Shifting a Service Delivery Model: Technical Assistance in Early Intervention

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Abstract

Early Intervention (EI) is Part C of the Individuals with Disabilities Education Act (IDEA). Traditionally, Part C services in Rhode Island were evaluated via perceptions of provider and caregiver satisfaction and focused narrowly on the developmental progress of young children. Results indicated high ratings of consumer satisfaction but little data associated with improved child functioning. The Paul V. Sherlock Center on Disabilities at Rhode Island College provides technical assistance (TA) to the Rhode Island Executive Office of Health and Human Services, the lead agency for Early Intervention in Rhode Island. The purpose of this TA is to maintain a high-quality Early Intervention system.

This article describes a TA system that matches the unique components of Part C and explains state efforts to promote change in its Part C service delivery model. This change consists of three critical components: changing roles; a focus on outcomes that are family-owned, functional, and measurable; and measurement of impact.

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Introduction

Evidence precedes new practice, and human service systems are typically delayed in adopting new evidence-based interventions while they shift policy and professional development. Early Intervention has provided traditional child-focused services for years and, at any point in time, current practice might depend on the background, comfort level, or beliefs of any particular provider. However, in order to maintain a consistent system of services and support that is equitable and effective for all eligible families and their young children, a Part C state system must establish a consistent, evidence-based service delivery model.

Each component of a service delivery system can contribute to, ignore, or even hinder the stated service delivery model. Clarification and support of such a model are the ongoing tasks of a technical assistance system. Rather than merely providing professional development, technical assistance must address billing, data entry and analysis, public awareness, and outcomes data. The challenge, clearly, is to address all components almost simultaneously and to intervene at the policy as well as the individual level.

Technical assistance staff need to broaden and deepen their working

knowledge of the data and billing system as well as the practical constraints of the day-to-day service delivery operations. A small, centralized team with working knowledge of all the system components referenced above needs to meet regularly to chip away at barriers and to make decisions for the promotion of a recommended service delivery model.

Where Did We Start?

The responsibility of ensuring high-quality Part C services for all eligible children and families, displaying vast differences across strengths, needs, lifestyles, expectations, and support systems, is a staggering challenge. This challenge includes the ability to recruit and retain a high-performing workforce. This workforce needs knowledge of child development, disability-specific content, evaluation and assessment, family systems, and adult learning strategies. The staff also needs skill development for interviewing, observation, coaching and consultation, priority-setting, and facilitation.

Over the past two decades, the role of service providers shifted from direct work with very young children in a controlled (de-contextualized) environment to working primarily with adult caregivers in home and community-based settings. The learning and progress intended for young children occurs not during these

sessions but in between visits. EI staff must be able to not only successfully implement intervention strategies themselves, but also coach parents and other caregivers to utilize those strategies effectively. In doing so, primary caregivers are able to support the generalization of their child's skills across settings.

In addition to a workforce skilled in coaching and consultation, staff must be knowledgeable with regard to procedural requirements, including the ability to identify all potentially eligible children and to provide to their families a timely response, eligibility determination, and an Individual Family Service Plan. However, those compliance elements are only the means to an end; the "end" is the impact on developmental and family functioning via evidence-based intervention strategies.

What We Found

The purpose of Rhode Island's Part C system is to enhance: 1) the developmental functioning of infants and toddlers with special needs, and 2) the capacity of families to meet the special needs of their infants and toddlers. Given recent emphasis on accountability, the lead agency and Rhode Island stakeholders wanted to ensure the identified goals were being met and the actual practices were effective. Of particular importance was an evaluation of the IFSP process, including: gathering functional information, prioritizing concerns, and evaluating

outcomes, which are at the heart of the Part C service delivery system.

The Sherlock Center TA staff examined a cross-section of IFSPs, which revealed outcomes that were either developmentally narrow (e.g., child will imitate two-word phrases), a means to an end (e.g., child will get an OT evaluation), or vague (e.g., child will improve cause-effect skills). The state decided to target the development of child-specific IFSP outcomes that would be family-owned, functional, and measurable. In order to achieve that, several components of the EI system of practice needed to be examined and perhaps modified: policy, training resources, paperwork, family engagement, and public awareness.

How Could We Do It?

How could Rhode Island's TA staff shift a Part C service delivery model from a traditionally narrow developmental one to one that focuses on the child's parents and caregivers as the agents of change for that child? How could Rhode Island providers shift to a system that is outcomes-based, not service-based? How could Rhode Island shift to a system centered on family-owned, functional, and measurable IFSP outcomes?

Professional development by itself is ineffective (Hall & Hord, 2006; Buysse & Wesley, 2006; Gladwell, 2000). What is required is a focus on adult

learning and a change in the day-to-day practice of Part C staff and administrators. A TA system must address all levels of a system including regulations, policy, program management, paperwork, service delivery, family participation, data and billing, and the measurement of results (Hall & Hord, 2006). Models that promote change focus on the adult relationships in which learning takes place and include consultation, coaching, mentoring lesson study, and communities of practice (Buysse & Wesley, 2006). Coaching, as an interaction strategy for adult learning, redefines the roles of the EI provider and of the family. As a model for service delivery, it shifts EI from professionally directed work with the child to supporting the key learners (the child's family and caregivers) in order to increase the child's participation and social communication in naturally occurring settings (Hanft et al., 2004).

What We Wanted To Be Different

Recruitment and Retention

A competent workforce with the necessary skills in the new service delivery model was needed. Recruitment efforts in Rhode Island target students and other potential hires who have ties to Rhode Island or have an interest in settling in the state. Another key recruitment group consists of family members

of children or adults with disabilities or who have participated in home-based services. Because of the diversity of the EI population, recruitment efforts prioritize targeting a similarly diverse potential workforce. However, in all cases, familiarity with and belief in the home and community-based service delivery model is critical to a good match with potential EI employers.

Rhode Island wants a workforce that has a belief in the efficacy of functional interventions. Recruitment and orientation efforts need to focus on a shift in perception of the motivation for entering the EI workforce. It also requires a shift in the perception of who is the primary "consumer" of services. Current recruitment efforts focus on student placements and internships in order to accomplish this. Student interns are included in professional development activities in order to clarify and demonstrate the efficacy of the service delivery model.

Routines Based Information and Interventions

In order to effect functional change in the lives of eligible children and their families, the teaching and learning must occur within typical settings and routines and not in de-contextualized settings, such as clinics. Children learn through repeated interactions with their environment over time (McWilliams, 2010), and

so it is that learning occurs while engaged with the “who, what, where, and when” of a child’s life.

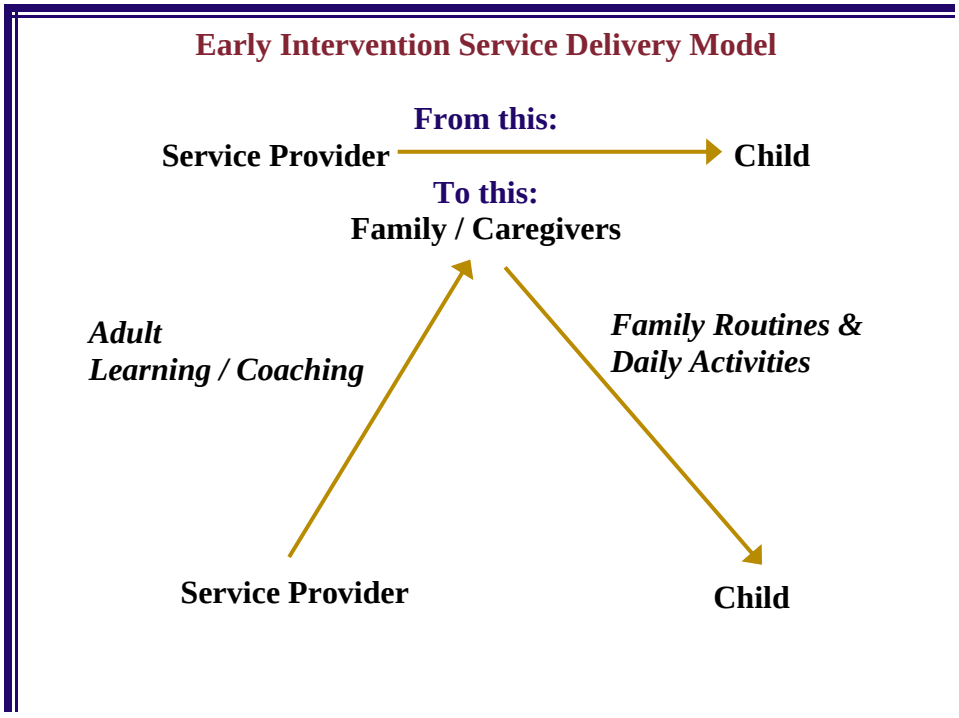
Learner-Focused Interventions

If a child’s family and caregivers are the primary “consumers” of EI services, then an effective adult learning service delivery model in Early Intervention is critical. The use of a “primary provider” model, sometimes called a “trans-disciplinary” approach, results in a supportive, interactive learning dyad. Other team members are utilized as needed, often in a consultant role. This model requires a significant investment of program time, training, and teaming to be effective. This is a challenge for programs in a fee-for-service system like Rhode Island’s because productivity standards are set high. However, this service delivery model reduces the perception that support for a child with disabilities or developmental delay requires access to multiple “specialists” in order to improve child outcomes.

Outcomes-Based System

Since RI Early Intervention is an outcomes-based system rather than a service-based system, the state avoids a prescriptive, rehabilitative system. We want to ensure that decisions about services occur only at the end of

programmatic conversations rather than at the beginning. There needs to be a detailed process of outcome development. This process begins with gathering relevant information and understanding the "who what, where, and when" of a child/family's life. Typical routines and family activities provide the content, strategies, agents of change, and generalization for the interventions themselves (McWilliams, 2010). The process ends with the child's caregivers learning and successfully utilizing effective strategies in order to impact the child's functioning. One supervisor said, "When the team conversations changed from constantly discussing services to discussing the IFSP outcomes, I knew we were onto something."

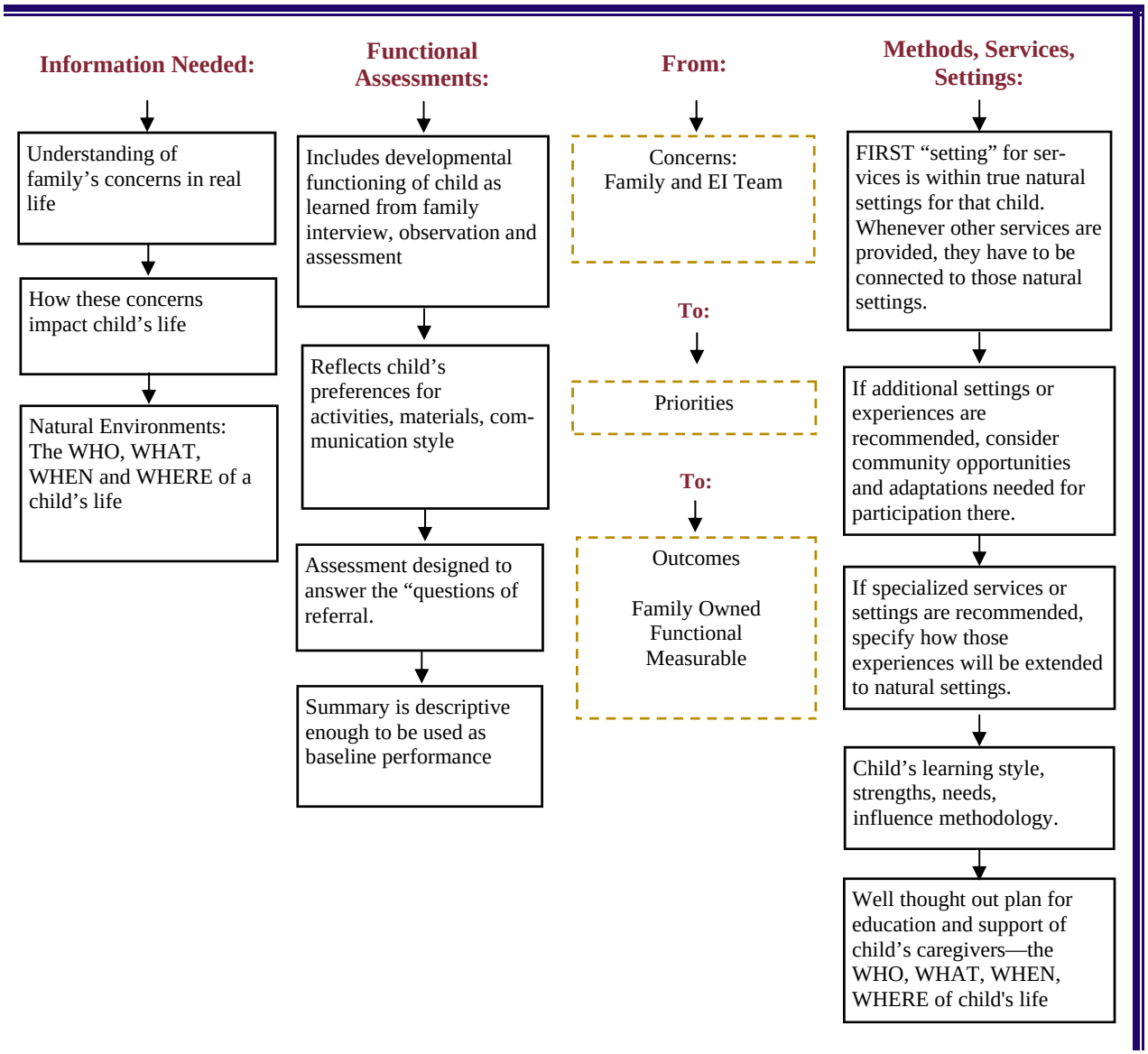


Where Should We Start?

RI's TA providers collaborated with the lead agency (RI's Executive Office of Health and Human Services) and with Family Support Staff from the RI Parent Information Network to plan and implement system change. The group decided that this effort would initially require a revision of the intake interview including how EI staff gathered relevant family and child information and how they explained the service delivery model to new families. Training was needed in interviewing skills and "listening with generosity" (Heller & Gilkerson, 2009). The queries had to shift from enrollment demographics and developmental history to information about family strengths and child participation in relevant family and community activities. This information is needed not only to gauge developmental functioning and potential eligibility, but also for the prioritization of concerns.

In addition, an individualized evaluation/assessment planning and implementation process was initiated. The planning for each child's evaluation/ assessment was designed as a sort of research project: articulate the questions, plan how to learn the answers, and result in a working hypothesis and/or programming ideas. In conjunction with a routines-based interview (McWilliams, 2010), the results of a functional assessment put the team

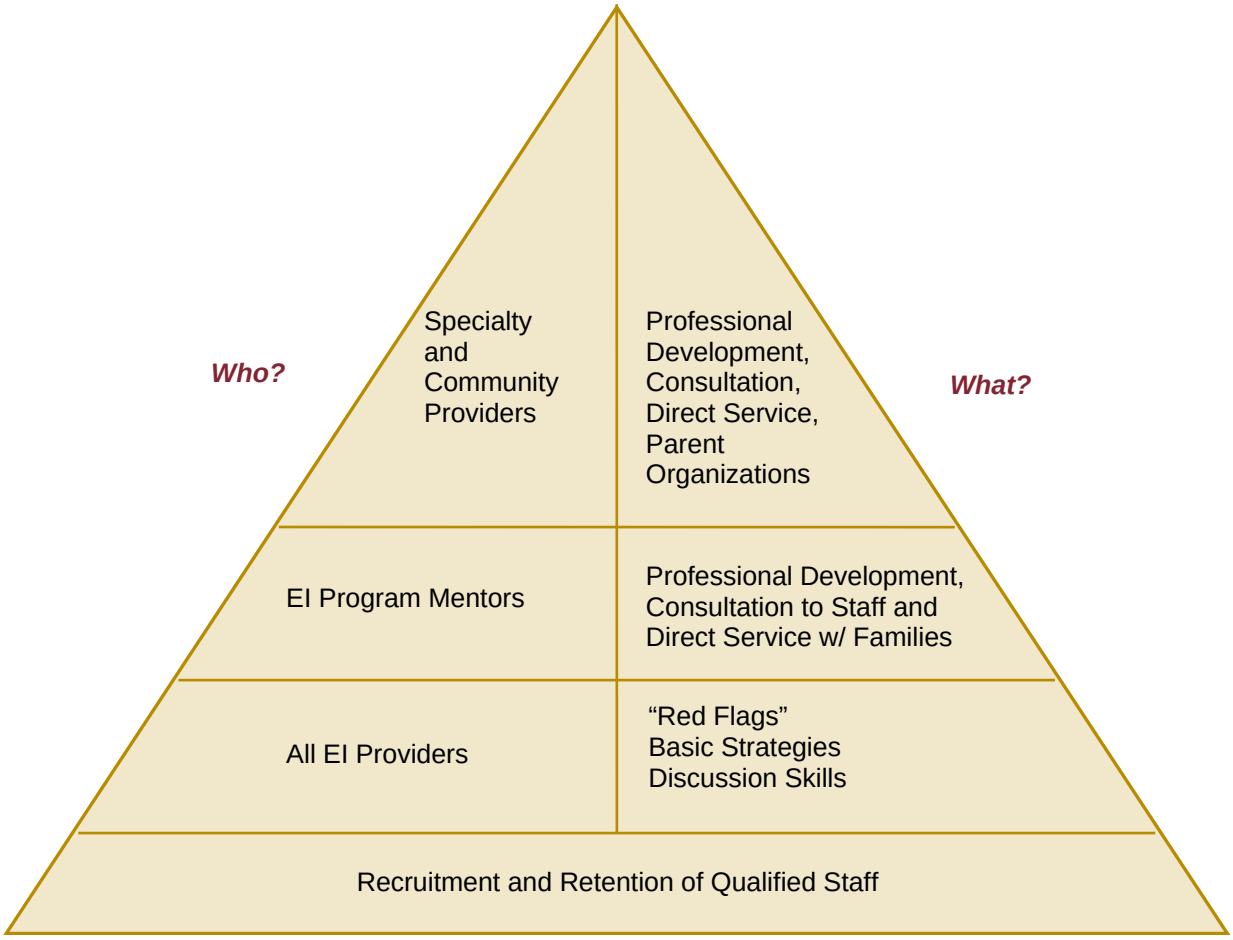
(including, of course, the family) in a better position to prioritize real-life concerns for program planning.



Instead of the next steps on a developmental checklist, IFSP outcomes have become a statement of change that the family wants to see for their child or themselves. This is the heart of the EI service delivery model. Service delivery focuses on the child's parents and other caregivers as the primary agents of change for that child.

Finally, the IFSP process itself was emphasized and institutionalized. It became a process that could be utilized over and over to gather information, establish baseline performance, prioritize, and develop specific strategies for each child/family. It became a process that could be made 'visible' and used successfully by families again and again, even when they exited from EI.

Early Intervention Pyramid Model



What We Created: An Infrastructure with Multiple Opportunities for Leadership

An early stage in this capacity building process necessitated building an infrastructure of memberships and program improvement teams through which TA could be successfully delivered. Clear messaging re: the new service delivery model would occur at multiple levels within the system, with barriers identified and overcome and supports provided at each level.

One example of this infrastructure is the EI Supervisor Seminar. This group convenes monthly with representation from every EI site. The purpose is to network and share resources, participate in presentations from community and specialty resources, and to develop skills for reflective supervision. Supervisors are charged with acting as a conduit of information to and from direct staff and state leadership. Reflective functioning needs to work on every level when supporting an EI system. Supervisors support staff so that staff, in turn, can consistently support families (Heller & Gilkerson, 2009). The fact that in Rhode Island all EI Supervisors can meet face to face on a monthly basis is an incredible advantage.

Because of networking, peer review sessions, and sharing of national and local resources, participants in this seminar have begun to identify themselves as

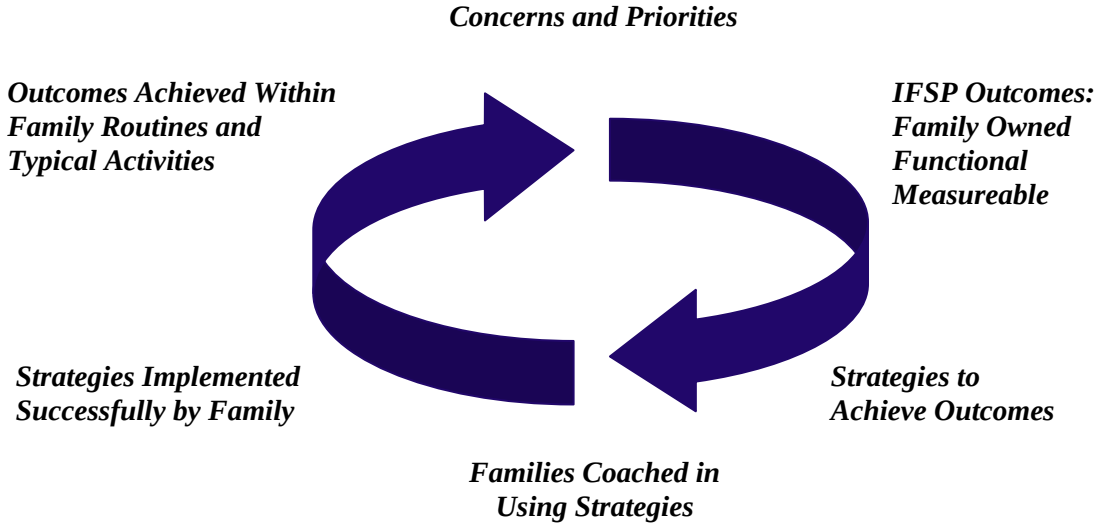
part of the same state-wide system, not merely as staff at independent agencies. The development of that identity has proved to be an effective system improvement. It has been well utilized as a venue for technical assistance and professional development.

Rhode Island recognizes the contribution of ‘in-state’ experts and experienced clinicians. We utilize multiple EI “mentor” groups as a train-the-trainer model for sharing critical information and skills to staff at all EI sites. These groups include supervisor-appointed staff who assume the role of on-site mentor for specialty populations children who are visually impaired, children who are deaf or hard of hearing, children who have an autism spectrum disorder, and children who present with infant mental health concerns. In addition, each site utilizes a Transition Mentor who gets additional professional development in this area and who has developed effective problem solving skills. It has been useful for state TA staff to begin to assist with a procedural issue by identifying the relevant program mentor in the area of concern and utilizing on-site expertise.

“Introduction to Early Intervention” is a four-day training that is required for all new staff. The training team is a parent-professional partnership and utilizes supervisors or experienced staff as ‘mentors’ during the training. Input from and feedback to program supervisors is a critical component for this

professional development. Each supervisor meets with new staff to plan for specific learning outcomes for the course. Professional development would never work for us as a "stand alone" event, but has to be tied to the program sites and be supported by program practice and state policy, paperwork, and funding.

The course uses the IFSP process as the framework for its curriculum. This, of course, necessitates focus on the skills of active listening, functional goal -setting, and an understanding of each family as a "culture of one." The curriculum has also evolved, increasing concentration on: viewing each child only within the context of his/her family; developing functional outcomes to impact day-to-day activities; and coaching family members to implement intervention strategies successfully. Therefore, the critical components of our outcomes-based, adult learner-focused service delivery model, is taught to every single Rhode Island EI provider and supported during program supervision.



How Will We Know We Are Successful?

The final component of our shift in service delivery model is in monitoring the impact of our efforts. We have changed the way we collect and use data. Initial monitoring efforts focused on compliance (e.g., timelines). New monitoring efforts focus on results. Rhode Island has demonstrated considerable gains in these indicators. For example, compliance with the requirement for timely services improved in five years from 66 to 94 percent (2006-2011). Compliance with the requirement for timeliness for eligibility determination and the initial development of the Individual Family Service Plan changed in the same time frame from 38 to 94 percent (2006-2011). This significant compliance allowed us to shift TA resources to a focus on results.

The Paperwork and Process Workgroup (2007) was a cross-program effort created to fill a need expressed by program supervisors. The goal was to reduce duplicative paperwork, make relevant data collection part of everyday tasks, and support the family-centered, functional IFSP process. The result was a streamlined paperwork and data entry flow that focused IFSP development on functional outcomes.

In 2008, Rhode Island responded to the Early Childhood Outcomes Center's (www.The-ECO-Center.org) work on child and family outcomes with a

Child Outcomes Workgroup. This group consisted of state TA staff as well as program staff. The group developed professional development activities and created developmental resources for Rhode Island teams to use for rating a child's functioning. When the state was ready to focus on valid and reliable data, the Child Outcomes Workgroup merged with the EI Data Review Team to implement training on quality assurance procedures for child outcomes data. Now a group of state staff, TA staff, and program staff are consistently available to monitor data for reliability and to examine program practices that are having positive impact on child performance.

For 2011, the state reported that 63 to 68 percent of the children who exited from EI had demonstrated significant functional improvement across the three national child outcomes. In other words, experience in EI has changed the developmental trajectories of those children. Families also reported in 2011 on the impact of EI on their confidence and competence. Specifically for the service delivery model, 92 percent reported that EI helped them help their child develop and learn.

TA on data collection and analysis is provided to program staff. Site-based Child Outcomes Quality Assurance Staff participate in professional development in order to increase ownership of the data and to provide real-time quality control

of the data. Child outcomes data is available to programs on a quarterly basis. This data can be disaggregated by program, by length of time in EI, by discharge status (e.g., eligible for Part B services), etc. in order to hypothesize improvement strategies.

Our real time EI data system provides data on compliance, referrals, populations, services, costs, etc. The state team examines this data regularly and shares data with programs consistently. The data system also allows programs to run a multitude of management reports to discern program and staff functioning week to week.

What We Have Learned

Implementing any type of systemic change on a state level leads to the realization that some strategies and practices work and others need to be massaged so that a smooth transition can be made. Our experience in bringing about this Service Delivery Model shift in Rhode Island has led to the following "lessons learned."

1. *It is important to get new information out to programs as soon as possible* (e.g., new state or federal clarification, a new resource, technical assistance from our national providers). We have accomplished this by disseminating a quarterly electronic newsletter

(TheLINK) of local initiatives, professional development opportunities, and resources for families of children with special health care needs. We have also set up an easy system for when a question has been asked by one provider (and answered by the lead agency or leadership team), the question and the answer is sent out to all providers.

2. *Stay current with research via collaboration with institutes of higher education*. In RI we take advantage of our AUCD network, and we also have a sub-contract with the state university. We also utilize people who teach relevant graduate courses in our project and grants development.
3. *Take advantage of technical assistance, grants, etc., from national sources in order to "jump start" initiatives and professional development.* To that end, we successfully applied for and received a grant from the National Professional Development Center on Autism Spectrum Disorders; and this enabled us to institute evidence-based practices, coaching, and data-based decision-making in three (3) pilot sites. We are currently working successfully to sustain and expand that model.

4. *State-level (or even regional level) infrastructures, such as the EI Supervisor Seminar, have resulted in local ownership of state-level initiatives and recommended practice.*
5. *Flexible budget funds are best used to recruit and utilize consultants for state projects that would otherwise get delegated to a lengthy 'to do' list.* RI TA providers have included consultants in infant mental health, early childhood education, and quality assurance.
6. *Parent Consultants (former EI parents who are supported by appropriate leadership training) contribute regularly in all EI professional development and recruitment activities.* The lead agency's contract with RI's Parent Information and Training Center (RI Parent Information Network) enables the participation of Parent Consultants in relevant state initiatives.

Final Thoughts

In order to be effective, the components of an EI TA system must match the unique characteristics of its EI system and service delivery model.

Part C System Profile	Needed Components of the TA System
Caregiver-focused service system Contextualized teaching (natural environments) Primary provider model Outcomes-based system Demands of a home-based and relationship-based system	Appropriate recruitment/retention Training in skills Training tied to teaming at programs Leadership development: multiple levels Reflective supervision Link TA to data and data to TA

Although much of Rhode Island's TA work focused on effective working relationships, relationships themselves cannot sustain a high quality Part C system. It is necessary to establish an infrastructure of memberships with real, ongoing opportunities for site-based decision-making and leadership development in order to "institutionalize" the new service delivery model. In addition, the state needs to support recommended practice by reviewing policy, billing, and other considerations and removing barriers to effective practice.

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