



First Steps

TRAINING TIMES

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Welcome back!

Almost 2000 intake/service coordinators and direct service providers completed the self-assessment for the inaugural edition of the *Training Times*. Along with the self-assessment, most providers expressed their opinions regarding the format and content of the *Training Times*. We are grateful for your input and have implemented several changes with this issue. The self-assessment is now in a multiple choice format. Please note, questions are content based and relate only to the material presented, not to your personal experience or agreement with the content. This is an open book assessment and a score of 80% is required to earn credential points. ***The assessment is now on-line.*** Once you have finished reading the *Training Times*, log on to www.utsprokids.org to take the assessment. Follow the directions to submit the assessment and you will be quickly notified of your score and you will receive documentation of the credential points you earned. No torn out pages, copies, or postage. ***The deadline for this assessment is May 15, 2005,*** assessment answers will be posted following that date. Please don't wait until the last day! If you must, you may mail in your assessment, but it will take longer to process (faxed assessments will not be accepted).

In this issue you will find two articles. ***Maximizing Your Role in Early Intervention*** was reprinted, with permission, from *PT Magazine*. The article will provide a review for our seasoned providers and a good foundation for those new to First Steps. It was suggested by a First Steps provider. We have received other article suggestions and are reviewing these for future issues. The second article, ***Sharing Information and Adaptations with Child Care and Preschool Providers***, is an original article from the Indiana Institute on Disability in the Community (IIDC). Also included are safety tips for home visitors, and an announcement for an opportunity to become involved in a research project. No need to rush to the BCD Updates for the latest information on what's changing in First Steps—you won't find any! Surely whatever they would have written today would be outdated by the time this issue reaches you. To stay informed, log onto the First Steps web page at http://www.state.in.us/fssa/first_step/index.html. UTS ProKids is also posting all state announcements on our web page at www.utsprokids.org. We do this because information to be posted on the state web page can get backlogged, especially when the legislature is in session.

Lastly, you provided us with a wealth of suggestions for topical trainings. Many of these were already in the works and some have already taken place. Please look over the list of topical trainings offered. We are completing our schedule of trainings for this fiscal year (through September 30, 2005). Please save the following dates for two Bureau of Child Development Institutes June 13, 14, & 15 and August 1, 2 & 3, 2005. These multi-day sessions are being developed to provide advanced level training, featuring national and local presenters, for First Steps, Healthy Families, Child Services and Child Care providers at minimal cost. Also in August, Larry Edelman, nationally known speaker is returning to Indiana to present, "Changing The Way We Think About Change". Larry was booked last Fall, long before we knew how badly we would need his sage advice on change and serving families and children in early intervention. Happy reading....

Ann Ruhmkorff - UTS ProKids

"Change is the law of life. And those who look only to the past or present are certain to miss the future" John F. Kennedy



INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

Maximizing Your Role in Early Intervention

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Early intervention--the provision of physical therapy and other services to children ages 0-3 under the Individuals with Disabilities Education Act (IDEA)--is a dynamic and rewarding area for physical therapists (PTs), according to PTs involved in such programs. They cite early intervention's distinguishing characteristics, including a family-centered orientation, a team approach, and the provision of services in a "natural environment."

As defined by Part C of IDEA, early intervention applies to children who are experiencing developmental delays or have a condition with a high probability of resulting in developmental delays. Part C is an optional program; states are not required to provide Part C services. However, if they opt in, then they are required to provide services to those categories of children. A child's early intervention service is specified in an Individualized Family Service Plan (IFSP). (See "Early Intervention in Brief.")

Natural Environment

Although many PTs are familiar with providing interventions in clinical settings, IDEA Part C requires--and PTs involved in early intervention endorse--a different perspective. The law specifies that, to the maximum extent appropriate to the needs of the child, early intervention services be provided in natural environments, including the home and community settings in which children without disabilities participate.

Children learn better in the environment in which they will be practicing their skills or exercises, says Beth McKittrick-Bandy, PT, MA, PCS. She explains, "[Physical therapy] does them no good if, while doing well in my gym by themselves, they can't generalize those skills in other situations like Sunday school or with friends." Also, she says, a PT can more accurately evaluate a child's progress by observing him or her at home or on the playground. Although she now is based in an acute care facility in Arkansas, McKittrick-Bandy formerly worked in early intervention for 11 years, both in a private clinic which contracted out to school districts and agencies and in a preschool early intervention program.

Toby Long, PT, PhD, says, "Our goal is to embed therapeutic strategies into routines irrespective of where they're occurring. For example, you can teach transfer skills from wheelchair to toilet in a variety of locations--home, work, restaurant, or library." Long is associate director for training at the Georgetown University Center for Child and Human Development and is Section Delegate for APTA's Section on Pediatrics. Lynn Jeffries, PT, PhD, PCS, points out that one step in the "natural learning process includes assisting families to identify other community locations where learning occurs."¹ Jeffries is on the staff in the Department of Rehabilitation Sciences, College of Allied Health, University of Oklahoma Health Sciences Center.

The definition of "natural environment" is not even limited by physical location. Long says, "'Natural environment' is defined by activities and routines within a context. It really depends on what you want for an outcome. You could provide your services in a variety of places--for example, a grocery store--if one of the family's goals is for the child to sit up in the grocery cart while the parent shops."

That said, there may be occasions in which a PT may be unable to provide physical therapy in a particular environment due to safety or other reasons, notes Barbara Connolly, PT, EdD, FAPTA. Connolly is president of APTA's Section on Pediatrics. In those cases, services might be provided in a child care facility or in another family member's home, Connolly says. If this occurs, the reason for the change in therapy environment should be clearly noted in the IFSP. PTs must be flexible in their approach: Frequent communication with the parent will make it easier to identify new places to work with the child and observe his or her progress.

"Flexibility is key, in order to meet the individualized needs of the child and his or her family," McKittrick-Bandy points out.

Family-Centered

Early intervention is explicitly family-centered. In fact the document that is developed to guide the services is the Individualized Family Service Plan, as specified in Part C of IDEA. Long notes that this stands in contrast to Part B of IDEA, which defines a parallel document, the Individualized Education Plan (IEP), for children over the age of 3. "Unlike Part C, which is family-centered, Part B services are child-centered. The child's needs are addressed in the IEP."

A recent presentation during a program on providing services in natural environments identifies the gathering of information from families as a key practice in the IFSP process.² A family's interests, assets, and priorities should be identified by asking such questions as:

- Where do you and your child spend time?
- What activities do you and your child like to do?
- What activities do you and your child have to do?
- What activities would you and your child like to do?

McKittrick-Bandy points out the importance of incorporating family dynamics when appropriate. For example, involving siblings in the therapy session may help them feel included.

The Team Approach

IDEA defines the role of the service provider as consulting with parents, other service providers, and representatives to ensure the effective provision of services; training parents and others to provide those services; and participating in a multidisciplinary team assessment of a child and the child's family, and in the development of integrated goals and outcomes for the IFSP.

The early intervention team consists of the parent(s) and health care and other professionals. These may include social workers, psychologists, occupational therapists, speech-language pathologists, and, of course, physical therapists. The composition of the team varies from child to child, reflecting the individual needs of the child and family.

Long explains why early intervention teams may not be limited to health care professionals. "Early intervention consists of a range of services, not professionals. Transportation can be an early intervention service. Assistive technology can be an early intervention service."

Collaboration is a critical component of teaming in early intervention. A variety of service delivery models are available (see below). The recommended and generally accepted models of practice are interdisciplinary and transdisciplinary. "[PTs] have a responsibility to discuss [a child's intervention] with the team, but all team members do. That can be an education process, too. Sometimes people don't know what PTs can or can't do," says Irene McEwen, PT, PhD. McEwen, an educator at the University of Oklahoma Department of Rehabilitation Sciences, has worked in early intervention in school systems in Washington and Arizona. She adds, "It's important to have good communication within a team."

That's a sentiment echoed by many PTs in early intervention settings. In her doctoral dissertation, *The Culture of a Transdisciplinary Early Intervention Team*,¹ Jeffries defines the basic elements of teamwork as "communication, collaboration, conflict prevention and resolution, and personal and professional development."

However, when team members are working under busy schedules, communication easily can break down

and coordinating services can become a challenge. Connolly offers a remedy: Plan contact times with team members in advance, either by phone or email. Don't leave it at an informal "when-I-have-time" schedule. If team members don't discuss cases frequently, they miss out on opportunities to share--and listen to--problems they are encountering or progress the child is making. Either of these can affect decisions regarding frequency and nature of physical therapy and other services.

Open and frequent communication is essential among all team members--and this includes the parents. By asking questions about the child's progress and listening to parents' concerns (and joys!), a PT can provide interventions more effectively and positively reinforce or gently correct the way a parent is working with their child. "If you don't listen, you won't know how much is learned between visits," says Kathryn David, PT, MS, PCS. David has been a pediatric clinical specialist for over 25 years, most recently working with the 0-3 population at an Iowa educational agency. She cautions that when therapists consider a parent "noncompliant," sometimes the real issue is that the PT hasn't fully listened to the parent.

Service Delivery Models

The role of the physical therapist in all models includes coordination, communication and documentation, and patient/client-related instruction. The specific role of the physical therapist and of other team members will vary depending in part on the service delivery model being used. A number of different models exist. In all service delivery models, the parents are full participants in the team and have the final say in the nature of interventions, including, but not limited to, frequency and duration of interventions and which outcomes are the highest priority. Long says, "The choice of model should be based on the needs of the child and family." The models include-

Multidisciplinary--In the *multidisciplinary* approach, professionals provide separate evaluations and assessments, set their own discipline-specific goals for the child, and implement individual intervention plans. The team members may communicate with each other on a less frequent and less formal basis than with other models.

Interdisciplinary--An *interdisciplinary* team requires interaction among the team members for the assessment and development of the intervention plan (IFSP). The team determines the best method for service delivery that may include one or more providers. Susan Effgen, PT, PhD, at the University of Kentucky, has worked in early intervention since the 1970s. She says the interdisciplinary model "helps in coordination [of services], because there are less folks involved in child's care in the home." She says that this model, when properly implemented, can lead to more people with relevant expertise providing hands-on services than in other models.

Transdisciplinary--Today, the most prevalent model is the *transdisciplinary* one, according to a 2002 survey reported by Jeffries.¹ This model calls for one team member to provide all the interventions. To accomplish this other members must teach the service provider aspects of their discipline. This is called role-release. Taken literally, therapists would have legal and ethical concerns "releasing" aspects of their discipline. Taken in a broader perspective, therapists may teach others activities or intervention strategies that do not require the expertise of the therapist. *The Guide to Physical Therapist Practice*³ provides for this practice in coordination, communication and documentation, and patient-client-related instruction. It is important that the family and other team members understand that when performing the activities the therapist taught them, they are only doing activities, *not* providing physical therapy.

Primary Service Provider--This is an example of the *transdisciplinary* model. In this model, a single, long-term service coordinator is assigned to a family from the point they enter into the program. The selection of service provider should be determined by the area of greatest need. The provider establishes a relationship and works with the child and family throughout the duration of the child's care. Long notes, "One reason the primary service provider evolved is that young children should not have to tolerate the interaction with four or five different professionals every week. With a primary service provider, a child can develop a significant relationship with one provider who is collaborating with the other team members."

A Summary of Early Intervention: Physical Therapy Under IDEA

The Individuals with Disabilities Education Act (IDEA, PL 105-17) is a federal law that supports the provision of public education for all children regardless of the nature or severity of their disability. Part C of IDEA is an optional federal program that supports early intervention for infants and toddlers (birth up to 3 years). All states currently participate in Part C. Under IDEA, states are mandated to provide identification, evaluation, treatment, and follow-up services to such children and their families to promote development and lessen the effects of the condition. Early intervention services must be provided at no cost to the family. (Ed. Note-Only Evaluation is at no cost, cost participation is allowed for ongoing services)

Implementation of IDEA Part C is the responsibility of each state through a lead agency appointed from education, health, human services, public health, or another related state agency. Part C requires that multiple agencies work together and collaborate on meeting the needs of infants and toddlers and their families in their states and communities. Eligible children are those who have a developmental delay or a medical diagnosis that has a high probability of a developmental delay. States define the eligibility criteria for developmental delay by addressing the child's development in cognition, physical, communication, social or emotional, and adaptive (self-help) domains or areas. Screening, evaluation, and assessment are distinct processes with different purposes under the provisions of Parts C and B. Screening (including developmental and health screening) includes activities to identify children who may need further evaluation in order to determine the existence of a delay in development or a particular disability. "Evaluation" is defined as the procedures used by "appropriate qualified personnel to determine a child's initial and continuing eligibility," consistent with the state definition of infants and toddlers with disabilities. It includes determining the status of the child in each of the developmental areas. "Assessment" is defined as the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify the child's unique strengths and needs and the services appropriate to meet those needs, and the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

Early intervention can be remedial, preventive, compensatory, adaptive, or promotive in nature. Services are specified in an Individualized Family Service Plan (IFSP). After a child is found to be eligible for early intervention, an IFSP meeting is held to determine the appropriate course(s) of action to take, based on the goals the parents have for their child. Attendees, in addition to parents, may include a physician, physical therapist, occupational therapist, the initial service coordinator, and others.

Physical therapy is one of the early intervention services under Part C of IDEA. Physical therapy may be the only early intervention service a child needs, or it may be part of a coordinated program. Physical therapists can be employed by a Part C lead agency or be hired by a contract with an outside agency or private practice. In states without direct access laws, PTs must obtain a referral from the child's physician prior to the evaluation and/or intervention.

Excerpted in part from Early Intervention: Physical Therapy Under IDEA. Available at [www.pediatricapta.org/graphics/IDEA Part C.pdf](http://www.pediatricapta.org/graphics/IDEA%20Part%20C.pdf).

Physical therapists, Connolly says, collaborate on a regular basis when teaching others on how to physically manage a child on a day-to-day basis. For example, a physical therapist may not always be available when it is necessary to position or reposition a child during speech therapy, so the PT must demonstrate to the speech pathologist the appropriate ways to position the child during therapy.

Alternatively, a physical therapist might need to teach the child sucking/swallowing in order to give the child fluids or food during a session. Sucking/swallowing is not something exclusive to speech pathologists, as it also qualifies as an oral-motor skill and is part of the APTA Section on Pediatrics' "Competencies for Physical Therapists in Early Intervention."⁴ and is included in functional training in self-care and home management in the *Guide to Physical Therapist Practice*.³

Empowering Parents

Empowering the parents is critical to the early intervention process because parents ultimately are the ones who will facilitate their child's progress. Connolly advises PTs: "Remember, this is the parents' child, not your own. We are not with the child 24 hours a day; the parents are. It's our job to empower the parent. It's not your *hands* that make the difference, it's your *brain* that makes the difference." When a PT is successful in teaching the parent how to work with their child, the child is more likely to develop the necessary skills, Connolly says.

One responsibility of a PT in early intervention is to educate parents by providing them with accurate and current information about their child's condition. At the time of initial evaluation, most parents are not knowledgeable about their child's particular medical condition and may not understand how their child's prognosis will translate into

everyday life activities, according to McKittrick-Bandy. This is true of both parents whose children were born with disabilities and those whose disabilities are acquired, such as in a car accident. "We have to educate and prepare parents in how to use home programs to help their child," McKittrick-Bandy says. She warns, "PTs often feel a strong need to help parents [with daily routines], but it is the job of the PT to teach them to advocate for their child and to make sure parents know what their child's needs are."

Even though at times it may be difficult, the team must respect the parent as the final authority on the goals for their child. IDEA gives parents the final say unless their decision endangers the child. This may result in differences of opinion between the PT and the parent about the child's needs. To effectively advocate for the child without overstepping one's bounds, Effgen suggests providing books, brochures, and Web sites to educate the parents about their child's condition. "Parent groups are also helpful to meet other parents who have children with similar problems, see how they've dealt with it, and learn why a therapist suggests certain things," she says.

By communicating openly, educating each other, and listening to the parents and other professionals on the team, PTs can empower parents and instill confidence in a child. Effgen says, "Parents really want to participate. It's critical getting them involved in daily activities."

Parent education also should take into account most parents' relative lack of knowledge about their rights under IDEA. A PT might need to explain how an IFSP works and how important the parents' role is in the IFSP process. For instance, parents may not know that IDEA requires reviews at least every 6 months—more frequently if the parents request—and should be evaluated annually. Nor may parents know that they themselves hold the final decision-making power. Of course, in order to make sure parents know the law, PTs must be well-versed in it. McKittrick-Bandy offers, "PTs should be encouraged to keep up with changes in the law so that they can pass this knowledge on to families."

And that's true for all PTs with pediatric patients, Long says. "Even if they're not involved in early intervention, PTs should know the system intimately because the children they see might be eligible for services if sought by the family. Services are provided not only for remediation, but also for support to the family to manage their child. Therefore, support could be from individual providers, or by helping the family get to a support group, transportation for the child, respite care, connecting the family to others in the community with the same disability, assisting with Medicaid, or completing paperwork for Social Security benefits. Although the physical therapist would not necessarily be providing that assistance, the entire early intervention system would be involved."

A Different Perspective

Long says, "The early intervention system has prompted in many practitioners a different way of thinking about providing intervention. It starts with 'What do you want the child to accomplish?' and works backward to figure out what services they need to accomplish that outcome. Always start from the endpoint, then develop your strategies."

One researcher in the area of early intervention describes a new paradigm for developing and implementing such programs.⁵ Characteristics of this approach include:

- Family-centered vs professionally-centered models
- Strength-based vs deficit-based models
- Empowerment vs expertise models
- Resource-based vs service-based models
- Enhancement and optimization of competence and positive functioning vs remediation of a disorder, problem, disease, or its consequence
- Professionals as agents of families and responsive to family desires and concerns vs professionals as experts who determine the needs of people from their own perspectives

Long also says that early intervention has prompted PTs to reevaluate their own role. She says, "Health care providers have assumed, 'If the person is in the room, they must need me' instead of asking 'What does this person need?' Even if he or she has a disability, what they need may have very little to do with your skills and abilities. The therapist needs to think about her role within a system of care. A system of care for children with disabilities is large and varied. It could include the family, the medical community, the education or early intervention system, the social service system, community-based resources such as libraries, parks, and activities. The providers of all these systems and activities could have skills to help the family reach their goals for their children and realize their dreams."

References

- 1 Jeffries LM. *The Culture of a Transdisciplinary Early Intervention Team* [dissertation]. Oklahoma City, OK: The University Of Oklahoma Health Sciences Center Graduate College; 2003.
- 2 Shelden M, Rush D. Enhancing Services in Natural Environments. March 31, 2004. Part of a Web-based conference call series sponsored by the OSEP Part C Settings Community of Practice. Available at www.nectac.org/~calls/2004/partcsettings/partcsettings.asp. Accessed October 7, 2004.
- 3 *Guide to Physical Therapist Practice*. 2nd ed. Alexandria, Va: American Physical Therapy Association; 2001.
- 4 APTA Section on Pediatrics' Task Force on Early Intervention. Competencies for Physical Therapists in Early Intervention. 1991:3(2).
- 5 Dunst CJ. Revisiting "Rethinking Early Intervention" *Topics in Early Childhood Education* Summer 2000. Available online at www.findarticles.com/p/articles/mi_m0HDG/is_2_20/ai_68206914. Accessed August 19, 2004.

For More Information

For additional information about early intervention and physical therapy, contact the following resources.

APTA Section on Pediatrics

www.pediatricapta.org

800/999-2782 x3254

Office of Special Education Programs, US Department of Education

www.ed.gov/about/offices/list/osers/osep/index.html

202/245-7459

National Early Childhood Technical Assistance Center

www.nectac.org

919/962-2001

IDEA Infant and Toddlers Coordinators Association

www.ideainfanttoddler.org

317/353-8075

Council for Exceptional Children

www.cec.sped.org

888/CEC-SPED

Hanen Workshop

Involving Parents as Language Facilitators – A 3-Day Hanen Certification Workshop for Speech-Language Pathologists on *It Takes Two to Talk* –The Hanen Program® for Parents.

June 23, 24 & 25, 2005

Indianapolis, IN

Hosted by ProKids, Inc.

In *Involving Parents as Language Facilitators*, speech-language pathologists also learn to lead *It Takes Two To Talk* — The Hanen Program® for Parents. In this innovative early language intervention program, SLPs teach parents how to promote their children's language development in every day interactions. The goal of this program is to enable parents to become their child's primary language facilitator so that language intervention becomes an ongoing process.

Go to www.Hanen.org for workshop and registration information. Space is limited to 14 participants (SLPs only).

Safety Tips For Home Visitors

The vast majority of First Steps services are provided in the natural environment, including family homes, daycare, and other community venues. For First Steps Intake/Service Coordinators and Direct Service Providers these home visits can pose dangerous situations. Your personal safety, as a First Steps provider must always be a top priority. A few small changes in your daily routine can help you can feel a lot more confident that you are doing everything possible to keep yourself safe. We all wish our visits could be made to those "vine-covered cottages with picket fences" but the reality is that most of us provide home care in less than optimal conditions in both urban and rural settings. Plan now to remain safe.

Here are just a few suggestions:

- Always carry a charged cell phone. Check with your carrier to make sure your cell phone can be tracked when you place a 911 emergency call.
- Know your service area. Drive through it, noting safest routes in and out, community centers, police and fire stations, hospitals, libraries, churches, restaurants and other public places that could provide a safe haven, if needed.
- Try to schedule visits to less safe areas during the daylight, and avoid unsafe areas at night.
- Let your family know when you will be arriving. Do not make unscheduled visits. Consider asking the family to meet you at the door. This is especially helpful when families live in large apartment complexes.
- Be observant and survey the area when approaching the family's home or apartment. If illegal or dangerous activity appears to be occurring, keep driving to a safe area and notify the family and police, if necessary. **When In Doubt Get Out!**
- Always lock your car. Do not leave articles in plain sight to avoid the risk of theft.
- Keep your car in good working condition and always check your gas before your visit.

- Dress conservatively, in comfortable clothes and shoes that allow you to move quickly.
- Do not carry a purse, keep your keys in your pocket.
- If someone attempts to rob you, don't resist. Give up your property, not your life. On the other hand if someone tries to force you into a vehicle or building, fight back (yell, kick) even if they have a weapon. You are at significantly greater risk if you are forced into a vehicle or building.
- When entering a home be observant; look for exits, weapons, drugs and dangerous situations. If weapons or drugs are seen or those present appear to be under the influence of drugs or alcohol, make a quick excuse to leave and report the situation.

Leave detailed schedules and contact information with your agency or other identified person, including:

- make, model, color and license number of your car
- home and mobile telephone number
- names, addresses and telephone numbers of children/families to be visited each day
- approximate times of visits,
- agreed time for you to make contact after your last visit

Develop a plan for what your agency or contact person should do if you fail to check in:

1. Call you on your mobile phone.
2. If no answer, telephone your home number.
3. If not there, telephone the home numbers of families visited, in reverse order.
4. If not found, allow the agreed upon time period to elapse, then inform the police.

Safety should always be your first priority!

Medicaid Enrollment

In its February 7, 2005 letter, the state notified all First Steps providers, except Service Coordinators and Developmental Therapists, that they are required to complete a First Steps Medicaid Enrollment packet (even if they are already a Medicaid provider). Enrollment is to occur in two phases. Enrollment packets for Phase I counties (Adams, Allen, Delaware, Elkhart, Grant, Hamilton, Hendricks, Howard, Johnson, Kosciusko, Lake, LaPorte, Madison, Marion, Marshall, Morgan, Noble, Porter, & St. Joseph) were due 2/28/05. The remainder of the counties are in Phase II and their enrollment packets are due 3/31/05. The state has posted instructions on its web page for those who missed the deadline or who need an extension.

Medicaid enrollment is required so that the state can bill the Medicaid Managed Care Organizations (MCOs) for eligible First Steps services. The state pays these MCOs a capitated rate (fixed monthly fee) to provide a set of covered, medically necessary services for children in their care. Some of these services (OT, PT, SLP and other services) should have been paid by the MCO and not directly by Medicaid. Your timely enrollment will allow the state to proceed in the process of ensuring that all the MCOs are appropriately billed for First Steps services. It had been erroneously reported in the media that First Steps providers double billed the state for First Steps services. This simply isn't true.

A video tape of the Medicaid Enrollment training held 2/18/05, handouts and the enrollment packet is available on the UTS-ProKids web site. Please be patient, the video clips download slowly. Questions regarding Medicaid enrollment should be directed to your Bureau of Child Development Consultant.



Remember your annual training fee includes registration for Service Coordinator Regional Meetings, the Mandatory Cluster Meetings and the Training Times.

Sharing Information about Adaptations with Child Care and Preschool Providers

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As therapists working within the First Steps system, we are providing services more and more frequently in community child care and preschool settings. This approach ensures that children are receiving therapies in one of the settings in which they will be using their new skills. A further advantage of this service delivery model is that it provides the opportunity to support the adults who have the potential to greatly influence the success of the children we see in their programs. It is important to remember that it is not only our specific therapeutic goals that need to be addressed, but children's ability to interact more easily and appropriately with their peers and the curriculum. This can come about through helping community care providers identify and use adaptations that meet the needs of young children with disabilities.

This article first presents a framework of nine types of general adaptations and then a guide you can share with community care providers to assist in choosing adaptations to support children and enhance therapeutic goals in their community settings. You will note that these are not precise categories, but a *framework* for thinking about how to logically and consistently encourage community care providers to adapt their strategies to meet the needs of the children we are supporting in their settings. *Please also remember that many of these adaptations are appropriate to children in their homes. We have chosen, in this article, to focus on community child care settings, but adaptations happen everywhere.*

Nine Types of Adaptations

<i>Environment</i>	<i>Time</i>	<i>Input</i>
<i>Output</i>	<i>Difficulty</i>	<i>Participation</i>
<i>Level of Support</i>	<i>Alt. Teaching Opportunities</i>	<i>Alternative Goals</i>

This table provides an overview of the types of adaptations. The types may be used together or individually. When you present the table to the community care providers, note the differences in shading and suggest that they may already be using the types that have no shading. Offer examples of some adaptations they already use, so that they can see the possibilities.

Group 1: The first set of adaptations are most transparent, easiest to understand and easiest to implement. They are the ones that we often suggest to community care providers as ways to assist all children in being full participants in all curricular areas, routines and activities. They involve helping the child to access the setting, equipment and materials, engage in the routines and learning experiences, and develop positive relationships with other children. Let's take a look at some examples below.

<i>Environment</i>	<i>Time</i>	<i>Input</i>
<i>Output</i>		
<i>Level of Support</i>		

Environment: *Adapt the flow of the room, seating, and positioning options. Adapt materials to meet the child's needs.* This adaptation is probably the one we first think of when discussing adapting for children with special needs. It involves such things as widening paths between furniture to allow for wheelchair access or making switch toys for children with limited motor control. Special equipment falls into this type of adaptation.

Time: *Adapt the time allotted and allowed for learning or task completion.* Some children need more time to complete a task that other children in the setting may find easy. This not only includes physical tasks such as dressing and undressing for diapering or recess, but also tasks that require processing of information, tasks that require either repeated presentation or practice, and transitions between activities that may be challenging for many children.

Level of Support: *Vary the amount of personal assistance provided.* Supporting the child to do the task rather than doing it for him/her allows not only for learning within that task, but also for growth of positive self-esteem. Hand-over-hand assistance is something that community care providers are already likely to be doing to help children pull off socks, put on a cap, grab a toy, or hold a spoon. Help community care providers see how supporting a child's elbow can allow greater small motor control while being less intrusive in the child's actions.

Group 2: The second set of adaptations provides support to individual children who may need a more focused learning experience. These entail changing the nature of the learning experience or routine by simplifying an activity, adjusting the amount of product expected, or presenting the material in smaller chunks. Let's take a look at some examples of these types of adaptations.

	<i>Difficulty</i>	<i>Participation</i>
	<i>Alt. Teaching Opportunities</i>	

Difficulty: *Adjust the skill level, complexity, or the rules of how the child approaches the activity.* When a provider adjusts the skill level, complexity, or the rules of how a child approaches the activity, they are adapting the difficulty of the task. Having a child put out one arm for his jacket rather than putting it on independently, or placing spoons rather than setting the whole table for lunch, are all examples of adapting the difficulty of a task. If this sounds like a logical progression of developmentally appropriate skills, IT IS!

Participation: *Adapt the manner or way in which the child is actively involved.* Not all children need to participate in all activities and routines in exactly the same way. Having a child turn the pages of a story book while you read rather than having her retell the story is an example of how a child can participate in a literacy activity without having high verbal skills. A provider can encourage a toddler to stand and "dance" holding onto a piece of furniture while the other children are dancing around the room.

Alternative Teaching Opportunities: *Use other opportunities in the day to teach the child concepts and/or skills presented in planned activities.* Encourage child care providers to look at opportunities throughout the day during which they can address the intended skill. For example, an outcome you might suggest would be making choices between water and milk, but choosing could also be addressed with which book of two, which rattle, or cuddle toy.

Group 3: The last adaptation involves the greatest amount of change in curriculum and instruction. Alternative goals are used when the goals of an activity are not individually appropriate for a child. This adaptation calls for an appropriate, but alternative goal to be designed for the child within the *same* activity in which peers are participating. As therapists, we are in a position to help the child care provider identify goals which will not only support our therapeutic outcomes, but assist them in finding ways to further include all children in all activities and routines in their setting.

		<i>Alternative Goals</i>

Alternative Goals: *Identify an individual goal or outcome within a learning activity that has a different focus for the other children.* An important skill is eye-hand coordination for manipulating small objects. Community care providers may present this as a group activity by seating all of the young toddlers face-to-face in their high chairs and placing a number of crackers on each child's tray. A child who is unable to eat crackers or other solid food could sit in her high chair with a button switch on her tray, and work on using the switch to activate a music tape or a toy.

A Guide to Choosing Adaptations for a Child

When helping a community care provider begin to choose adaptations, take a few minutes together to consider the child's development, strengths and needs, plus the child's individual goals or outcomes. Choose an appropriate adaptation or group of adaptations that will enable the child to participate and learn. Start with the most natural, least intrusive adaptations.

(continued on page 12)

The adaptation that you choose should answer questions such as the following:

- Will it help the child to get to the learning experience, use the materials, or participate in the routine?
- Will it help the child to communicate with adults and peers?
- Will it help the child to gain the knowledge or acquire the skill expected in the learning experience?
- Will it enable the child to complete the activity or routine and demonstrate success?
- Is it the appropriate amount of support so that the child is challenged, yet can succeed?
- Is it the most natural and least intrusive adaptation possible, to support the child’s participation, learning, and membership?

During the activity, it may become apparent that further adaptations are necessary or that too many supports have been provided. Compare the responses of all the children taking part in the activity. Consider whether the activity is working effectively. If not, adjust the complexity, length, or other aspects for everyone. Observe the participation and responses of the individual child to determine if child-specific adjustments should be made. Adjustments may take three forms:

- A change in the **type** of adaptation used.
- A change in the **amount** of adaptation needed.
- A change in the **number** of adaptations used.

Early intervention is all about increasing children’s skills and development within every day routines, activities, and places. Since participation in community child care and preschool settings is common among young children, including those with disabilities, it is critical that children have successful experiences within these community settings as well as at home. This success is greatly influenced by the child care and preschool providers who work with the children. While early interventionists know many adaptive strategies, community child care and preschool providers may not have this knowledge. Early interventionists can use the nine types of adaptations and framework presented in this article for guiding community providers in learning how to meet the needs for young children in their care.

Nine Types of Adaptations

<p style="text-align: center;"><i>ENVIRONMENT</i></p> <p>Adapt the flow of the room, seating, and positioning options. Adapt materials to meet the child’s needs. <i>For example:</i> Add cups and spoons with large, thick handles to the water table for the child who has difficulty holding smaller items.</p>	<p style="text-align: center;"><i>TIME</i></p> <p>Adapt the time allotted and allowed for learning or task completion. <i>For example:</i> Call the child to be first to put on a coat for outdoor play so that he has the time to do it independently.</p>	<p style="text-align: center;"><i>INPUT</i></p> <p>Adapt the way you present information and materials to the child, including the way you talk. <i>For example:</i> Use gestures or object cues along with your spoken words to help a child understand what the next activity will be.</p>
<p style="text-align: center;"><i>OUTPUT</i></p> <p>Adapt the way the child communicates, including the way he responds to what is learned. Adjust how much you expect to be accomplished. <i>For example:</i> Arrange two objects in positions that will help the child choose a play activity by looking at one or the other.</p>	<p style="text-align: center;"><i>DIFFICULTY</i></p> <p>Adjust the skill level, complexity, or the rules of how the child approaches the activity. <i>For example:</i> Ask the child to put objects in a wide open box as opposed to a small container.</p>	<p style="text-align: center;"><i>PARTICIPATION</i></p> <p>Adapt the manner or way in which the child is actively involved. <i>For example:</i> A child can participate in a music activity by activating the tape with a switch while others sing and clap.</p>
<p style="text-align: center;"><i>LEVEL OF SUPPORT</i></p> <p>Vary the amount of personal assistance provided. <i>For example:</i> Put your hand over the child’s to guide his movement for placing puzzle pieces and then lessen your help as the child begins to show independent ability.</p>	<p style="text-align: center;"><i>ALTERNATIVE TEACHING OPPORTUNITIES</i></p> <p>Use other opportunities in the day to teach the child concepts and/or skills presented in planned activities. <i>For example:</i> Use over-sized dress-up clothing to work on dressing skills typically emphasized in arrival and departure or diapering and toileting times.</p>	<p style="text-align: center;"><i>ALTERNATIVE GOALS</i></p> <p>Identify an individual goal or outcome within a learning activity that has a different focus for the other children. <i>For example:</i> Encourage a child to open her mouth to indicate readiness for the next bite, while others are learning to self-feed. This child’s goal is communication as opposed to self-help.</p>

Training Calendar Highlights

You can learn more about any of these trainings at <http://earlychildhoodmeetingplace.indiana.edu/>. You are advised to enroll early as many courses have class size limits.

On-Line NOW	First Steps Medicaid Enrollment (Video Training) UTS-ProKids hosted the Enrollment Training on February 18th. You can view this training on-line. Also on the web site are copies of the FSSA letter, enrollment packet and a copy of the training handouts. There is no charge for this on-line training.	www.utsprokids.org
March 23-24, 2005	SC Level II Training (mandatory for new Service Coordinators) All new Service Coordinators must complete Level II training within one year of enrollment, but not earlier than 6 months after enrollment. Two days, \$75 (Lunch on your own) Additional date ...July 28 & 29, 2005 Indianapolis, IN	Indianapolis, IN
April 1, 2005	Environmental Factors in Social/Emotional Development The social/emotional development of young children is influenced by many factors. Denise Senter will address a variety of these issues, including family dynamics, poverty, mental health, substance abuse and abuse/neglect. 8:30AM—4:00PM. Through IIDC—special price \$40.	Plymouth, IN
April 14, 2005	How Literacy Can Facilitate Sitting, Standing, Jumping... This presentation will offer literacy activities than can easily be incorporated into all early intervention disciplines. Literacy activities will be discussed and modeled that facilitate the development of communication, gross motor, fine motor, and social/emotional skills. Presented by Karen Thatcher, Ed.D., CCC-SLP & Claudia McVicker, Ph.D Ball State University. \$25 at Ivy Tech Muncie	Muncie, IN
May 17, 2005	Early Intervention in Everyday Routines, Activities and Places Elizabeth Traub, IIDC	Indianapolis, IN
May 4, 2005	Insurance Basics for Service Coordinators & Parents Michele Trivedi, parent of a child with autism with a Master's degree in Health Services Administration will present information on health insurance as it pertains to autism, Indiana Insurance Mandate and how to obtain services. \$25 Warren Township Education Center.	Indianapolis, IN
May 5 & 6, 2005	Integrating the Neurological and Emotional Development of the Child on the Autism Spectrum Presented by the Indiana Resource Center on Autism. Participants will develop a working knowledge of the principles underlying "floor time" therapy with children on the autism spectrum. \$150 two day workshop, Radisson Hotel at the Airport—Indianapolis, IN	
May 25, 2005	New Provider Orientation Follow—Up (Mandatory for new providers) New providers must attend this half day session within one year of enrollment Additional Dates June 24, 2005 Valparaiso, IN July 21, 2005 Columbus, IN	Indianapolis, IN
June 1, 2005,	Home Visiting	Indianapolis, IN
June 13-15, 2005	Bureau of Child Development Institute—2 separate conferences Save the dates...National and local presenters, advanced level training Additional dates August 1, 2, & 3, 2005	Indianapolis, IN
August 20, 2005	L. Edelman - Changing The Way We Think About Change	Indianapolis, IN
Sept 15, 2005	Writing IFSP Outcomes Michael Conn Powers, IIDC	Bloomington, IN

Don't forget to attend your Cluster Meeting. All Intake/Service Coordinators and Direct Service Providers are required to attend the designated meeting in their Cluster between February and June 2005. Some dates locations have changed, please check the early childhood calendar.

May is Service Coordinator Regional Meeting month. All Intake/Service Coordinators should be registered for the semi-annual mandatory meeting. **The Cluster 12 Service Coordinator Regional Meeting was overbooked and registrations exceeded fire code limits. A second meeting has been added on May 5, 2005. A letter was sent to all Service Coordinators who initially registered for the May 4, 2005 meeting explaining that they must re-register for one of the above dates.**

Child Obesity Prevention—Indiana (CHOP-IN)

First Steps Providers and Service Coordinators your help is needed.

The growing epidemic of childhood obesity demands the development of practical, effective and evidenced-based prevention programs. Childhood Obesity Prevention—Indiana (CHOP-IN) is a project with the overall priority to reduce the incidence of childhood obesity in Indiana. **The successful implementation of this project requires all First Steps providers and service coordinators to participate in an online pretest and survey.**

The first year of this project is a needs assessment of the First Steps Early Intervention System and involves assessing: current knowledge of obesity prevention; current data collection during referral, intake and eligibility determination; recommended actions and available resources; and training and information needs related to childhood obesity. The results of the needs assessment will be used to develop: 1) a screening tool for early intervention of at-risk children to improve precision of referral and consultation; 2) statewide educational training sessions for First Steps providers and service coordinators regarding the screening tool, the epidemic of childhood obesity, and how to address this issue with the families they serve; and 3) a compilation of resources for providers and service coordinators, via the First Steps web site and Cluster System Point of Entry offices.

When completed, CHOP-IN will contribute evidenced-based, best practice guidelines for preventing childhood obesity, and will help improve the health of a substantial number of children and families. This project is a collaborative effort of the Riley Child Development Center, Indiana University, and the First Steps System and is funded by the Indiana State Department of Health. Contact Steve Viehweg at sviehweg@iupui.edu or Lorrie Ippensen lippense@iupui.edu for questions.

Log on to: www.utsprokids.org, click on Partners and Links to take the online test and survey.

Directions for On-Line Self-Assessment



Everyone is encouraged to complete their *Training Times* self assessment on-line. Once you have read *Training Times*, simply log on to the UTS-ProKids web site at www.utsprokids.org. Click the Newsletter button. You will be asked to log in. Each First Steps provider has been assigned a unique identification number, you will find that number on the address label of your copy of the *Training Times*. Once you have successfully logged in, complete the requested information and take the assessment. You will receive an immediate confirmation that your assessment has been submitted. Your assessment will be graded and you will receive your score and credential point verification via email with 14 days. You may also submit comments regarding the *Training Times* and training suggestions, while online.

If you are a new provider or you did not receive a personal copy of the *Training Times* you must email jreynolds@cibaby.org to receive your unique identification number. Please **do not use another person's number**, as credential points will not be credited to your file. If you are enrolled as an agency and as an independent provider you should only will receive one identification number. If you received two copies of the *Training Times* with two different numbers, please contact Julie Reynolds by email at jreynolds@cibaby.org.

Remember the deadline to complete your assessment is May 15, 2005.

Self-Assessment

For faster results and an email confirmation of credential points, take this assessment on-line at www.utsprokids.org. Those choosing to use this paper version, must MAIL (no faxes will be accepted) this page (a quality copy is acceptable) to UTS-ProKids Training Times; 2511 E. 46th Street Suite E-1; Indianapolis, IN 46202. DEADLINE is May 15, 2005.

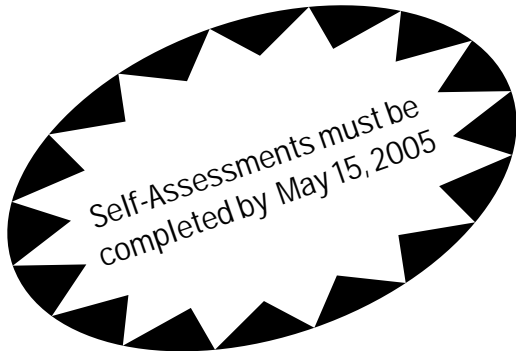
Name: _____ ID # from address label _____

Address: _____

- _____ 1. When choosing adaptations, encourage the child care provider to:
- choose the most intensive adaptation first, then decrease the intensity as needed.
 - choose the most intrusive adaptation first, then decrease as needed.
 - choose the least intrusive, most natural adaptation first.
 - both a and b.
- _____ 2. Using an alternative goal to adapt a group activity or routine means:
- Finding another time or routine in which to teach the child the skill.
 - Changing the activity or routine for the group so the child can succeed.
 - Helping the child to work on an individual goal that can be addressed within the same activity in which the group is engaged.
 - Providing the child with a different activity that will support development.
- _____ 3. When helping child care providers to adapt an activity or routine by adjusting time, they should consider:
- giving the child more time to complete the activity.
 - shortening the length of time an activity takes.
 - repeating the activity more frequently over the course of the day.
 - all of the above.
- _____ 4. Which is not an example of adapting level of support?
- Hand-over-hand for tying shoes
 - Supporting a child's elbow with your hand to help child bring a spoon to his mouth
 - Using pictures to show steps of washing hands
 - Helping a child get on top of a climber by guiding her feet on ladder steps
- _____ 5. To be safe, home visitors should:
- Carry a cell phone
 - Leave a daily schedule and contact information with their agency or another person
 - Make an excuse to cut the visit short if those in the home appear to be under the influence of drugs or alcohol
 - All of the above
- _____ 6. All of the following are reasons why IDEA Part C services are required to be performed in the natural environment, **EXCEPT**:
- Children learn better in the environment in which they will be practicing their skills or exercises.
 - The child's progress can be more accurately evaluated through observations in the home or playground.
 - Services in the natural environment cost less than in a clinical setting.
 - The natural environment includes activities and routines within a context, and not just a physical location.
- _____ 7. The service delivery model characterized by a one IFSP team member providing all the interventions is the
- Primary Service Provider Model
 - Transdisciplinary Model
 - Multidisciplinary Model
 - A & B
- _____ 8. Early Intervention is best provided by
- A rigid curriculum plan for each therapy session.
 - Five or six disciplines interacting with the child and family weekly.
 - Determining what the child needs to accomplish and working backward to determine what services are necessary to accomplish that outcome.
 - Emphasizing therapy over parent education.
- _____ 9. The most reliable source of information on any First Steps change is
- A Yahoo group or chat room
 - The state First Steps web page
 - Your neighbor who is a friend of the Governor
 - The news media
- _____ 10. First Steps providers have been double billing the state Medicaid program.
- True
 - False

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First Steps Stakeholder Forums



On March 2, 2005, FSSA Secretary Mitch Roob held a First Steps Stakeholder Forum for families, providers and advocates at the Indiana Government Center following a gathering of First Steps supporters at the State House. Sec. Roob made a brief presentation and then opened the floor to comments from those present. Written questions were also accepted and answers will be posted on the state web page. Because of the short notice and inclement weather, additional forums are scheduled.

The next Stakeholder Forum is scheduled for 1:00 PM, Friday, March 18, 2005 at The IU Southeast Campus in New Albany, Indiana. FSSA Secretary Roob, his staff and Dawn Downer, Part C Coordinator will be present. They will accept public comments regarding the First Steps System.

The third and final forum will be scheduled in the near future in northern Indiana. Watch the Indiana First Steps web page for information on date, time and location.

If you are unable to attend a First Steps Stakeholder Forum, you may submit your comments and/or questions to the First Steps web page at : http://www.state.in.us/fssa/first_step/index.html. Click on Policy Information and scroll down to the comment section.