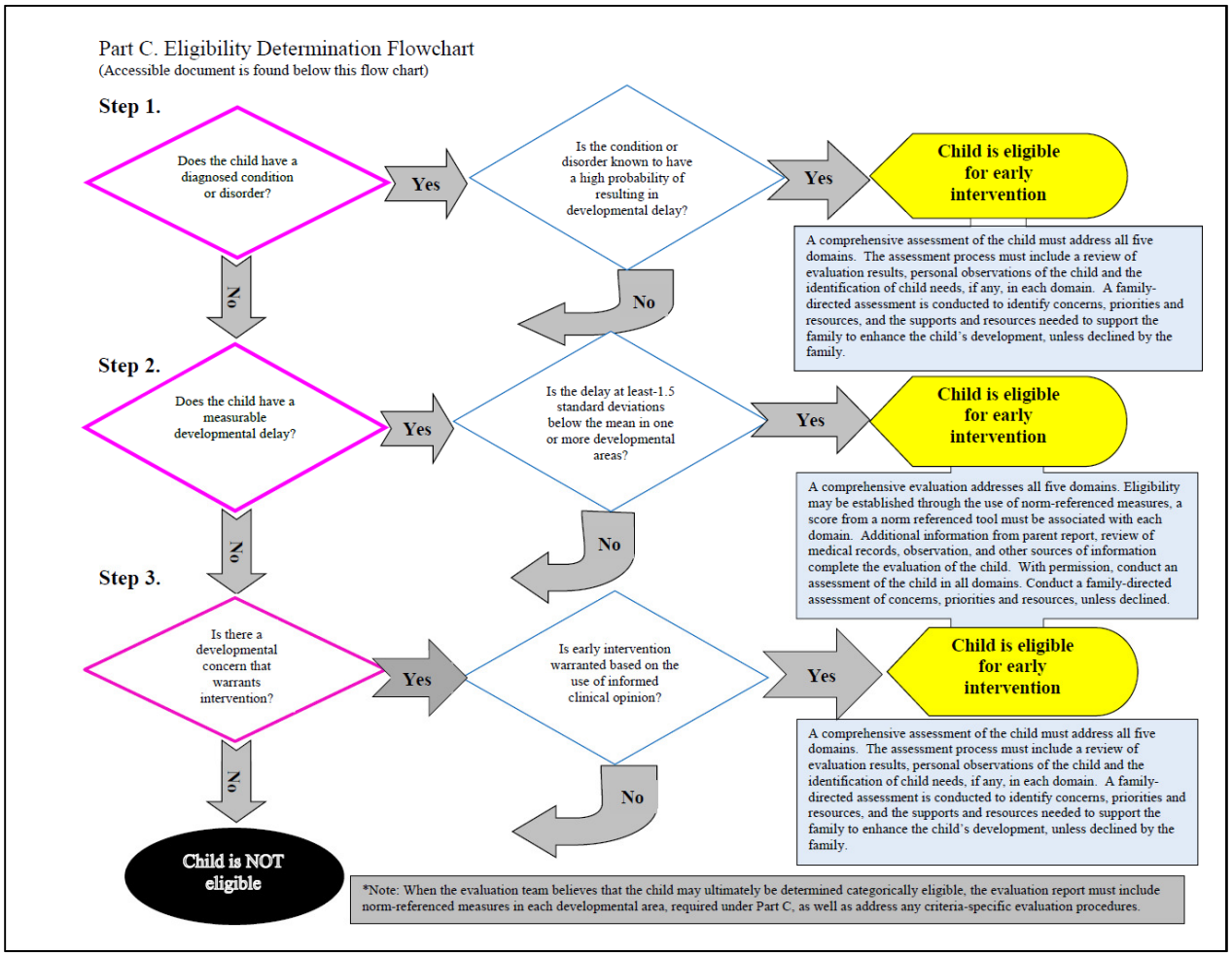
Local Service Clubs

- May provide one time funding for a family of a child with a disability who needs equipment or other special needs and can't afford the one time purchase.

Miller, C., (2012) *Connecting Families to Community Resources* and *Service Coordination: It's all about Relationships*.

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.8
Part C Eligibility Determination Flowchart



Step One: Does the child have a diagnosed condition or disorder?

1) If yes, is the condition or disorder known to have a high probability of resulting in developmental delay?

   a. If yes, the child is eligible for early intervention and the team must complete a comprehensive assessment of the child in all five domains. The assessment process must include a review of evaluation results, personal observations of the child and the identification of child needs, if any, in each domain. A family-directed assessment is conducted (unless declined by the family) to identify their concerns, priorities and resources, and the supports and resources needed to support the family to enhance the child's development.

2) If no, answer next question.

Handout 4.8

Part C Eligibility Determination Flowchart, cont.

Step Two: Does the child have a measurable developmental delay?

1) If yes, is the delay at least -1.5 standard deviations below the mean in one or more developmental areas?

    a. If yes, the child is eligible for early intervention based on comprehensive evaluations that address all five domains. Eligibility may be established through the use of norm referenced measures, a score from a norm referenced tool must be associated with each domain. Additional information from parent report, review of medical records, observation, and other sources of information complete the evaluation of the child. With permission, conduct an assessment of the child in all five domains. The assessment process must include a review of evaluation results, personal observations of the child and the identification of child needs, if any, in each domain. A family directed assessment is conducted to identify concerns, priorities and resources, and the supports and resources needed to support the family to enhance the child's development, unless declined by the family.

2) If no, answer next question.

Step Three: Is there a developmental concern that warrants intervention?

1) If yes, even though evaluation data does not indicate eligibility, is early intervention warranted based on the use of informed clinical opinion?

    a. If yes, the child is eligible for early intervention and the team must complete a comprehensive assessment of the child in all five domains. The assessment process must include a review of evaluation results, personal observations of the child and the identification of child needs, if any, in each domain. A family-directed assessment is conducted to identify concerns, priorities and resources and the supports and resources needed to support the family to enhance the child's development, unless declined by the family.

2) If no, the child is **not** eligible for early intervention.

Please note: When the evaluation team believes that the child may ultimately be determined categorically eligible, the evaluation report must include norm-referenced measures in each developmental area, required under Part C, as well as address any criteria-specific evaluation procedures related to the categorical eligibility.

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.9
Informed Clinical Opinion (ICO)

Informed Clinical Opinion (ICO) is the way in which qualified personnel utilize their cumulative knowledge and experience in evaluating and assessing a child and in interpreting the results of evaluation and assessment instruments. 34 C.F.R 303.321

Qualified personnel must use informed clinical opinion (ICO) when conducting an evaluation and assessment of the child. The Lead Agency (MN Department of Education) must ensure that informed clinical opinion (ICO) may be used as an independent basis to establish a child's eligibility even when other instruments do not establish eligibility. In no event may informed clinical opinion (ICO) be used to negate the results of evaluation instruments used to establish eligibility.

In applying Informed Clinical Opinion (ICO) during the evaluation/assessment process as staff members consider:

- Interview information from family members
- Evaluations of the child
- Observations of the child
- Reports received from other agencies and individuals involved with the child

When establishing eligibility using ICO independently, clearly describe the rationale, incorporating information from multiple sources.

"It is intended that ICO be used as the deciding factor in eligibility determination only when there are truly unique circumstances not captured by tests, and those circumstances or factors are significant enough to make the case that the child has a delay even though all of the test scores do not reflect this". (Missouri First Steps, 2006).

(34 C.F.R. 303.321)

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

Handout 4.10
Service Coordinator Checklist

This document could be helpful as you follow up on a referral to Part C. Remember that this offers a beginning framework that highlights the minimum due process components that must be followed in Minnesota. Feel free to use this framework and customize it by adding your own district or interagency components.

Child Name:

Date of Birth:

MARSS ID:

School District #:

____Do we have a flyer that highlights our philosophy/expectations/contact information to share with parents?

____Date of referral

____Date that evaluation, assessment and initial IFSP meeting is due ____

- ____Developmental/Health History
- ____Release of Information
- ____Enrollment forms for district
- ____MARRS form
- ____ECSE Outcomes Summary Form; Entry to Part C
- ____Medical Assistance billing forms

____Meeting Notice: Initial date____

____Prior Written Notice (PWN) for screening (if applicable)

____Parental consent for screening (if applicable)

____Prior Written Notice (PWN) for evaluation/assessment

____Parental consent for evaluation

____Meeting Notice: Evaluation Results date____

____Child Assessment completed (Routines Based Intervention RBI or other tool) date____

____With permission, Family Assessment (tool & interview) date ____

____Meeting notice: IFSP meeting date___

____Prior Written Notice (PWN) for Part C Service

____IFSP date

____IFSP authorizing signature ___

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

References

Federal IDEA Part C 34 CFR. 303.34 - 303.303; 303.404; 303.25; 303.27; 303.9; 303.403; 303.421; 303.320; 303.24; 303.321; 303.322; 303.41

How to Draw an Ecomap
eHow.com http://www.ehow.com/how_6772859_draw-ecomap.html#ixzz1lXVrKZIL

Shackleford, Jo,(2002).Informed Clinical Opinion. University of North Carolina-Chapel Hill. http://www.ectacenter.org/~pdfs/pubs/nnotes10.pdf Accessed April, 2012

Miller, C., (2012) *Connecting Families to Community Resources* and *Service Coordination: It's all about Relationships*.

Miller, J., & Peterson, S., (1999). *Colorado Guidelines for Service Coordination: Early Childhood Connections for Infants, Toddlers & Families.* Colorado Springs, CO: PEAK Parent Center, Inc.

Minnesota Statute (2011), 125A.07; 3525.1351; 3525.1350; 3525.3790

Minnesota Department of Education, Early Learning Services (2012).Post-Referral Actions. Roseville MN:Department of Education

Trivette, C. J., (2006). *An Eligibility Determination Algorithm for Part C Early Intervention Enrollment.* Orelena Hawks Puckett Institute: Morgantown, NC
www.puckett.org

Resources

Minnesota Help Me Grow
www.mnparentsknow.info

The Home Language Questionnaire, Minnesota Department of Education
http://education.state.mn.us/MDE/JustParent/EngLearn

The Post Referral Actions
Screening: An Optional Response to a Referral, and Part C Eligibility Flowchart, Minnesota Department of Education, Early Learning Services
http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/index.html

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MINNESOTA SERVICE COORDINATION MODULES

MODULE 5 - HANDOUTS

Table of Contents

Handout 5.1
Writing Measurable Outcomes or Measurable Result

Minnesota Department of Education

Measureable outcomes are:

- ✓ actions
- ✓ behaviors or
- ✓ skills

that can be:

- ✓ seen,
- ✓ heard, or
- ✓ reported reliably by others, including family members

Why is this result or outcome being addressed?

Describe why this outcome is important to the family

What is already happening? What is the child doing now? What has been tried? What is working?

- This section equates to the "present levels of performance" section of the IEP, describing what the child and family are currently doing specific to this functional outcome

A routines-based interview and criterion referenced assessment are good sources of information to describe "what is already happening"

We will know we are successful when…

- Describe how you will measure the achievement of each functional outcome

Criteria should:

- not require interpretation or guessing to determine when an outcome has been achieved
- establish realistic reference point for parents, caregivers and early intervention providers so they will easily see or hear that an outcome has been achieved
- specify where and when to observe a behavior or action

Handout 5.1
Writing Measurable Outcomes or Measurable Result, cont.

What will happen within the family's everyday routines, activities and places:

- Describe how the selected intervention methodologies will be implemented throughout the natural learning opportunities that are part of the family's daily routines

This section should clarify how members of the IFSP team or other caregivers are embedding intervention into activities such as meals, play, bath, bedtime and other important daily routines

Writing Timeline that will be used to determine the extent to which progress is being made:

- The timeline documents when an outcome is expected to be achieved
- The timeline could specify a date or an event important to the family

"Ariel will walk to the car all by herself by December 1."

Or

"Ariel will walk to the car by herself by the time her baby sister is born."

Handout 5.1
Writing Measurable Outcomes or Measurable Result, cont.

Minnesota Department of Education

Outcome example: (IFSP DATE: May 1, 2012)

Measurable outcome:

Leroy will play together with his brother and express himself without hitting.

Why is this result or outcome being addressed?

Mom reported during a family assessment that Leroy and his brother do not share or play well together. Mom said that she is unhappy with this routine and would like some support.

What is already happening?

Leroy will play by himself and with his Mom. He is not able to share toys like trucks, blocks, electronic games or most other toys they have in their home with his brother. Mom has bought 2 trucks, 2 electronic toys and other toys that the boys seem unable to share and use without fighting. Mom states that they will still fight when playing with these toys. When Leroy is upset he will often hit his brother instead of asking for a new toy as his Mom wished he would.

We will know we are successful when:

Leroy will point or look at the toys he would like to play with rather than hitting his brother to obtain the toy at least five times during each play time for two weeks observed and reported by his parents.

Timeline that will be used to determine the extent to which progress is being made:

This outcome will be met by the time Leroy and his family travel to see grandparents in January, 2013. Progress toward this outcome will be monitored weekly by the primary service provider during regular home visits.

What is happening in the family's everyday routines, activities and places?

Mom will support Leroy and his brother during one 30 minute play time at the end of the day by helping Leroy remember to point to the toy he would like to play with.

Mom will create a list of words that she feels would help make play time work better in their day.

Staff will create a picture activity that will support Leroy as he plays with his brother. It will include real pictures of the desirable toys and symbols for words that will support his play.

Leroy, after direct teaching from the staff and daily use with his family in a 30 minute play time, will point to the picture of the toy he wants at least one time each day.

Staff will use the information found on the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) web site to teach Mom some ways to reduce the hitting that occurs during playtimes.

Handout 5.1
Writing Measurable Outcomes or Measurable Result, cont.

Minnesota Department of Education

Rating Activity for IFSP Outcomes

Participation-based, high Quality (YES) vs. Skills-based, Substandard (NO)

Rating Criteria*

1) The OUTCOME is necessary and functional for the child's family and life.
2) The OUTCOME reflects real-life contextualized settings (e.g. not test items).
3) The OUTCOME is discipline-free.
4) The wording of the OUTCOME is jargon-free, clear and simple.
5) The wording of the OUTCOME emphasizes the positive.
6) The OUTCOME avoids the use of the passive words (e.g. tolerate, receive, improve, maintain).

Review these outcomes using criteria above. Place a "yes" or "no" in each box to determine if the outcome would meet High Quality indicators.

Sample IFSP Outcomes	1. Necessary/ Functional	2. Real-life Contextual Settings	3. Discipline-Free	4. Jargon-Free	5. Positive	6. Not Positive
1. Kamika will sleep through the night.						
2. The occupational therapist will assist Jana in grasping objects.						
3. Leroy will play together with his brother and express himself without hitting.						
4. Walker will make some friends at story time at the library.						
5. Marcus will stack 4 blocks.						
6. I want my child to walk.						
7. Miles will be happy and relaxed when his mom leaves him at child care.						

*When the child's contextual information (medical or developmental information, evaluation and assessment results, family interview, etc.) is available, the following IFSP outcome criteria can also be evaluated:

The OUTCOME is based on the family's priorities and concerns.

The OUTCOME describes both the child's strengths and needs based on information from the initial evaluation or ongoing assessment.

Handout 5.1
Writing Measurable Outcomes or Measurable Result, cont.

Rating Activity for IFSP Outcomes: Correct Answers

Participation-based, high Quality (YES) vs. Skills-based, Substandard (NO)

Rating Criteria*

1) The OUTCOME is necessary and functional for the child's family and life.
2) The OUTCOME reflects real-life contextualized settings (e.g. not test items).
3) The OUTCOME is discipline-free.
4) The wording of the OUTCOME is jargon-free, clear and simple.
5) The wording of the OUTCOME emphasizes the positive.
6) The OUTCOME avoids the use of the passive words (e.g. tolerate, receive, improve, maintain).

Review these outcomes using criteria above. Place a "yes" or "no" in each box to determine if the outcome would meet High Quality indicators.

Sample IFSP Outcomes	1. Necessary/ Functional	2. Real-life Contextual Settings	3. Discipline-Free	4. Jargon-Free	5. Positive	6. Not Positive
1. Kamika will sleep through the night.	Yes	Yes	Yes	Yes	Yes	Yes
2. The occupational therapist will assist Jana in grasping objects.	No	No	No	No	Yes	No
3. Leroy will play together with his brother and express himself without hitting.	Yes	Yes	Yes	Yes	Yes	Yes
4. Walker will make some friends at story time at the library.	Yes	Yes	Yes	Yes	Yes	Yes
5. Marcus will stack 4 blocks.	No	No	Yes	Yes	Yes	Yes
6. I want my child to walk.	Yes	No	Yes	Yes	Yes	No
7. Miles will be happy and relaxed when his mom leaves him at child care.	Yes	Yes	Yes	Yes	Yes	Yes

http://www.ectacenter.org/~pdfs/pubs/rating-ifsp-iep-training.pdf to find the complete activity regarding IFSP and IEP outcomes.

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.

References

Raspa, M., Bailey, D. B., Nelson, R., Robinson, N., Simpson, M. E., Guillen, C., Olmsted, M., & Houts, R. (2010). Measuring family outcomes in early intervention: Findings from a large-scale assessment. *Exceptional Children, 76*(4), 496-510.

Federal IDEA Part C, 34 C.F.R.303.13; 303.26; 303.34; 303.126; 303.209; 303.310; 303.321; 303.324; 303.342; 303.342(b); 303.342; 303.342(b); 303.344; 303.345;

McWilliam, R.A. (2010a). *Routines-Based Early Intervention.* Baltimore: Paul H. Brookes.

Minnesota Statutes**:** 125A.32; 125A.33(a) Service Coordination

Waisman (2010). The Four Phases of Service Coordination. In M.J. McGonigel, & B. H. Johnson, & R. K Kaufmann,. (Eds.). *Guidelines and recommended practices for the individualized family service plan* (p.1). (2nd ed.). Bethesda, MD: Association for the Care of Children's Health.

Resources

Child Outcomes Summary Form (COSF) Directions and resources

http://education.state.mn.us/MDE/SchSup/DataSubLogin/EarlyChildSpecEducOut/

Child Outcomes Summary Form Crosswalks to Early Childhood Assessment Instruments

http://projects.fpg.unc.edu/~eco/pages/google_results.cfm?q=COSF%20crosswalks

Early Learning Resources, Early Childhood Special Education, MN Department of Education

http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/index.html

Electronic Code of Federal Regulations: Part 303-Early Intervention Program for Infants and Toddlers with Disabilities

http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=0ea5e86646f9f4dd507bcfb481fcf213&rgn=div5&view=text&node=34:2.1.1.1.2&idno=34

Family Outcome Survey (In Multiple Languages) on the Minnesota Department of Education website

http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/index.html

Family Outcome Survey: Additional Information at ECO

http://projects.fpg.unc.edu/~eco/pages/google_results.cfm?q=Family%20Outcomes%20Survey

Family Supports:

Bridges to Benefits-This site links families to public support programs. The site also provides an eligibility screening tool and a link for support for individuals with disabilities who need assistance to complete the screening tool.

http://mn.bridgetobenefits.org/

Minnesota Parents Know Website

http://parentsknow.state.mn.us/parentsknow/index.html

MN State Statutes 2012

https://www.revisor.mn.gov/statutes/?id=125A.33

Routines Based Interview (RBI) Siskin

Http://siskin.org/www/docs/112.190

Video Taping for Program Development

Video Self Modeling Resource:

http://www.siskin.org/www/docs/12/

Writing IFSP Outcomes:

How to tell if your IFSP goals are Functional?

http://www.ectacenter.org/~pdfs/topics/families/GoalFunctionalityScaleIII_2_.pdf

Participation Based, High Quality IFSP Outcomes: Rating Activity for IFSP Outcomes

http://www.ectacenter.org/~pdfs/pubs/rating-ifsp-iep-training.pdf

This handout was developed to support the content of the Service Coordination Modules, 2012 and is not intended to stand alone.