DAUPHIN COUNTY MH/ID PROGRAM
POLICY AND PROCEDURE

Department:    MH
                ID
                EI
                Admin
                Crisis

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Approved

Title: Determining Service Provision, Frequency, and Required Documentation

Policy: The Dauphin County Early Intervention Program recognizes and respects the pivotal role of the family and caregivers in the lives of their children. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the child. The services and supports provided to children and their families and/or caregiver are determined by the team and designed using a variety of different early intervention approaches. Decisions about which approach to choose is determined by the team and based on the kind of support a family and/or the child’s caregiver needs to develop confidence and competence to help their child learn.

Definitions:

Modeling – demonstrating how to do certain activities with a child’s family and/or the child’s caregiver. For example, the therapist may demonstrate how to encourage a child to close their lips around a spoon during mealtimes or how to play with toys to encourage their interaction and communication.

Direct Instruction – teaching a child’s family or caregiver how to practice certain skills. For example, the therapist may teach a family how to perform exercises to keep their child from losing range of motion in tight muscles or how to help their child get on a swing at the local playground.

Consultation and Collaboration – providing ideas and resources, encouragement, and support to assist a child’s family and/or caregiver to problem solve ways to help the child achieve the goals identified by the family. For example, if a child is not able to sit quietly at circle time
at a child care center, the team members may suggest adaptations the teacher can make to help the child succeed and ways that fit easily into that environment. For a child who is having problems sleeping at night, team members may suggest a change in the bedtime routine to incorporate activities that have a calming effect.

Coaching – The use of a primary coach who uses all of the strategies above to implement the process of coaching to build the capacity of care providers to promote child learning and development in family, community, and early childhood settings. Coaching is an interactive process of observation and reflection in which the coach promotes the other person’s ability to support the child in being and doing.

Primary Coach Approach – A team approach to supporting care providers in which one team member is selected as the primary coach. The team member focuses on coaching the identified caregiver as the primary interventionist. The primary intervention strategy is to implement jointly-developed, functional, discipline-free IFSP/IEP outcomes to promote increased child learning and participation in real-life activity settings with ongoing coaching and support from other team members.

Procedure:

1. There are six questions which therapists must answer as part of each child’s team of family members and professionals to guide intervention and choose the most appropriate service model (Hanft & Place, 1996). Each question must be answered in order, beginning with the first, which focuses on desired outcomes. Typically, therapists are asked to determine whether or not a child needs therapy, and how frequently, before key information is identified.

   A. What does the child need to learn/develop? Determining what the child needs to learn and to develop is the crucial point at which to begin, since outcomes should guide intervention. Answering this question should lead to a discussion about educational or family-directed outcomes and eventually result in identification of IFSP outcomes. In order to knowledgeable talk about a child’s development, therapists may need to complete formal evaluations and should observe the child in key natural environments.

   B. What will facilitate the child’s learning/development? Once therapists know where to go, they can identify how to get to the desired destination. For example, if the outcome for a newborn boy with cerebral palsy is to take his bottle with even milk flow, then what strategies will improve the baby’s performance? Do sensory processing problems interfere with appropriate arousal? Is a special nipple for the bottle needed? And most importantly, what information do the parents need in order to feed their baby in a relaxed manner?

   C. Whose expertise is needed to help the child achieve outcomes? Most therapists are generally asked to respond to “Does this child need occupational or physical therapy or speech/language pathology, and how often?” before considering the child’s
desired outcomes or needed strategies. The answer that almost always follows is “yes” or “probably” since therapists can always think of ways to enhance a child’s development in their domain of expertise. However, if asked whether occupational therapy can help a particular child achieve a specific outcome such as activating a toy with a presser switch, a very different set of criteria must be considered.

D. How should services be provided? Once the outcomes, intervention strategies, and disciplinary expertise are decided, then the next decision is how the service should be provided. Which service model will best assist the child to achieve desired outcomes? The professional literature identifies various models (e.g. direct, integrated therapy, consultation, collaborative teaming and monitoring), which can readily be combined with one another. Exclusive use of either end of the service continuum (direct service vs. consultation) for all children misses opportunities to provide flexible services to help achieve desired outcomes. While the use of a consultation model alone can help achieve certain outcomes, direct intervention by the therapist should always be paired with some form of collaborative consultation and coaching of the primary care providers in the child’s life. Young children spend most of their time at home, in childcare settings, or in community activities with their family members; consultation expands the impact of therapy to help children function in these natural environments.

E. Which consulting model will I use to translate my knowledge to others? Questions 5 and 6 relate to choosing a consultation model in which the therapist analyzes how to help another adult with their child-related responsibilities. The term “methods” refers to how therapists choose to translate their knowledge and expertise through instruction, modeling, demonstration, support, etc. The crucial point is how to help other people with their responsibilities and concerns, not ask them to be a therapist. If a child really needs a therapist to do the intervention that is what direct service is for. Coaching focuses on using therapists’ knowledge and experience to assist family members and other adults in their interactions with the child. This is one of the delicate considerations so much more complex than direct service. It is often easier to provide the therapy yourself than to figure out what the parent, teacher or childcare provider needs to know and then pinpoint how to help them do it. Coaching parents and caregivers on how to provide effective learning opportunities for their children during family activities and routines is the preferred method of treatment in Dauphin County.

F. How shall I interact with professionals/family members? This final question is dependent on developing skills in communication and interpersonal interactions. Depending on the situation and personalities of your “consultees”, you must choose from a variety of styles ranging from expert to collaborative consultation. Therapists should operate on a “sliding scale,” adapting to various environments and needs of staff and parents. If you use only one interactional style, you will limit the effectiveness of your consultation as you interact in different situations. Effective therapy, regardless of how it is delivered, is meaningful to the people involved and helps children achieve desired outcomes. Effective consultation starts with an analysis of a child’s strengths and needs in their daily environments and incorporates
the knowledge, experience, and desired outcomes of family members and other providers to assist them in their child related activities.

2. Session notes are a written summary of the activities provided during a session, the child/family’s response to the intervention, and the progress noted during the session. Session notes are part of the child’s records at the CMU and at your agency. Session Notes must include the following:

A. Include the child’s name on each page.
B. Include the specific outcome from the IFSP.
C. Document the amount of time.
D. Document where the service delivery occurred.
E. Be signed and dated by the child’s caregiver.
F. Be signed and dated by the early intervention staff.
G. Document suggestions for family practice opportunities or the activities the family will try before the next visit.
H. Session notes should clearly state what occurred during intervention sessions so that other interested people who were not present (other team members for example) can understand the activity. Answer the Who, What, Where, Why, and How questions. Clarify how the intervention relates to the IFSP outcome and how the caregiver was able to use the strategies offered.
I. Progress should be noted from one session to the next.
J. Missed sessions should be documented with reasons for cancellation, and documentation of “make-up” sessions should be evident if the EI professional was responsible for cancelling the regularly occurring session(s).

3. Session notes can be written during the treatment session and used as a teaching tool. This is a great time to summarize and explain treatment strategies, share progress information, and listen to parents/caregivers about the progress their child is making and/or continuing areas of concern. On a regular basis, session notes should include documentation about the child’s progress as well as the strategies shared with/practiced by the family during sessions and throughout their daily routines. In addition, any discussions with families about use of community activities should be documented.

4. The note must be legible. Notes must be consistent with the intervention page of the IFSP regarding how the team will measure progress. In addition, the note should indicate if there is a need to change or revise the IFSP, method of delivery, etc.

5. Session notes must be sent or faxed to the service coordinator on a monthly basis. Copies should be maintained in the child’s records. A copy of the session note should be left with the family.

6. All services provided to a child/family must be documented as a session note. A session note should be written for each treatment session. If working with multiple eligible
children in one session, each child must have an individual session note. Any inability to provide a service, which is scheduled, must be documented as well.

7. Progress monitoring is a necessary part of the early intervention process. Measuring ways in which the child/family are meeting the identified outcomes documents the impact of early intervention service provision. It assists in determining if strategies are working and whether modifications or revisions in the outcomes or services are necessary. Early intervention progress monitoring follows a seven-step process.

A. Determine measurable outcomes and objectives. The IFSP team must write precise and measurable outcomes and objectives that provide a clear picture of what the child and/or family will accomplish in the next six months.

B. Determine what data should be collected, i.e.
   i. Frequency
   ii. Percentage
   iii. Duration
   iv. Quality of performance
   v. Level of assistance needed
   vi. Fluency

C. Determine where the data will be collected, i.e.
   i. Home
   ii. Grandmother’s house
   iii. Playground
   iv. Child care program
   v. During feeding
   vi. During bath time

D. Determine how often the data will be collected, i.e.
   i. Weekly, during the therapist’s visit
   ii. Every morning
   iii. Every 2 weeks

E. Determine who will collect the data, i.e.
   i. Therapist
   ii. Parent
   iii. Child Care Provider/Teacher

F. Select data collection tools and schedules. Data collection tools must be selected or designed. Commonly used tools include: surveys, observations, checklists, anecdotal records, interview with caregiver, videotaping, photographs, rating scales, frequency sampling, event recording, and time sampling.
G. Present the data. Visual representation of the data provides a picture of the progress and helps to clarify the written word or list of information used to make decisions. Ways to show data visually include: graphs, charts, and checklists. Visual representation of the data is a very useful tool, but is not required on progress monitoring reports submitted to the family and SC.

H. Evaluate the data/ Quarterly Progress Monitoring. Collected data must be reviewed regularly and formally reported to the family and the CMU on a quarterly basis. A “quarter” should run from the date of the Initial or Annual IFSP, and progress must be reported every 3 months. The data is analyzed to determine if the child is making progress and to determine how well the child is responding to the intervention being implemented. If the Quarterly Progress Monitoring Report includes charts, graphs or lists, the report must also include a summarizing statement of the child’s functional use of the skill related to the IFSP outcome and family routines. Quantifying the degree of progress (or lack of progress) with words such as “improved” and “more” are vague, and should be more specific. Instead, saying a child now has “10 more words/gestures” or is “able to walk across the living room” gives better detail to the amount of progress seen over the previous 3 months. Dauphin County has a Quarterly Progress Monitoring Report form that should be used when summarizing child and family progress toward IFSP outcomes.

I. Adjust intervention based on the data. When data patterns indicate, make necessary changes.

J. Communicate progress. Communication about the child’s progress should actively involve the parent and caregivers. It is important to keep lines of communication open regarding the effectiveness of intervention. Progress, or a lack of progress, should be part of session discussions, noted on session notes, and written formally on Quarterly Progress Monitoring reports. Families and caregivers should routinely receive copies of any written information as it is completed.

8. Early Childhood Accountability in Pennsylvania (ECAP): The purpose of Pa.’s system for measuring progress is to get a statewide picture of how children receiving early intervention services perform on three Child Outcome Indicators across a variety of settings and situations in their lives. The three indicators were established by the Office of Special Education Programs (OSEP) to align learning expectations with the Pennsylvania Early Learning Standards for Infants and Toddlers in order to create greater continuity and coordination among our early learning programs. The outcomes are:
   A. Positive social-emotional skills and relationships.
   B. Acquisition and use of knowledge and skills.
   C. Use of appropriate behaviors to meet needs.

9. One service provider on the child’s early intervention team is responsible for completing the OUNCE developmental profile and ECO report in Pelican as assigned by the SC.
They will need to decide the extent to which the child displays behaviors and skills expected for his or her age. They make this decision at the child’s entry and exit from the early intervention program. The assigned provider will use the OUNCE scale, family input, observations from service delivery sessions, IFSP outcome achievement data, and information from other service providers on the Team to help make this decision.

A. Entry data - gathered and completed within 60 days of the development of the IFSP.

B. Exit data - gathered within 60 days prior to the child’s anticipated exit from the birth-three early intervention program, following at least 6 consecutive months of service. Children moving to another County EI birth to age three program within Pennsylvania do NOT need to have Exit data in Pelican prior to moving, but children moving out of the state of Pennsylvania DO.

See next page for examples of community locations for Early Intervention Services

Also see EI Manual 2002, revised October 2009 and November 2011, September, 2013

Examples of where Early Intervention Occurs

The places where children and families daily experience typically occurring learning opportunities that promote and enhance behavioral and developmental competencies.

- Libraries
- Grocery Stores
- Car Rides
- Malls and Shopping Centers
- Wal-Mart
- A Neighbor’s House
- Fast Food Restaurants
- Playgroups and Play dates
- Hall Manor Family Center
- Parades
- Local Swimming Pools
- Gymnastic Programs
- Horseback Riding
- Toys R Us
- K-Mart
- A Local Women’s Shelter
- Grandma’s House
- Child Care Centers
- YWCA
- YMCA
- Playgrounds and Parks
- Chuck E. Cheese

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