FFY 16

Iowa’s SSIP Phase III Year 2
Progress Report – Part C

Submitted April 2, 2018
Iowa Department of Education
For more information contact:
Cindy Weigel, State Coordinator,
Vision

Every infant and toddler with or at risk for a developmental delay and their families will be supported and included in their communities so that the children will be healthy and successful.

Mission

Early ACCESS builds upon and provides supports and resources in partnership with family members and caregivers to enhance children’s learning and development through everyday learning opportunities.
# Iowa Part C State Systemic Improvement Plan Phase III Year 2

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Tania recently attended a workshop on caregiver coaching in natural environments. As an early intervention practitioner, she was excited to learn how to build her skills in providing services for infants and toddlers and their families in their home and community settings. Tania learned about the importance of not just sharing information with caregivers but using specific practices such as caregiver coaching to support family capacity building, the process in which practitioners partner with caregivers to increase their competence and confidence. The following week, Tania reviewed her notes and handouts about how practitioners and caregivers can collaborate through joint planning, observation, opportunities for practice, problem-solving, and reflection. She tried coaching each family she worked with and felt successful with some families, but she felt stuck with other families. She kept thinking about the Lamar family.

The Lamar family was receiving parenting services through child protective services, and Mr. Lamar was concerned that his son would be removed from him if he did anything wrong. Tania and Mr. Lamar had made headway in joint planning; he watched as she demonstrated use of instructional strategies, and he interacted with his son Maki throughout the session. However, when Tania tried to guide him to try a specific learning opportunity (e.g., “This would be a good time to try offering a choice”), he quickly stopped and said he had another chore to do. Tania reflected on sessions with the Lamar family, and she was feeling stuck in the “opportunities for practice” component of the coaching process. Active practice of embedded intervention strategies during the session would provide opportunities to build on Mr. Lamar’s strengths and work together through feedback and reflection to identify the next steps based on the interaction. She wondered how she could support family capacity building when the active practice opportunities were limited. Tania decided that to start, she would focus on building up Mr. Lamar’s confidence and competence by offering him specific feedback without any expectation of him doing something new.

Family capacity-building practices are defined as “practices that include the participatory opportunities and experiences afforded to families to strengthen existing parenting knowledge and skills and promote the development of new parenting abilities that enhance parenting self-efficacy beliefs and practices” (Division for Early Childhood [DEC], 2014, p. 10). When practitioners expand the focus of services from imparting knowledge and skills to caregivers to also building caregivers’ confidence and self-efficacy through a collaborative family-centered relationship, caregivers are equipped to flexibly use, adapt, and problem-solve the best ways to support their child’s development in everyday routines and activities (Brown & Woods, 2016).

In a capacity-building approach, practitioners learn about caregivers’ needs and priorities as the foundation for goal setting, recognize and build on family strengths for embedded learning opportunities, and provide meaningful supports and resources to enhance child development and family functioning (see Recommended Practices F5 and F6 in DEC, 2014, p. 10). (Trivette, C. M., & Keilty, B. (Eds.). (Ottley, Brown, Romano, Grygas Coogle, & Lakey, 2017.)
In Iowa, service providers like Tania continue to build their capacity to partner with families so that Early ACCESS services meet families' needs, strengthen their capacity to help their children, and ultimately enhance children's outcomes. An overview of the 2017 activities that support progress towards helping families to help their children develop and learn (Iowa’s State-identified Measureable Result, or SiMR) and the impacts of those activities are illustrated in the graphic below. Iowa’s State Systemic Improvement Plan (SSIP) provides updates on the 2017 work that has been implemented, data that was collected around the work, and what that meant for infrastructure improvements and systems level change as well as provider change.

**Iowa's Early ACCESS Early Intervention System Improvements 2017**

<table>
<thead>
<tr>
<th>Practice + Professional Development</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECSE, OT, PT, SLP, SC*</td>
<td>Internal Coaches</td>
</tr>
<tr>
<td>Cohorts move through 10 month Family Guided Routines Based Intervention (FGRBI) training</td>
<td>Continuous internal coach training &amp; support</td>
</tr>
<tr>
<td>50</td>
<td>15</td>
</tr>
</tbody>
</table>

**Outcomes**

**REDUCE:** Direct child teaching

**INCREASE:** Focus on family FGRBI knowledge FGRBI skills

**REDUCE:** Practice Drift

**INCREASE:** Fidelity Scale-up Sustainability

**Impacts**

**FAMILY**
- Family's ability to help their child
- Opportunities for child to practice and learn

**SYSTEM**
- Support use of evidence-based practices
- Family engagement
- Statewide in-service system
- Institutes of higher education

*ECSE=Early Childhood Special Educators; OT=Occupational Therapists; PT=Physical Therapists; SLP=Speech Language Pathologists; SC=Service Coordinators
A1: Theory of Action, including the State-identified Measurable Result (SiMR)

Almost six years ago, Iowa began to shift from compliance-focused early intervention to achieving better results for children and families served in Early ACCESS. Armed with deep reflection on practice, analysis of the early intervention system, and research on what works best for infants and toddlers; it was clear that more could be done to provide high-quality early intervention that is evidence-based and sustainable (reported in SSIP Phase I and II). Using Iowa’s area education agency (AEA) system, the Iowa Distance Mentoring Model (IA DMM) of professional development for Early ACCESS continues to support service providers’ practice shift to using Family Guided Routines Based Intervention (FGRBI) and Caregiver Coaching.

In FGRBI, it is the parent or caregiver who promotes child learning. The service provider supports and enhances the caregiver’s consistency and effectiveness to implement early learning opportunities within natural environments. Therefore, Iowa’s change efforts focus on building the competence and confidence of caregivers to embed interventions that are meaningful to the family into their everyday routines and activities. This will create increased opportunities for practice and learning for the child that simply would not occur while directly teaching the child. Ultimately families will be the ones implementing interventions and, therefore, seeing progress in their child’s development and learning. This would lead to an increase in the percentage of families reporting that Early ACCESS has helped them help their child develop and learn, Iowa’s SiMR (OSEP Indicator C4C). (See SiMR highlighted by the blue box in the Theory of Action.)

**Early ACCESS Theory of Action**

*Vision:* Every infant and toddler with or at risk for a developmental delay and their families will be supported and included in their communities so that the children will be healthy and successful.

<table>
<thead>
<tr>
<th>Strands of Action</th>
<th>If Early ACCESS</th>
<th>Then</th>
<th>Then</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>...uses coaching caregivers in family-guided, routines-based interventions</td>
<td>...Iowa will have high quality early intervention content and practices</td>
<td>...Iowa will have confident and competent caregivers; increased opportunities for teaching and learning throughout the day; and a state infrastructure to support and sustain evidence-based early intervention services</td>
</tr>
<tr>
<td>Personnel Development</td>
<td>...uses evidenced-based active implementation frameworks</td>
<td>...Iowa will have highly skilled early intervention staff</td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td>...fully implements all of the ECTA System Framework quality indicator elements and has all the subcomponents in place</td>
<td>...Iowa will have a high quality IDEA Part C system</td>
<td>...Infants and toddlers served in Early ACCESS will receive individualized services in natural settings and demonstrate improved functional outcomes</td>
</tr>
</tbody>
</table>
Iowa's efforts to shift from the traditional practice of teaching the child to building skills and support for caregivers began with the end in mind—improved outcomes for infants and toddlers. This helped determine the evidence-based practices service providers needed in order to work with families, which in turn helped identify the evidence-based professional development that needed to take place and the organizational supports needed to achieve improved results. The data and infrastructure analysis shared in the SSIP Phase 1, along with the implementation and evaluation plans from Phase 2, have informed improvement efforts throughout implementation.

**A2: Improvement Strategies and Principle Activities**

Iowa remains committed to 3 overall improvement strategies (submitted in Phase I) that, when taken together, are intended to improve caregivers' abilities to help their children develop and learn as well as build a strong state system to support the use of evidence-based practices. This section highlights the improvement strategies with their corresponding principle activities that took place in 2017.

**Improvement Strategy 1 of 3**

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2017</th>
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</thead>
</table>
| **Improvement Strategy 1: New Instructional Practices** | **Iowa Distance Mentoring Model** of Professional Development (IA DMM) training for Cohort 5 and 6 providers on use of Family Guided Routines Based Intervention (FGRBI) and Caregiver Coaching.  
**IA DMM** training for Cohort 5 and 6 internal coaches to support fidelity, scale-up and sustainability of practice. |

**Iowa Distance Mentoring Model (IA DMM) of Professional Development for Cohort 5 and Cohort 6 Service Providers and Internal Coaches** (http://dmm.cci.fsu.edu/IADMM/IA%20DMM%20Intro/player.html).

Iowa continues to contract with Florida State University's (FSU) Communication and Early Childhood Research and Practice Center to provide their Distance Mentoring Model (DMM) for Early ACCESS. DMM is a professional development approach designed to facilitate coordinated and consistent high-quality early intervention services and supports. DMM integrates evidence-based practices and plans for systematic change by engaging key stakeholders throughout the development, decision-making, implementation, and evaluation of the model.

Early intervention providers identified the need for professional development to learn how to coach effectively, to teach parents how to embed the intervention strategies that work the best in everyday routines, and very importantly, how to support adult learners. DMM uses a dynamic technology-supported approach that includes: (1) individualized video-feedback, (2) self-paced application of coaching competencies, (3) peer-partner mentorship, and (4) face-to-face group trainings.
Iowa Part C SSIP Phase III Year 2, FFY 2016

Measurement, self-assessment, and reflection on the use of recommended practices for teaching both children and adults are included in a 10 month sequence of professional development. Participating service providers are coached and learn how to coach. Peer coaches gain experience with each other supported by expert mentoring sessions with Florida State University’s DMM staff. FSU equips internal coaches with knowledge, skills, and tools to mentor and support their colleagues to implement FGRBI with fidelity. Internal coaches will be able to: implement FGRBI reliably in their own practice, reliably identify the key indicators for FGRBI in their peers’ home visits, and systematically coach peers within their agency to help them achieve fidelity in FGRBI in their practice. Adults learn by doing in DMM; peers work together to give and receive performance-based feedback in a manner parallel to how they coach caregivers.

(http://dmm.cci.fsu.edu/IADMM/index.html)

During 2017, Cohort 5 had 26 providers and 9 internal coaches finished the training. Cohort 6 had 24 providers and 6 internal coaches begin the training (ends mid 2018) for a total of 50 providers and 15 internal coaches participating during 2017. Each cohort received a training timeline as well as a calendar of events outlining the schedule for the year including dates of activities with corresponding resources and materials. The training timelines are illustrated below.

The IA DMM training is essential to: (1) changing the practice of service providers; (2) changing the behaviors of caregivers; and (3) improving the results of families and children served in Early ACCESS.
### Improvement Strategy 2 of 3

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2017</th>
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<tbody>
<tr>
<td><strong>Improvement Strategy 2: New Implementation Strategies</strong></td>
<td>Incorporate implementation science frameworks in order to develop the capacity to make effective, statewide, and sustained use of evidence-based practices.</td>
</tr>
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</table>

- **Continued** webinar series for implementation teams; held annual face-to-face Joint Implementation Team Meeting.
- Conducted needs assessment with implementation teams and created individual agency implementation plans based on results.
- Held five 2-day stakeholder meetings (Early ACCESS Leadership Group) where updates and progress, barriers & successes were discussed.
- Used planned communication process to update written implementation team reports.
- Used data to inform changes for training and selection of internal coaches.
- Used written commitments through contracts from participants and administrators to provide time/resources for the training.
- Created public relations promotional and training videos, distributed them to AEAs and Early Childhood Iowa network as well as posted on public websites.
- Created "Foundations of Early Intervention" online module for institutes of higher education to use with students
- Community of Practice (webinar series, FaceBook, website) to support practice change.
- Maintained IA DMM FGRBI website, emails, cohort specific webinars, internal coach specific webinars, YouTube videos to support practice change.

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### Iowa Distance Mentoring Model (IA DMM) of Professional Development, Implementation Science, and Impacts on Infrastructure

The IA DMM project uses an integrated stage-based framework for implementing Family Guided Routines Based Interventions (FGRBI) and Caregiver Coaching. This framework builds on previous syntheses in implementation science literature. The framework says that implementation happens in four discernible stages and 3 common threads, or core elements, exist across each of these stages. The 3 core elements include: (1) building and using implementation teams to actively lead implementation efforts; (2) using data and feedback
loops to drive decision-making and promote continuous improvement; and (3) developing a sustainable implementation infrastructure that supports general capacity and innovation-specific capacity for individuals, organizations, and communities (Metz, Naoom, Halle, & Bartley, 2015).

The principle activities completed in Iowa in 2017 align to the 3 core elements of this framework. It is important to note that these activities, which are part of the professional development (PD) for service provider practice change, are leading to permanent infrastructure changes in Early ACCESS. In other words, the processes, products and structures that are created as part of IA DMM are not going away once training ends. This directly impacts current and future in-service PD leading to a higher quality personnel/workforce infrastructure for Iowa's early intervention system. A few items for each core element are highlighted below.

Core Element: Implementation Teams

- **Continued** webinar series for *implementation teams*; held *annual face-to-face Joint Implementation Team Meeting*.

Regional implementation team activities were facilitated by FSU for approximately 80 team members to expand communication within each agency to build capacity for decision-making and monitoring progress of implementation. Iowa has 9 Regional implementation teams (RITs). Some AEAs have created sub-teams in order to more effectively support implementation in a smaller localized area. Information from RITs is shared with the State Work Team who is responsible for state-level implementation. Each of the RITs meet based on the needs of their area.

State-level implementation is the responsibility of the State Work Team (SWT). The SWT is made up of staff from the Iowa Departments of Education, Public Health, and Human Services and University of Iowa's Child Health Specialty Clinics. The 4 state agencies have a written Memorandum of Agreement that formalizes their commitment to supporting the statewide early intervention infrastructure. The State Work Team meets all day, twice a month. Between the full-day meetings, members are in contact often via email, calls, and smaller group meetings.

Webinars, emails, and meetings where RITs can meet with each other and alongside the State Work Team are critical to the continued improvement of the teams' functioning. All RITs now include the internal coaches who can provide deeper knowledge of FGRBI and Caregiver Coaching to the teams. In addition, they serve as a “leader from the middle” and communicate broadly between the providers and the administration the importance of the practice changes taking place.

These teams, which include service providers, program coordinators, administrative staff, and others; are key groups of stakeholders that provide leadership to system change efforts. This has a direct impact on improving the quality of the governance infrastructure of the early intervention system.

Right now, these regional and state team structures are focused on implementation of FGRBI and Caregiver Coaching. At a recent stakeholder meeting, there was a discussion about the use of different early intervention teaming practices across the state. After talking about these differences and what to do about possible training and support, an early intervention supervisor said, "Why can't we just use what we've been doing in DMM?" She recognized that IA DMM is a vehicle for delivering professional development around any evidence-based practice and not just FGRBI. Iowa's investment in IA DMM is an investment in infrastructure change—not simply a training to bring a new practice to the state.
Some activities in IA DMM fall within more than one core element of the integrated stage-based framework for implementation. For example, the Joint Implementation Team Meeting crosses boundaries between implementation teams and using data and feedback loops.

Core Element: Data Use and Feedback Loops

- Conducted a needs assessment with implementation teams and created individual agency implementation plans based on results.
- Held five 2-day stakeholder meetings (Early ACCESS Leadership Group) where updates and progress, barriers & successes were discussed.
- Used a planned communication process to update written implementation team reports.
- Used data to inform changes for training and selection of internal coaches.

The summer prior to each new round of training, FSU facilitates a face-to-face Joint Implementation Team Meeting. Implementation team members come to Des Moines where IA DMM implementation data is shared to inform the next round of training. Data reviewed and discussed during these meetings include: participation and completion rates of video recordings and self-assessments; journey reflections; service provider survey results; frequency counts of provider contacts with FSU; Google analytics; external coach feedback; fidelity measures; and, stakeholder input gathered during the Joint Implementation Team Meeting. In 2017, fidelity data was used to help identify providers who would be invited to become internal coaches. This process has been in place and used successfully since June 2013.

On June 7, 2017, the focus of the Joint Implementation Team Meeting was on the results of a needs assessment conducted earlier in the year. The needs assessment and planning tool (Appendix A) was created to help the state better integrate FGRBI into all parts of the early intervention system. The meeting resulted in each agency selecting their top area to focus on and creating an action plan for the upcoming 2017-2018 year. Needs assessment areas included: public awareness, first contacts, evaluation and assessment, IFSP, intervention, and monitoring progress. Updates on plans and implementation team reports are collected at stakeholder meetings throughout the year.

Core Element: Implementation Infrastructure for Individuals, Organizations, Communities

- Continued FGRBI Community of Practice (webinar series, FaceBook, website) to support practice change.
- Maintained IA DMM FGRBI website, emails, cohort specific webinars, internal coach specific webinars, YouTube videos to support practice change.
- Used written commitments through contracts from participants and administrators to provide time/resources to the training.
- Created public relations promotional and training videos, distributed them to AEAs and Early Childhood Iowa network, and Wednesday Wonders electronic newsletter as well as posted on public websites.
- Created "Foundations of Early Intervention" online module for institutes of higher education to use with students.

These principle activities represent infrastructure work that impacts individuals, organizations and communities. It is important to have activities across all 3 of these groups in order to fully sustain the improvement efforts. At the individual level, Iowa has carried out activities that promote the use of the specific evidence-based practices such as the development of the FGRBI Community of Practice, holding webinars, using YouTube to post videos of practice in action, and updating the IA DMM website.
organizational level, Iowa completed activities such as using contracts that build and support buy in for the improvement activities. Activities at the community level included the creation of the public relations materials and products for institutes of higher education to help ensure that Early ACCESS practices are understood and accepted by parents and other stakeholders. A few principle activities are highlighted in further detail below.

During 2017 new promotional materials were created. Larry Edelman, consultant with FSU, added new videos to Iowa's expanding library of Early ACCESS providers' home visits. These high quality videos capture what early intervention looks like using new practices and are posted on a private websites for use by service providers in training. The videos have extensive examples of content specific to Iowa that can be used to illustrate key pieces of FGRBI. They are also posted on the Iowa Family Support Network (IFSN) public website (iafamilysupportnetwork.org). Videos range from a few minutes in length to over 10 minutes depending on content. They have become important learning tools used by: new and veteran service coordinators and providers; families; referral sources; AEA and other agency staff that have limited or indirect roles in Early ACCESS; institutes of higher education; early childhood programs; and the general public. Iowa early intervention videos have been shared on other state and technical assistance center websites. For example, Michigan and the Early Intervention Video Library (collaboration with Virginia's professional development center) have linked to Iowa videos. Connecticut Birth to Three featured Iowa's videos on their blog.

A stakeholder task team of AEA Early ACCESS liaisons and higher education faculty created content for the "Foundations of Early Intervention" online module. The module is intended for community college and university students to take prior to any early intervention field experience in Iowa. It is also for higher education faculty to use as a resource in their courses. This was the latest module created for Iowa by the Florida Center for Interactive Media at Florida State University.

Written agreements were used again in 2017 in order for administrators, service providers, and internal coaches to know what commitments were needed in order to participate in training activities. For example, internal coach (IC) agreements listed: (1) qualifications of an IC; (2) IC professional development activities for online training, video and self-reflection, trio coaching activities and assignments; and (3) expectations following the training sequence. See Appendix B for a copy of the Internal Coach agreement.

Wednesday Wonders is an electronic newsletter that is released twice a month and currently has 550 recipients on the distribution list. All newsletters are posted on the Iowa Family Support Network (IFSN) public website (iafamilysupportnetwork.org). The purpose of this newsletter is to have a consistent, predictable way for Early ACCESS stakeholders to stay current on happenings. Additionally, recipients can share information with other stakeholders such as practical advice, training announcements, video clips, and success stories. It is a newsletter for stakeholders, by stakeholders. A copy of the Wednesday Wonders that announces the availability of the "Foundation of Early Intervention" online module is attached (Appendix C).
**Improvement Strategy 3 of 3**

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2017</th>
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<tbody>
<tr>
<td><strong>Improvement Strategy 3: New High Quality System</strong></td>
<td><img src="image_url" alt="Diagram" /> Use the ECTA System Framework self-assessment processes in order to develop a high-quality Early ACCESS system that encourages, supports, and requires implementation of evidence-based practices.</td>
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- **Recruitment of stakeholders** to address increasing family engagement; creation of family engagement task team and plan for increasing family partnerships throughout the early intervention system.

- **Completed** ECTA System Framework Self-Assessment for Governance component.

- **Improved statewide in-service** personnel development and technical assistance system for providers across disciplines through IA DMM; Strengthened relationships with institutes of higher education (IHE) through sharing of Wednesday Wonders e-newsletter that's released twice monthly, early intervention field guide, foundations of early intervention online module, and having dedicated space on Early ACCESS website for IHE.

- **Completed** ECTA System Framework Self-Assessment for Personnel/Workforce component.

The Iowa Administrative Rules for Early ACCESS states that the Departments of Education, Public Health, and Human Services and the University of Iowa's Child Health Specialty Clinics "shall enter into an interagency agreement to formalize their joint commitments to the establishment and ongoing implementation and evaluation of a comprehensive, integrated, interagency Early ACCESS system." See IAC 281-120.801(2). That written agreement is the Memorandum of Agreement (MOA) mentioned earlier in this report. The MOA Action Plan submitted with the SSIP Phase II outlines the work that is completed in order to meet the obligations of the MOA. The ECTA System Framework ([http://ectacenter.org/sysframe/](http://ectacenter.org/sysframe/)) is used to organize the MOA Action Plan to ensure Iowa works towards creating a high quality early intervention system.

The State Work Team is responsible for carrying out the plan and the Signatory Agency Leadership Team (administrators from Iowa Departments of Education, Public Health, Human Services, and University of Iowa's Child Health Specialty Clinics) monitors progress and supports the work team.

Work done specifically to improve the quality of Early ACCESS governance included forming a stakeholder task team to develop a plan for engaging families in all parts of the Early ACCESS system. Iowa rated low on this item in the ECTA System Framework governance component self-assessment and ranked family engagement as a high priority item. The 8 member task team included 2 parents who have young children with disabilities (1 was also the chair of the Iowa Council for Early ACCESS); staff from the Iowa Departments of Education and Human Services; college faculty member; and, staff from the ASK Resource Center, Iowa's Parent Information and Training Center. A series of meetings were held from March through September 2017 to prepare a plan...
that will support family engagement in Early ACCESS system-level activities. A new task team will be created in 2018 to implement the plan.

Parents always serve as chair for the Council and are represented best in Council activities. Outside of the Council, family engagement is minimal. Families contribute to the in-service training of FGRBI by consenting to make videos which is highly valued and well used. There is much to do to improve family engagement beyond these opportunities. The work of this task team is critical for progress and improvement of governance of the Early ACCESS system.

Personnel/Workforce infrastructure improvements were described above. IA DMM activities are recorded as evidence of progress in the self-assessment. It is clear that many activities are contributing to a higher quality Personnel/Workforce Component of the infrastructure for both in-service training and preservice training as we strengthen relationships with Iowa’s institutes of higher education.

**A3: Specific Evidence-Based Practices Implemented To Date**

**Family Guided Routines Based Intervention (FGRBI) Training for Service Providers**

The *foundational components of FGRBI* are the content of what is being taught through the Iowa Distance Mentoring Model of professional development for Early ACCESS and are briefly described below (http://fgrbi.fsu.edu/approach.html).

**Family Centered Individualized, Culturally Responsive Services and Supports**

Family members are often unfamiliar with the process of embedding intervention in the child and family's natural environments. Sharing information with family members and caregivers about daily routines and the embedded intervention strategies sets the stage for active family participation in their child's early intervention program. Time spent discussing and demonstrating how young children learn throughout the day illustrates how parents and caregivers support their children's development in meaningful and functional interactions.
**Everyday Routines, Activities and Places**

Assessment in natural environments occurs in a variety of naturally occurring daily routines. The process accommodates the priorities and concerns of families by encouraging families to share information about routines and activities most appropriate for and preferred by the child and family.

**Embedded, Evidence-Based Instruction**

The basic premise of natural environments is involving the caregiver in the teaching and learning process with the child. It is crucial to identify ways to share information with diverse caregivers about various teaching strategies in ways that match their learning styles.

**Functional Participation Based Outcomes**

The quality of routines-based intervention depends on the creation of a meaningful and functional intervention plan. The child’s outcomes should reflect the learning targets necessary to participate in the routines and activities identified as important to the family and provide sufficient opportunity to practice throughout the day. The teaching and learning opportunities should be planned to correspond to locations, preferences, and interests of the child and involve adults and other children in the child’s life.

**Coaching**

Caregiver coaching is a graduated teaching and learning process designed to build capacity in caregivers to have the competence and confidence to independently implement strategies and supports when the interventionist is not present (Friedman, Woods, & Salisbury, 2012; Hughes & Peterson, 2008).

Service providers across the state of Iowa have been immersed in learning, practicing, and reflecting on FGRBI practices. In 2017, as Cohort 5 was nearing graduation, a statewide survey was conducted to determine whether the AEAs had a training need for more service providers. Based on data collected, Cohort 6 was recruited and began training in the fall. Approximately 160 providers representing 5 different disciplines have participated in the first five cohorts.

**Cohort 1 through Cohort 5 IA DMM Participants By Discipline**

Participants instructed to select multiple disciplines if appropriate

Ex: ECSE + SC

ECSE=Early Childhood Special Education
SLP=Speech-Language Pathology
OT=Occupational Therapy
PT=Physical Therapy
SC=Service Coordination

During 2017, Cohort 5 providers finished their training sequence and Cohort 6 had their first face-to-face 2-day training and started recording home visits, completing self-assessments, and participating in coaching feedback sessions with the internal coaches as well as external coaches from FSU.
Family Guided Routines Based Intervention (FGRBI) Training for Internal Coaches

Selecting Internal Coaches

In 2016, IA DMM began to train and support peer internal coaches to address sustainability and internal capacity within Iowa to spread and implement FGRBI after external support from FSU is withdrawn. To achieve this, FSU began to train peer internal coaches to use a multicomponent professional development process to support additional providers who had not yet participated in the training or were newly hired in the field. Peer coaching is a promising practice in early childhood education (Johnson, Finlon, Kobak, & Izard, 2017; O’Keefe, 2017; Tschantz & Vail, 2000) and in early intervention (Fox, 2017). In 2017 Cohort 5 had 9 internal coaches complete their first year of training and begin year 2. Cohort 6 added 6 internal coaches who started their first year of training. Internal Coach qualifications include:

- Completed IA DMM training with a minimum of 80% on FGRBI Key Indicator fidelity checklist and participated in five feedback sessions. Coaches may be chosen from graduates of C1-C5 who meet the listed qualifications.
- Interested in becoming an internal coach.
- Able to spend a minimum of four hours per week in internal coaching activities.
- Willing to participate in Community of Practice coaching activities as well as C6 monthly feedback sessions.

Training Internal Coaches

It is critical to equip the internal coaches with the skills and tools necessary to support other providers to adopt FGRBI. This included providing online training materials and modules, face-to-face workshops, networking with other internal coaches, and video feedback for fidelity of implementation. In order to coach others, internal coaches needed to reach fidelity in implementing FGRBI, in scoring others’ use of the FGRBI Key Indicators, and in conducting the coaching sessions themselves. These internal coaches began operating in the fall of 2017 with providers from their local agencies. As internal coaches, they provided face-to-face training, facilitated online modules, conducted coaching sessions using videos of provider sessions with children and families on their caseload, and provided feedback via Torsh TALENT, an online video annotation system.

Implementation Science: Using an Integrated Stage-Based Framework

Changing Iowa’s culture of early intervention from traditional child-focused services to where the focus is on coaching the caregiver to support the child takes time and a great deal of work. Using an integrated stage-based framework helps to ensure that Iowa’s investment in FGRBI and Caregiver Coaching becomes successfully integrated into all levels of the early intervention system and that providers skillfully provide services to families and children.

In Section A2: Improvement Strategies and Principle Activities under Improvement Strategy 2 (pages 6-9), there is a description of activities that occurred during 2017. These activities are meant to illustrate an intentional application of components of implementation science in the context of Iowa’s early intervention system improvement activities. The use of implementation science is complex and at times feels fragile, as if everything could fall apart at any given moment; however, a core group of individuals are committed to being...
the glue that holds everything together. The 9 member State Work Team is the "keeper of the culture" for the change efforts. The State Work Team is ultimately responsible for making sure the activities align to the change processes.

As implementation teams strengthen...buy in from administrators at all levels increases...partnerships with community organizations build...providers across disciplines increase their understanding of the impact of FGRBI...communities become aware of the shift in Early ACCESS...and families grow in their understanding about how to further help their children develop and learn...the culture will shift. Stakeholders will be invested in continued success and shared responsibility will be the norm. The work outlined in the State Systemic Improvement Plan is the map for how to get to that destination. The planned year of arrival is 2023—10 years after beginning the shift from a system focused on compliance to one that focuses on improved results for children and families.

A4: Brief Overview of the Year’s Evaluation Activities, Measures, and Outcomes

The Early ACCESS Theory of Action (page 3) claims that if providers use FGRBI and Caregiver Coaching and if evidence-based professional development includes the use of implementation science and if the ECTA System Framework is used to develop a high quality early intervention system, then caregivers will be confident and competent in helping their children develop and learn which creates more opportunities for practice and learning throughout the day; and Iowa will have a state infrastructure to support and sustain the use of evidence-based practices. This will lead to improved outcomes for the children that are receiving services in Early ACCESS.

Providers across different disciplines are trained, surveyed, observed, and interviewed to support knowledge and practice change. Caregivers are surveyed, interviewed, and observed to gain an understanding of how providers impact caregiver behaviors and practices. At the same time, support structures are put in place to ensure that everything done with providers and caregivers is done as expected or with fidelity, and can be scaled up and sustained statewide. This process is not as straight as the arrow in the illustration suggests.

Not all providers are trained at the same time; providers are at different stages of learning and implementing; caregivers’ needs are all unique; agencies do not all operate the same; and implementation supports are under constant strain as systems resist change even when it is wanted and needed. Collecting information about service providers, caregivers, and support strategies and structures ensures that Iowa is on the right
path to improving outcomes for families and children served in Early ACCESS. Therefore, evaluation continues to be an essential part of Iowa's improvement efforts.

This overview provides information on evaluation activities completed with (1) service providers, (2) caregivers and (3) the early intervention system over the past year. Data that is generated as a result of these activities is found in Section C: Data on Implementation and Outcomes (pages 25-47).

**Provider Level Evaluation: How do service providers change in their abilities to implement FGRBI?**

Observations, Self-Assessments, Interviews

Videos of home visits are key tools used for observation of key components of the Family Guided Routines Based Intervention (FGRBI) and Caregiver Coaching. The Self-Assessment Session Summary form (Appendix D) is the collection tool used by all service providers, internal coaches and external coaches from FSU to capture these key measures: (1) family routine categories, (2) SS-OO-PP-RR framework and FGRBI key indicators, and (3) coaching strategies. SS-OO-PP-RR is the framework for home visits and stands for Setting the Stage (SS), Observations and Opportunities to Embed (OO), Problem Solving and Planning Intervention (PP), and Reflection and Review (RR).

In addition to key measures, the self-assessment collects information on functional outcomes, intervention strategies for the child's targets, and reflective questions on practice to help put the key measures into the context of the overall plans for helping the child and family.

Prior to External Feedback Session

Every agency has service providers that participate in the training as a trio. On a rotating schedule, each member within the trio video records an entire home visit with a family that has agreed in writing to participate. The provider reviews the video and completes the self-assessment. The self-assessment and video recording are uploaded into Torsh TALENT, an online video annotation system. TALENT allows for easy uploading and makes the video accessible to all trio members, the trio's internal coach, and the external coaches at Florida State University. Trio members review the recorded home visit and make comments related to key indicators of FGRBI and coaching using features within TALENT.

The internal coach watches the video in TALENT and comments on each of the key indicators observed and other elements of the interactions that characterize FGRBI and Caregiver Coaching. She may also ask providers a few reflective questions to help them think critically about their interactions with families, or add some specific feedback about parts that are going well. The internal coach uses her comments in TALENT to complete the Self-Assessment Session Summary. For help scoring the indicators, coaches use the rubric found in the Key Indicators Manual so that they can see the scoring criteria for each item. The scored document is emailed to the external coach for her to check the internal coach's reliability with her scoring. These steps are completed two days before the external feedback session so that the internal coach scores can be compared to the external coach scores.

During External Feedback Session

Once both internal and external coaches have scored the Self-Assessment Summary Session form, a feedback session is held via Zoom. This allows Florida and Iowa participants to see each other and watch the video
recording together. The aim of Year 1 training for internal coaches is to gradually increase their role and responsibilities during these sessions so that by the end of the year, they have both the competence and confidence to lead sessions on their own. During the first month, internal coaches observe during the feedback session and make comments as they feel comfortable. Each month they lead a greater amount of the coaching session so that near the end of the cohort training sequence internal coaches are able to facilitate on their own with the external coach present. Checklists are used to make sure all parts of the coaching and feedback sessions are mastered.

**After External Feedback Session**

After a feedback session, internal coaches are required to:

1. Complete a quick recap/review if trio members have additional comments/questions.
2. Follow up with the trio members to remind them of their monthly goals, provide encouragement, and check in on the completion of the videotaping for the next session.
3. Review videos in exemplar library to increase their competence with the Key Indicators and expand knowledge on FGRBI.
4. If needed, schedule coaching session with external coach to practice SS-OO-PP-RR or discuss FGRBI.

This sequence (recording a home visit, doing the self-assessment, reviewing and reflecting with peers in the trios and the internal coach, and holding the external feedback or coaching session with Florida State University) repeats with each trio member. The data collected during these feedback sessions is compared to the baseline data and each subsequent feedback session to show progress towards fidelity. Data are shared in Section C2: Demonstrating Progress and Making Modifications (pages 32-36) which will show progress in implementing FGRBI and Caregiver Coaching.

Observation is critical to ensuring behavior change. Torsh TALENT has taken observations to a new interactive level which enhances the IA DMM training. However, from a system perspective, there is the concern for sustaining the use of TALENT beyond the training period. Efforts are underway to increase the exposure to this online learning platform within the AEA system. External early childhood funds have been secured for 2018 to expand use of TALENT beyond the IA DMM training so more people can experience using TALENT. Possibilities for statewide use beyond early intervention are being explored. With increased interest, there is greater potential for securing Torsh TALENT into the future and beyond the IA DMM professional development project.

**Interviews on Most Significant Change**

Early ACCESS trio members participated in interviews with Larry Edelman, IA DMM Consultant, during their second face-to-face workshop which was held six months into the training sequence. Twenty-four (24) service providers from various disciplines (e.g., early childhood special educators, service coordinators, speech-language pathologists, occupational therapists) voluntarily participated in the brief structured interviews.

Findings from these interviews are shared in Section C2: Data on Implementation and Progress (pages 35-36) and show descriptive evidence supporting progress in using the evidence-based practices of FGRBI and Caregiver Coaching. Iowa feels strongly that both quantitative and qualitative data are important to use when considering progress in shifting the practice of the entire early intervention system. Each piece of data provides unique understanding into the total change process. Together, these two types of data help to more fully inform the work.
Family Level Evaluation: How confident do families feel about working with their child throughout the day? Has coaching changed how effective families feel about helping their child? Are families demonstrating increased participation and proficiency in helping their child develop and learn?

Surveys, Interviews, Observations

Parent Survey

Families who participate in IA DMM receive either an online survey by email or paper survey through the United States Postal Service approximately 60 days after service providers complete the training sequence. The Early Intervention Parenting Self-Efficacy Scale (EIPSES) was developed to quantify parent perspectives about their ability to facilitate positive child outcomes within the context of early intervention programs and via interactions with early intervention practitioners (Guimond, Wilcox & Lamorey, 2008). Iowa uses the results of this survey as a "dip stick" measure to see how parents are feeling at this point in time. There is discussion of changing the survey to be a post-then-pre retrospective format administered at the end of the training sequence. This would ask parents to first answer the questions on how they currently feel for each item, then think back to the time before participation in the IA DMM project and answer the same question. This would give useful information on how much the perspective of the parent has changed over time. The results of the analysis are in Section C2: Data on Implementation and Progress (pages 37-38).

Parent Interviews

Florida State University (FSU) DMM project staff contacted families, scheduled calls, and conducted telephone interviews with parents of Early ACCESS Cohort 5 between May 1, 2017 and July 10, 2017. Eleven (11) parents shared their experiences and provided feedback as they responded to a sequence of questions about their services in the natural environment using coaching by their providers. The same interviewer spoke with all parents and the calls lasted between 12 and 40 minutes. Calls were recorded with the parent’s verbal permission and transcribed by staff verbatim. The transcripts were analyzed and a report developed by a "blind" student coder, not a member of the FSU DMM team. A Florida State University DMM faculty member reviewed the report for accuracy and consistency.

Interviews result in rich descriptive information that compliments the numerical, or quantitative, data gathered through surveys, self-assessments and checklists. The results of the analysis are in Section C2: Data on Implementation and Progress (pages 38-39) and confirms that parents do feel more confident and competent in helping their children develop and learn throughout the day in their family routines. Overall, the parents had many positive comments about their providers and would encourage other families to use the coaching approach.

Observations of Caregiver Key Indicators

The primary aim of Part C services is to support the family’s confidence and competence in promoting their child’s developmental needs. Although supporting family capacity is a fundamental goal for services for children under 3, it remains a difficult construct to define and measure. There are limited options for measuring family capacity-building practices in the context of intervention sessions that match the model that Early ACCESS providers are being coached to use (FGRBI; Woods, Kashinath, & Goldstein, 2004).
In order to meet the need to measure family participation in early intervention, FSU developed a tool to describe and quantify the caregiver’s role in home-based intervention sessions. This tool, called Caregiver Key Indicators, is intended to be used in conjunction with the providers’ fidelity measure (FGRBI SS-OO-PP-RR Key Indicator Checklist), and in some ways mirrors the provider fidelity items. Instead of measuring provider fidelity, though, this tool examines behaviors from the vantage point of how the caregiver participates in the intervention sessions. The Caregiver Key Indicators uses video observation of full-length home visits in order to assess whether caregiver-child interactions are primary in the session, whether the parent participates and practices embedding strategies in routines, whether the caregiver engages in problem-solving and reflection on the intervention with the provider, and whether the caregiver helps contribute to an action plan with the provider for the time between visits. The 12-item tool offers an overall percentage of indicators identified as either present, partially present, or not present.

This tool is a means for providers and program administrators to see the ways in which providers are engaging the family rather than a way to evaluate a family’s participation or non participation. In other words, it isn’t used to judge families. The tool measures how much families are able to participate based on the interactions with the providers. Providers and caregivers have a bidirectional relationship, and a family’s engagement and growth in capacity is linked to what the provider does during each intervention session. Some providers may create opportunities for the caregiver to practice strategies in routines, but the family may not have a clear role in planning and problem-solving. Likewise, providers may offer caregivers opportunities to share information and discuss developmental challenges, but they may struggle to create practice opportunities for the caregivers to try strategies in every day routines during the session. There is an expectation that relationship exist between the provider’s fidelity scores and the scores on the Caregiver Key Indicators.

**System Level Evaluation:** How do implementation team members shift in their knowledge and use of evidence-based implementation? How did systems change to accommodate this initiative?

**Team Reports, Focus Groups, ECTA System Framework Self-Assessment**

**Regional Implementation Team Written Reports/Updates, Meeting Agendas and Notes**

Regional implementation team (RIT) reports are updated via Google Docs 5 times per year prior to the EAGL meetings. Information updated each time by all agencies includes:

1. Who is attending the meetings?
2. Have you engaged disciplines other than ECSE teachers in the work of scaling-up FGRBI? If so, what disciplines did you engage? How did you engage them?
3. What data do you review routinely in meetings?
4. What data would you like to review in meetings (but you do not have)?
5. Highlights from the meetings.
6. Barriers or problems addressed or working on at regional level.
7. Help or support needed from the state-level implementation team.
8. What would you like to discuss during the Early ACCESS Leadership Group meeting?

All agencies record on the same Google document. This supports communication among agencies as they can see what each other has reported. Discussions and actions happen based on the topics in the reports and are
recorded in the Early ACCESS Leadership Group meeting notes. The State Work Team consistently reviews the reports paying special attention to questions 7 and 8 so that appropriate actions can be taken. The reviews provide information that helps the state determine regional needs in order to support progress on implementation of FGRBI and Caregiver Coaching across Iowa.

**Regional Implementation Team Focus Groups**

In October 2017, RIT focus groups were conducted across the state. Of the 8 focus groups scheduled, 7 were completed. Small groups of 3-5 people included RIT members from at least 2 different agencies. Questions asked were:

1. What did your agency do to accommodate FGRBI and the coaching of caregivers?
2. How did your agency accommodate the change in professional development practices?
3. What are the barriers that impact service providers in your agency from implementing FGRBI and coaching caregivers?
4. What policies does your agency have that might impact the implementation of FGRBI and coaching caregivers?
5. What successes have you seen as a result of the implementation of FGRBI and coaching caregivers?

Focus groups were video recorded and will be transcribed and analyzed in 2018. Results will be used to further support the successful use of implementation teams to sustain the changes to the Early ACCESS system. Results will be shared in next year's SSIP report.

**ECTA System Framework Self-Assessments**

Building and sustaining high-quality early intervention systems is a complex and ongoing process. To support states, the Early Childhood Technical Assistance Center (ECTA Center), funded by the Office of Special Education Programs (OSEP), has developed a framework that addresses the question, "What does a state need to put into place in order to encourage/support/require local implementation of evidence-based practices that result in positive outcomes for young children with disabilities and their families?"

The purpose of the ECTA System Framework is to guide state Part C and Section 619 Coordinators and their staff in:

1. evaluating their current systems;
2. identifying potential areas for improvement, and;
3. developing more effective, efficient systems that support implementation of evidence-based practices.

The ECTA System Framework is organized around 6 interrelated components: Governance, Finance, Personnel/Workforce, Data System, Accountability and Quality Improvement, and Quality Standards.

The self-assessment is an Excel-based tool that provides a structure for state Part C programs to record the current status of their state system and set priorities for improvement. It is a companion to the ECTA System Framework and the DaSy Data System Framework ([http://ectacenter.org/sysframe/selfassessment.asp](http://ectacenter.org/sysframe/selfassessment.asp)).

During 2017, Iowa added evidence to the self-assessments for the Governance and Personnel/Workforce components of the framework. State Work Team members reviewed activities completed in both of these areas and, as a team, recorded the evidence into the Excel-based tool. Once evidence was added, the self-assessments were scored. Using the DaSy/ECTA Frameworks Self-Assessment Comparison Tool, the state was able to generate a report on the changes to the Early ACCESS infrastructure. Data are shared in Section C2: Demonstrating Progress and Making Modifications (pages 44-47).
A5: Highlights of Changes to Implementation and Improvement Strategies

Improvement strategies remain the same as planned and submitted in previous SSIP reports. Implementation has slightly shifted each year. The Iowa Distance Mentoring Model of professional development involves a continuous improvement process driven by stakeholder input and data. Shifts in the makeup of cohort groups and improvements to activities happen based on feedback from the preceding cohort.

Based on feedback and data from Cohort 5 no changes in trio structure took place; however, there was a need for training an additional internal coach in some regions of the state. In previous years, pairs of providers participated (Cohorts 1-3) and then quads (Cohort 4) of providers. This was followed by trios of with an internal coach (Cohort 5). Currently, there are still trios of service providers with the original internal coach and 1 new internal coach (Cohort 6). The addition of the new internal coach is necessary to prevent practice drift and ensure FGRBI is delivered with fidelity and the practice is sustained over time.

Information reported in Section C: Data on Implementation and Outcomes (pages 25-47) supports continued implementation of FGRBI and Caregiver Coaching via the Iowa Distance Mentoring Model of professional development. It also supports the use of the ECTA System Framework and the corresponding self-assessment as a way to organize and track system improvements.

SECTION B: Progress in Implementing the SSIP
B1: Description of Implementation Progress

During 2017, Iowa made progress in implementing all 3 areas from the Theory of Action: provider practice change, use of evidence-based professional development/implementation, and infrastructure development. Results of progress in each area are described separately even though some activities do not fall discretely into one area.

Provider Practice Change

Progress in provider change has resulted in an increase in: (1) number of service providers trained; (2) FGRBI knowledge, skills and use of new skills; (3) fidelity of practice; (4) scale-up; and (5) sustainability. Provider change has resulted in a decrease in: (1) direct child teaching and (2) practice drift.

Completion of Cohort 5 FGRBI training sequence and starting Cohort 6 took place as scheduled. To determine if participants in IA DMM were maintaining fidelity of the FGRBI practice, 21 former participants from Cohort 1 through Cohort 4 were randomly selected to participate in a sustainability study in the spring/summer of 2017. Participants uploaded a home visit video of a current family they were serving into Torsh TALENT. Providers could choose whether or not to complete a Key Indicator Self-Assessment form and have a distance mentoring session to get feedback from the external coaches.
Upon receipt, Florida State University scored the videos using the Cohort 5 FGRBI and SS-OO-PP-RR Key Indicators Checklist (Appendix D, side 2). The Cohort 5 Key Indicator Checklist was improved from a 9 item checklist used for Cohort 1 through Cohort 4 to a 12 item checklist. After scoring the videos using the 12 item checklist, recordings were reexamined with a checklist adjusted to be more consistent with less stringent criteria used in Cohorts 1-4. The established benchmark for fidelity is use of 80% of the FGRBI and SS-OO-PP-RR Key Indicators during a home visit. Below are the means and ranges for percentage of key indicators observed on the most recently developed Cohort 5 Key Indicator Checklist and on a key indicator list adjusted for previous years training.

<table>
<thead>
<tr>
<th>Average score using the Cohort 5 SS-OO-PP-RR Key Indicators on 12 point scale</th>
<th>Mean %</th>
<th>% Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score using nine items and definitions that would have been available to Cohorts 1-4</td>
<td>62.7</td>
<td>33.3-91.7</td>
</tr>
<tr>
<td>Average score using nine items and definitions that would have been available to Cohorts 1-4</td>
<td>79.9</td>
<td>55.6-100</td>
</tr>
</tbody>
</table>

After adjustments, the mean scores reach the fidelity benchmark for the videos collected from the random sample of Cohort 1 through Cohort 4 IA DMM participants. Although the average percentage scores reached the benchmark for fidelity, the range shows that some service providers need added support to be considered at fidelity. In addition to the Community of Practice that is available to all participants, this data supports the need for internal coach positions within the Early ACCESS system. Internal coaches, in addition to the external coaches, are needed to support fidelity and sustainability of practice change at this stage of implementation. Internal coaches for Cohort 5 were recruited and selected from those providers who had completed the IA DMM training and met a list of criteria including practicing at fidelity. The goal over the next 5 years is to develop a pool of internal coaches so that each agency has access to 3 trained internal coaches at all times.

A sustainability check is scheduled to happen each summer using a random sample of all trained service providers. Data will be used for three main purposes: (1) to identify providers not at fidelity and give them support to reach fidelity of practice; (2) to identify providers at fidelity in order to provide encouragement and support for continuing their practices; and (3) to identify potential candidates for new internal coach positions.
Evidence Based Professional Development (PD) and Implementation

*Progress in using evidenced-based PD and implementation* has contributed to an *increase in*: (1) family's ability to help their child and (2) opportunities for child to practice and learn. Additionally, evidenced-based PD and implementation practices impact: (3) fidelity, scale-up and sustainability of practice; and (4) quality of the in-service PD system.

Because evidence-based professional development and implementation practices are a part of IA DMM, Iowa is in the best possible position to have a positive impact on families and children served in Early ACCESS while *building an early intervention system that will support the use of evidence-based intervention practices, professional development practices and implementation practices*. In 2017, an increased amount of time was spent working to support implementation teams at the regional level. These regional implementation teams (RITs) have differences in membership and operating procedures within each agency in order to meet the local needs of that agency. An improvement in 2017 included having every RIT add the internal coach for their region as a member. Having someone with this level of practice knowledge on the team is critical in supporting providers' fidelity of practice which will support the families' ability to help their child through embedding interventions in everyday routines and activities.

To strengthen relationships among teams and with other stakeholders, RIT members from every agency were invited to regularly scheduled Early ACCESS Leadership Group (EAGL) stakeholder meetings via Zoom. Approximately 30 individuals attend the EAGL meetings with roughly 10 of them being members of RITs. Holding the RIT meetings while other Early ACCESS stakeholders are in the room and engaged with the implementation teams has added a new level of understanding of implementation and everyone's roles and responsibilities. Florida State University DMM staff joined as well and facilitated discussions and activities. This format for holding meetings for all the regional teams is likely to continue as long as everyone benefits from them. Using technology to support infrastructure improvements, such as building strong implementation teams, opens the doors to individuals that may not otherwise be able to participate. Service providers have been in parked cars between home visits and able to join in statewide conversations around supporting the successful implementation of FGRBI and Caregiver Coaching.

In Section A2: Improvement Strategies and Principle Activities under Improvement Strategy 2 (page 6), there is a long list of activities that, even though part of the professional development and implementation, have a direct impact on improving the Personnel/Workforce Component of the Early ACCESS infrastructure. As a result of many IA DMM professional development activities, Iowa is improving the in-service training system more and more each year.

Ongoing Support to Reach Fidelity

The Community of Practice (CoP) continued holding webinars and maintaining the IA DMM website throughout 2017. This ongoing support was *requested by stakeholders*. Conversations held during the Early ACCESS Leadership Group (EAGL) stakeholder meetings throughout the year provided dedicated time to talk about IA DMM and the continued need for supporting providers in reaching fidelity once they graduated from the training. The CoP webinars and access to information and materials on the website are key to sustaining the use of evidence-based early intervention practices. They are no longer considered *new pieces of the Early ACCESS system infrastructure*; they will become permanent features. In late 2017, conversations began around strategies for how the CoP and FGRBI website will be continued once the FSU contract ends in 2023.
This will require analysis of finances, technology, and personnel resources so a plan can be created over the next year and implemented prior to 2023.

Based on *stakeholder conversations* at the EAGL meetings, there is a continuous challenge of hiring new staff that are not trained to work with families nor have knowledge of FGRBI, while recognizing FSU will not always be available to provide training. The idea of a "one-stop-shop" for interactive training modules, videos, and materials was brought up as a solution. The one-stop-shop would support: (1) administrators as they create onboarding processes for new staff; (2) internal coaches and current providers as they support new providers in using FGRBI or to refresh their knowledge and skills; (3) statewide consistency in service delivery within the early intervention system; and (4) institutes of higher education who can access information for students interested in becoming early interventionists. This will be a *new feature* that will *improve the infrastructure* for providing *in-service* professional development and for influencing *preservice* training.

Families are also supporting improvements to the infrastructure through the creation of videos of home visits. *Families have contributed to the teaching and learning* of the new evidence-based practices. It is no small task to open your doors and expose your family for the sake of improving services for other children and families. These families recognize the importance of seeing the service providers in action as they illustrate their new skills and early intervention practices. It is powerful when the family, in their own words, shares how these practices impact them and their child.

**Infrastructure Change**

*Progress in infrastructure change* has resulted in a (1) *more effective governance* through stakeholder activities to *strengthening family engagement*, and stronger *leadership supporting* the use of *evidence-based practices*; and (2) *more effective system of personnel development* through *improved in-service* training and technical assistance, and *improved preservice* alignment with early intervention.

The infrastructure improvement plan, called the MOA Action Plan, was reorganized to align with the ECTA System Framework for IDEA Part C programs. By using the framework to organize the work plan, evidence of progress can easily be enered into the self-assessments.

Information on the Family Engagement Task Team and IA DMM activities were entered as evidence in the Governance and Personnel/Workforce section of the self-assessment in preparation to re-score in order to evaluate progress in infrastructure change. At this time, Iowa is focusing on the Governance and Personnel/Workforce components of the framework. Results of the updated self-assessments are reported in
Section C2: Demonstrating Progress and Making Modifications (pages 44-47). Comparison data shows that the activities reported in Section A2: Improvement Strategies and Principle Activities (pages 4-11) had a positive impact on the quality indicators for both components.

B2: Stakeholder involvement in SSIP implementation

Who's Who in Early ACCESS: Stakeholder Groups, SSIP Phase I, II and III

The following groups routinely engage in Early ACCESS activities. Long-standing relationships between and within these groups allow for smooth transitions when membership changes due to retirements, new hires, changing roles or jobs, or expiring terms for membership. Each group has a role in supporting the successful implementation of Early ACCESS in Iowa. This includes engaging with implementation strategies, continuous improvement and evaluation.

In addition to permanent long-standing groups, task teams form for the purpose of dealing with specific, time-bound activities. During the current reporting period, 16 different task teams (e.g. service coordinator competency training revision, Every Student Succeeds Act,) formed and included diverse groups of stakeholders that volunteered to work on different aspects of the early intervention system:

1. Family Routines/Family Assessment
2. Early Intervention Field Experience
3. Transition C to B
4. Central Directory
5. Family Engagement
6. Service Coordination Webinar
7. Inclusion
8. Part C Procedures
9. Every Student Succeeds Act
10. Medical Assessment
11. Early Childhood Iowa Core Services
12. Autism Navigator Implementation Plan
13. Iowa Early learning Standards Update
14. Regional Implementation Team Evaluation
15. IEP/IFSP Data System-Request for Information
16. General Supervision and Monitoring

Differentiated Accountability

There is always an electronic format for joining so that anyone from across Iowa can participate. It is not unusual that a service provider "attend" a task team meeting from a car between home visits or that a family member be at home with the sounds of children and pets in the background.
There is a prevailing belief that having the voice of people who are impacted most by the work must be included in helping to define problems, develop and carry out solutions, and define success. This belief translates into action through the task team and stakeholder group work. See Appendix E for list of 10 stakeholders groups with membership details.

SECTION C: Data on Implementation and Outcomes  How we know we are moving forward.

Iowa's State-identified Measureable Result (SiMR) is the Office of Special Education Programs (OSEP) Indicator C4C, "Percent of families participating in Part C who report that early intervention services have helped the family help their children develop and learn." Data are reported to OSEP each year and compared to previous years' data to look for change. The table below shows Iowa's data from the baseline year of 2013 through the current Federal Fiscal Year (FFY) 2016.

<table>
<thead>
<tr>
<th>FFY</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>87.00%</td>
<td>89.00%</td>
<td>91.00%</td>
<td></td>
</tr>
<tr>
<td>Data</td>
<td>85.00%</td>
<td>83.25%</td>
<td>86.35%</td>
<td>85.54%</td>
</tr>
</tbody>
</table>

Source: GRADS360®

Reviewing these numbers could lead to the belief that efforts to improve family outcomes were not working. However, until evidence-based practices are used statewide with fidelity and a high quality infrastructure is in place, using Indicator C4C data is not the best way to demonstrate progress. It is important to think of progress towards the SiMR as being defined and measured in additional ways that actually inform change efforts. This includes evaluating provider knowledge, provider practices, caregiver practices, and changes in the Early ACCESS system.

The Early ACCESS Evaluation Plan (SSIP Phase II) helps to monitor progress of implementation plans and supports any mid-course corrections that may need to be made. It provides evidence to show progress on practice improvements, system improvements and eventually better results for families and children. Iowa is moving forward.

C1: Evaluation Measures and Outputs

This section focuses on data from implemented activities over the past year. First, information is shared that explains the relationship between the Theory of Action, improvement strategies, logic models and the evaluation plan (SSIP Phase I & II). It is important to understand these connections as each element supports or informs the others. The remainder of this section will provide results of Iowa’s evaluation activities shared in Section A4: Overview of Evaluation Activities (pages 14-19).
Connecting the Dots: Theory of Action, Improvement Strategies, Logic Models and Evaluation

The Theory of Action identifies 3 parts of the early intervention system (practice, professional development, and infrastructure) where actions are required in order to improve the Early ACCESS system. From each of these parts or "strands of action" Iowa identified 3 improvement strategies (use evidence-based practice/FGRBI, use evidence based professional development/implementation science, and use ECTA System Framework) that will ensure eligible children and families have improved outcomes. A logic model was created for each improvement strategy and provides a visual framework for describing the relationship between resources or inputs, activities, and results or outcomes. Each short, intermediate and long-term outcome on the logic models is measured using the tools and methods described in the evaluation plan. There are direct, intentional connections between the Theory of Action, improvement strategies, logic models, and the items on the evaluation plan. Together, these tools help build the structures needed to get better results for families and children in Early ACCESS.

Monitoring Outputs to Assess Implementation Effectiveness: Provider Face-to-Face Trainings, Torsh TALENT

Face-to-Face Trainings

Early intervention service providers are the direct recipients of the professional development (PD) activities and it is important to evaluate the training effectiveness. The following information demonstrates if the training is meeting the needs of the providers and where additional support is still required. To address the skewing of data that can happen when using a pretest at the beginning of training and then a posttest at the end, a post-then-pre survey was completed after the training content was delivered. This way providers could truly think about what they knew before the training and what they knew at the end of the 2 days.

Analysis of results offers trainers information about remaining needs of providers, which leads to improvement of future training elements that address the needs (e.g., webinars, emails, online resources, expert coaching sessions, community of practice).

Learning Based Assessment of Training (LBAT) Model was used to analyze the post-then-pre survey responses (Awab, 2015). The questions that LBAT addressed were:

1. Keeping the learning objectives of the training in mind, what was the level of pre-existing knowledge of the participants? Simply put, how much of the training contents they knew already. \( \text{(Pre-test score)} \)
2. What was the net learning of the participants? How much of the learning could be attributed to the training? \( \text{(Post-test score minus pre-test score)} \)
3. Was there a learning lag? If yes, how much? How much more the participants needed to learn to fully achieve the learning objectives. \( \text{(100 minus post-test score)} \).

Note: all the above are calculated in terms of aggregate percentages.
The goal is to increase net learning which will reduce the learning lag. The first face-to-face 2-day training session occurred shortly after participants were selected and pre-training videos recorded and submitted to FSU. The final face-to-face 2-day training session occurs around 6 months later.

The figure below displays the results from the face-to-face workshop with Cohort 5 trio members that took place 6 months into their training sequence. Every trio member (N=28) and internal coach (N=9) in attendance completed the survey. This information is critical for understanding where participants learning was at the six month point in the training sequence. This is only one example of the post-then-pre surveys completed during the training sequence.

**RESULTS**

<table>
<thead>
<tr>
<th>Definitions:</th>
<th>Pre-Existing Learning</th>
<th>Net Learning</th>
<th>Learning Lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test Score</td>
<td>Post-test score minus pre-test score. This is the score attributable to the training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 minus post-test score. This is the learning lag.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| IA DMM Final Face-to-Face Training, Cohort 5 Trio Members, Day 1, (N=28) |
| --- | --- | --- | --- |
| | Pre-Existing Learning | Net Learning | Learning Lag |
| I can identify strategies for building family capacity in adult learning | 60.63% | 55.63% | 8.75% |
| I can list components of embedded intervention | 23.13% | 23.13% | 25.00% |
| I can list everyday routines & activities to coach families to embed intervention | 66.25% | 66.25% | 16.25% |
| I can describe general & specific caregiver coaching strategies | 28.13% | 28.13% | 28.13% |

**The Position of the Green Band:** The green band represents the net learning of the trio members. The bottom of this band, on the spectrum of 0-100 percent, tells how familiar the providers were the training content prior to attending. If the bottom is above 30 percent, that means that the training contents were already familiar to participants. This is to be expected since the providers were 6 months into the training sequence. The top of the green band indicates how difficult it was for the providers to learn from the training.

**The Health of the Green Band:** Typically the fatter the green band the better with the benchmark in this regard being 50%. Anything less would mean a fatter yellow or red band. In the case of this training, the yellow band or knowledge the providers brought into the training was large, which is to be expected since this training is 6 months into the training sequence. This training added to provider knowledge and left small percentages of learning lag or content that still needed to be learned in the remainder of the training sequence.
A second example illustrates the same post-then-pre survey process and LBAT analysis. The figure below displays the results from the face-to-face workshop with Cohort 5 internal coaches that took place 6 months into their training sequence.

RESULTS

As expected, internal coaches came into the training with high levels of preexisting knowledge since they had completed provider training with high fidelity and they were 6 months into their training sequence. Data indicate there is some learning lag (red band) that will need attention during the remainder of the training sequence.

Other Training Data: Open-ended Questions, Quality and Relevance of Training

Open-ended questions are part of the survey administered at the end of the face-to-face training. Questions include:

1. Best Feature of the IA DMM Professional Development Session was...
2. Any Suggestions for Improvement?
3. Other Comments and Reactions I Wish to Offer

Answers were analyzed and results used to improve future trainings.
The table below shows an example of data collected from providers related to facilitation quality and relevance of the content to the providers' work.

RESULTS

<table>
<thead>
<tr>
<th>IA DMM Final Face-to-Face Training, Cohort 5 Trio Members, Day 1, (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Means and Frequencies</strong></td>
</tr>
<tr>
<td>Question (Answers on a scale of 1-5)</td>
</tr>
<tr>
<td>1. The facilitation was of <strong>high quality</strong>. (n=28)</td>
</tr>
<tr>
<td>2. The information was <strong>relevant</strong>. (n=27)</td>
</tr>
<tr>
<td>3. The conversations held were <strong>critical for my future work</strong>. (n=28)</td>
</tr>
<tr>
<td>4. Overall, this training was <strong>very beneficial</strong>. (n=28)</td>
</tr>
</tbody>
</table>

All information from the post-then-pre questions, responses to the open-ended questions and information on facilitation and relevance, are used to improve the next training sequence.

Torsh TALENT Training Tool: Provider Interviews

Understanding if using Torsh TALENT helps or hinders the learning for providers and internal coaches is important. In order to determine how helpful TALENT was, interviews were conducted to gather data.

The feedback and coaching process greatly improved with the introduction of Torsh TALENT. Feedback from providers and internal coaches has been overwhelmingly positive. During the February 2017 face-to-face training for Cohort 5, interviews were conducted and video recorded for 15 service providers and 9 internal coaches. They were asked the following question, "*In a nutshell, how was working with Torsh TALENT?*" Interviews were transcribed and summarized into statements below. Many descriptive data are available to support the 12 statements; however, only a few quotes have been added as examples.

Results

**Feedback from Cohort 5 trio members regarding Torsh TALENT:**

1. Overall all feedback from this cohort was extremely positive regarding the use of Torsh TALENT and how it can be utilized to review their own practices and those of their trio members.

   *Torsh TALENT for me has been a godsend because it's user friendly, and from a technology perspective, I don't always have that opportunity to keep embedding technology into my practice when you are out in the trenches. So this has been a refreshing change to use Torsh*
TALENT to see how I can reflect on my own practice as a therapist and a clinician but also to see how my colleagues are practicing. When I do run into a glitch, and that's my own lack of technology skills, I can call Kat and she either answers immediately or answers by email. So I always feel like I have an available resource to help me if I can't quite get past (an issue), and it's usually on my end but I haven't had a problem. It's been a joy to use actually.

2. The ability to insert comments exactly at a specific time and place in the videos was identified as a very positive aspect of this software.

   It's nice that you can see little written notes on your video and you can see that example of that picture of that strategy that they (coaches) are describing; it's a powerful tool.

3. The ability to work at distance from each other through technology was identified as a plus, also.

   It was nice for us to be really far away from each other and yet we weren't limited by the distance. We were able to still share videos and comment.

4. Several Cohort 5 members indicated that reviewing and reflecting on their own and others practices impacts their work.

   I know when I've looked at other videos of my trio and seen how we see things, and see it just a little differently, or see it in the same way, that it has made an impact on our teaching.

5. The only concerns reported were by those who didn’t have strong internet connections or had issues with the equipment. The connection issue may be a concern when service providers work from an office or their homes in rural communities around Iowa.

   We've had a hard time uploading, but that was because of my computer and the video camera; just within our agencies, so that's been a challenge.

Feedback from Cohort 5 Internal Coaches regarding Torsh TALENT:

6. Similar to the responses from Cohort 5 trios, the Cohort 5 Internal Coaches unanimously supported the use of Torsh TALENT as a professional development resource to assist in tailored feedback and reflection. Many of these coaches had participated in Cohort 1 for their original training and were able to note how superior Torsh TALENT is compared to earlier software used.

   Oh, I like Torsh. I was in Cohort 1 so you have to think about what we did to get videos uploaded at that time. This is like a Cadillac compared to that. I love it.

7. The ability to specify comments within the video was identified as a key strength to this software.

   I think it's been wonderful…the real-time comments, so that you can really see when and where someone’s commenting; exactly what they are talking about. I think it specifies the coaching a little bit more and doesn't keep (the feedback) so broad. It's real easy to upload.

8. At least one coach indicated that the cohort members were more intentional in their reflections given this new software compared to past feedback sessions.

   They (the cohort members) are much more intentional about the video pieces and tying it into the key indicators because they are focusing on not just general statements of "oh, that's great"
which I know in all of our other cohorts before we tend to be so positive but maybe not delving
into the meat of what's going on within the video. I see Torsh helping with that piece of it, and
then for us to be able to have that record right there, live time, to go back and reflect upon how
maybe we could have done that a little bit differently in our own trio and then again with
Florida State. So, it’s been great.

9. One coach indicated that the naming or labeling of the videos was clearer compared to past practices.

Last year I would upload my video and assume it was there because what I’d get was a series of
letters and numbers and symbols and a date. I thought well, that must be it. Now you know
exactly what it is and you can go back in and you can watch it. I love the ability to be able to
make the comments right on there and to be able to share that with my trio members.

10. Several internal coaches indicated that they are using or would like to use Torsh TALENT when supervising other
service providers (who may not be in IA DMM Cohort 5).

I’d love to be able to use that with our agency, ‘cause that’s one of the things I think about if I’m
going to roll this out to our agency. I know the frustration I had in regular cohorts doing
videoing and sending the video and uploading the video and all of that. ...I think that would be a
major difficulty, trying to roll it out, if I don’t have a good system to be able to do that.

11. Several internal coaches wondered how accessible this resource will be once the affiliation with FSU ends.

I’m not sure if once we are done with Florida State are we done with Torsh. So when you said
what will I need from my AEA when we talked about technology, it's been such a great service
for coaching that I would hope we would continue to work in that format.

12. A few comments reflected the concern of not knowing what will happen after work with FSU ends and whether
coaches will have access to a system like Torsh TALENT (due to the perceived expense) or ownership of the files.

I love it. I love it. I was going to talk to my technology team about it as we are all looking at
professional development, self-reflection, using videos...I've gotten a little bit of feedback in the
rumor mill that it's super expensive. Whether it is or not, I'm not sure, but it's been very
effective. It’s been great. I think it’s a secure site. I think it offers great means of feedback. I
think the uploading problems that people complained about, that was the same no matter
where we were at so I just don’t think that entered into it. I think it has been a great platform
for this project.

It is clear from the interview results that Torsh TALENT has improved the training experience for providers and
internal coaches. One AEA has already purchased TALENT through their agency for all their Early ACCESS
providers. As mentioned previously in the section on evaluation overview, efforts are under way to address
continued use of TALENT beyond IA DMM.

Surveys and interviews help to monitor progress of implementation plans and supports any mid-course
corrections if needed. Surveys have provided evidence that trainings are effective in changing provider
knowledge. Feedback on using Torsh TALENT provided assurances that this tool is beneficial in supporting
professional development.
Provider Progress—Moving Towards Improved Family & Child Outcomes

Cohort 5 provider progress is measured through observations and interviews. Evaluation data indicates that progress is being made in implementing evidence-based practices.

Observations

Observation data provides information on progress in using FGRBI practices. Observations are made by the providers, trio members, internal coaches and external coaches through viewing the video recordings of home visits. This process was described in A4: Brief Overview of the Year’s Evaluation Activities, Measures, and Outcomes (pages 14-16). The Self-Assessment Session Summary form (Appendix D) is used to collect the data on the following measures: FGRBI SS-OO-PP-RR Key Indicators, Caregiver Coaching strategies, and routines used. This is the same form that is used for all observations and fidelity checks.

Baseline is established by external coaches (FSU) reviewing Cohort 5 provider videos of a home visit that was recorded approximately 1 month prior to attending the initial face-to-face training. Subsequent videos are observed by the same people using the same processes every time. Evaluation data on progress comes from the external coach scores from the Self-Assessment Session Summary form.

RESULTS: Key Indicators

Provider Key Indicator Data from Coaches’ Observations for Cohorts 1-5

Since introduction of the Key Indicator Checklist, 2 predominant trends have been consistent. First, each cohort displays growth over time. The Key Indicator Checklist is completed as a measure of fidelity via video
Provider Progress, continued

observations collected during each provider’s home visit while enrolled in the professional development sequence.

When looking at the chart for mean percentage of Key Indicators used, growth ranged from 8 points in Cohort 3 to 31 points in Cohort 2, with an average of 19 points over all of the cohorts. Second, each cohort begins higher baseline than the previous cohort. These two findings reflect the impact of the professional development, both on the cohort and the overall population of early intervention providers within the agencies. The Key Indicators are becoming an institutional measure of performance.

Interestingly, Cohort 4 and Cohort 5 achieve 80% and above on average at the final measure of the professional development sequence, the level identified as designating fidelity of implementation. Cohort 5 started at an average of 72% indicating FGRBI is familiar and applied within the agencies even by individuals without specific training in the approach by the FSU team. This finding is an important benchmark for full implementation and sustainability.

Reliability Check

Blind coders are used to provide data to the external coaches who are assessed routinely to ensure they remain reliable. The external coach observes the video and compares Key Indicator coding to that of the blind observer. Clinical and consensus judgment occurs when disagreements are noted. Most disagreements are based on clinical contexts or content not available to the blind coders and result in additional points for the early intervention providers thus differentiating the scores between the external and blind coders.

Key Indicator Item Analysis

Improvements in items 4, 8, 9, and 11 are seen over time as providers receive coaching. These items were refined for Cohort 5 based on data collected previously on Cohorts 1-4. The Key Indicators went from 9 items for Cohorts 1-4 to 12 items for future cohorts beginning with Cohort 5.
Provider Progress, continued

- Items 1, 2, & 7, general and specific updates and feedback are most commonly used.
- Item 3, sharing developmental information, has been altered to require it to be related to IFSP and family priorities and the why of the 5Q (5 questions to support caregiver embedded interventions).
- Item 4 specifies engaging the caregiver to participate in planning the session including what, when, and how of 5Q.
- Item 5, observation, requires 30 seconds before coaching within a routine.
- Item 6 includes all 8 coaching strategies and credit is earned when more than 2 are observed in more than 2 routines.
- Item 8 combines number of routines with problem solving for generalization (where of 5Q)—revised for C5.
- Item 9 combines reflection with use of intervention strategies (how of 5Q)—revised for C5.
- Item 10 combines reflection with review of the session focusing on self-efficacy.
- Item 11 addresses measurement or how will I know it is working of 5Q—new in C5.
- Item 12 is a plan led by parent including the 5Q—revised for C5.

RESULTS: Caregiver Coaching Strategies

The chart shows the average number of specific coaching strategies observed at each time point for each cohort. Specific coaching strategies include direct teaching, demonstration with narration, caregiver practice, guided practice, general feedback, specific feedback, reflection, and problem solving.

Similar to the Key Indicators, the Coaching Strategies are increasing in frequency and consistency of use by EI Providers within home visits. Cohort 5 began PD at a higher level of use than Cohort 1 through 3 concluded the PD sequence. This data analysis does not reflect the frequency of use of each type of coaching strategy during the visit but rather an overall frequency. More specific details will be available for Cohort 5 in the near future.
RESULTS: Routines

Average number of routines categories observed at each time point for each cohort are displayed in the chart to the right.

Data do not show a significant change over time in the number of routine categories coached during each home visit. The average after completion of the training sequence is 2.25 routine categories per visit. On a positive note, this means that providers are coaching across categories of play, caregiving, literacy, chores, etc. and not just coaching within play.

This is slow to change and will become a priority in future cohorts. Parents need the opportunity to practice and receive feedback in multiple settings and activities for the most efficient and effective learning.

Results: Provider Interviews—Most Significant Change

Transcription data from Cohort 5’s interviews of 24 service providers from different disciplines were examined and coded through the computer program NVivo designed to analyze qualitative data. The transcripts included service provider’s responses, and were named and numbered to ensure anonymity (e.g. Respondent #1). The respondents were coded into “Nodes” based on their responses to the questions. Nodes are specific starting places in a file that can code text and then be sub coded.

Data was coded based on the following two reflective prompts:

1. Please describe the most significant changes that you’ve made in your work with children and their families that have been influenced by your participation in IA DMM.
2. Please describe any aspects of your work with children and their families that continue to be difficult or challenging.

Similarities in the reflective responses from the service providers that participated in Cohort 5 of the Iowa Distance Mentoring Model for Early ACCESS were identified. During the feedback interviews, 24 service providers identified the changes they have made based on being involved in IA DMM. The most prevalent changes identified were in the areas of interaction and service delivery. Service providers stated that changes in how they interacted now with the families they served: helped them to support their families better; helped
them to engage the caregiver in making decisions, problem solving and reflecting on what works for them; and listening more to what was important to the families. Providers stated that how they interacted with the families and met the needs of the child were highly supported by the IA DMM trainings.

Challenges also were identified from the service providers. To support the families in the intervention process, the service provider had to learn more and gain comfort with coaching. **Team challenges were the most frequently reported during the interviews.** These challenges were about how the team itself had difficulties in the process of moving from direct teaching to the coaching process.

**Planning, problem solving and leading were identified as the most frequent challenges the service provider/caregiver team faced.** Service providers stated that in the area of planning they thought “the hardest part has been to plan what we are going to work on at the next visit with the family” or helping the families “pinpoint simple and very important routines and activities when there is a lot that you can be working on.” Problem solving had similar reoccurring themes such as challenges in “the ability to effectively problem solve with families” and “help them [the families] identify what could we have done differently”. Leading was a theme that also occurred in the changes that the service provider identified, but this theme focused on helping the families become the active interventionist with the child rather than assuming the leadership as the provider. Service providers stated that sometimes it was “hard to get the parents to be involved with their own children” and that some challenges were getting the families to “involve us with the strategies that are always implemented during their daily routine.”

**Conclusion**

Changes in implementation from the service providers have supported the overall validity of the Distance Mentoring Model. Intrinsic changes support the coaching framework and gives credibility to coaching in natural environments. Additional information from the coding process will help support the next steps in the Distance Mentoring Model’s support in training. In previous cohorts, challenges that were identified included technological issues, product feedback and scheduling conflicts. These challenges were identified and remedied. Considering the challenges that the most current cohort experienced will help with making modifications to the framework of DMM for future cohorts and statewide sustainability.

**Provider Progress Summary**

Provider practice change leads to supporting and sustaining caregiver knowledge and behavior changes which ultimately leads to changes in family and child outcomes. Data collected throughout 2017 shows progress in changed provider practices for IA DMM participants. Work continues on improving fidelity, scale up of practice and sustainability.
Caregiver Progress—Moving Towards Improved Family & Child Outcomes

Cohort 5 caregiver, or parent, progress is measured through surveys, interviews and observations. Evaluation data indicates that progress is being made in caregiver use of intervention strategies within daily routines.

EIPSES: Early Intervention Parenting Self-Efficacy Scale

Increasing caregiver's competence and confidence to help their children develop and learn is critical to measuring progress towards Iowa's SiMR. Caregiver competence is defined as the degree to which parents perceive themselves as being personally effective and capable in helping their child. Caregiver confidence is defined by the scale as the extent to which parents believe child outcomes are a function of the early intervention. In other words, are caregivers confident that what they are doing in Early ACCESS makes a difference in their child's development and learning?

The information below represents how parents were feeling at the end of the IA DMM training. Cohort 1 through Cohort 3 data are combined because the EIPSES was completed for the first time at the end of Cohort 3 training without identifying which of the 3 cohorts each family belonged to. The response rate was 45% (41 of 91 surveys). Cohort 4 (response rate 23 of 44 or 52%) and Cohort 5 (response rate 24 of 44 or 55%) families each received the survey at the end of their service providers' 10 month training sequence.

RESULTS

<table>
<thead>
<tr>
<th>Parent Competence in Implementing Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max (7)</td>
</tr>
<tr>
<td>Min (1)</td>
</tr>
<tr>
<td>Cohorts 1-3 (N = 40)</td>
</tr>
<tr>
<td>Cohort 4 (N = 23)</td>
</tr>
<tr>
<td>Cohort 5 (N = 24)</td>
</tr>
</tbody>
</table>

Results show that parents report feeling competent in their abilities to promote their child’s development (average scores range from 5.83 to 5.98 on a 7 point scale). This means that parents perceive themselves as being personally effective and capable in helping their child. Coaching strategies appear to have an impact on helping families to help their child. Further testing and analysis is necessary to confirm this relationship.
Caregiver Progress, continued

Cohort 5 parents report feeling *confident* in their abilities to exert control over their children’s early intervention outcomes (average score 5.60). The higher results for Cohort 5 families appears to correspond with the higher use of Key Indicators at fidelity by Cohort 5 providers. Cohort 5 is also the first group of providers to have both an internal and external coaches which may have had an impact on provider practice. The better the provider is at implementing FGRBI and Caregiver Coaching, the greater the parents’ confidence as measured by the EIPSES. Further testing and analysis is necessary to confirm this relationship.

**Conclusion**

Cohort 5 parents report feeling *competent* in their abilities to promote their child’s development (average score 5.98 on a 7 point scales) and slightly less *confident* in their abilities to exert control over their children’s early intervention outcomes (average score 5.60). This is very different than Cohort 1 through Cohort 4 who were equally competent in their ability to do the interventions (average 5.89 and 5.83) but less sure that the interventions would produce the outcomes wanted for their child (average confidence scores 3.38 and 3.31).

**Parent Interviews**

As mentioned in the evaluation overview, 11 Cohort 5 parents participated in interviews between May 1, 2017 and July 10, 2017. The same interviewer spoke with all of the parents with calls lasting between 12 and 40 minutes. Calls were recorded with the parent’s verbal permission and transcribed by staff verbatim. The transcripts were analyzed and the report developed by a “blind” student coder, not a member of the FSU DMM team. An FSU DMM faculty member reviewed the report for accuracy and consistency.
Caregiver Progress, continued

Interview questions were aimed at eliciting families' experiences related to their early intervention experience. Questions were asked related to Family Guided Routines Based Intervention (FGRBI) and Caregiver Coaching.

**Interview Protocol**

Questions From the Family Interviews

1. What did you see as the advantages of working together with your provider to support your child’s learning and everyday routines, activities, and places using your own materials and toys?
2. What did you see as the disadvantages of working together with your provider to support your child’s learning and everyday routines, activities, and places using your own materials and toys?
3. Did you see any differences between coaching and any other early intervention services you’re receiving in or outside of Early ACCESS?
4. What kind of routines, meaning snacks, getting dressed, and play activities, and places did you use that worked best for you and why?
5. Your provider gave you feedback on how you used your intervention strategies or what your child did in response to your help. How useful did you find the feedback?
6. Your provider encouraged you to participate, to problem solve, and to make decisions about what you wanted to do. To what extent did these discussions help you know what and how to teach your child?
7. Planning and review was also included in the home visit to what extent did these discussions help you to know what to do in between visits with your provider?
8. This next section is about self-efficacy, how confident do you feel about working with your child in your routines throughout the day and how has that changed over time?
9. How is the coaching approach similar to or different from any other early intervention services you’ve experienced or participated in?
10. Would you encourage another family to participate in using this coaching approach?

The purpose of these interviews was to understand families' experiences with early intervention when providers use FGRBI and Caregiver Coaching. Parents had a good understanding of the questions that were asked and responded in great detail. Findings indicate that families had positive experiences with supporting their child's learning in everyday routines and activities within the natural environment. They indicated increased confidence and competence in their ability to help their child develop and learn because of the support received by their service providers. Families are using interventions in different routines that provide increased opportunities for their children to practice and learn. See Appendix F for details of family interviews.
Caregiver Progress, continued

Caregiver Key Indicators

The Caregiver Key Indicator tool is used to measure participant videos before they receive professional development (PD), during the PD sequence, and after to measure change as a result of the provider’s training. The goal in IA DMM evaluation is to measure not only what the provider is doing, but how the providers impact the family’s engagement and participation in intervention sessions. The Caregiver Key Indicator tool was piloted with Cohort 4 and was first used with Cohort 5. The video recording that is used for evaluation of provider practices is the same video used to measure the Caregiver Key Indicator items; however, a different observation lens is being applied for recording caregiver data.

RESULTS: Key Indicators

![Bar chart showing mean percentage of Caregiver Key Indicators observed by blind coders at each time point.]

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>48.2</td>
<td>25-66.7</td>
</tr>
<tr>
<td>Video 1</td>
<td>58.5</td>
<td>25-83.3</td>
</tr>
<tr>
<td>Video 2</td>
<td>57.7</td>
<td>16.7-83.3</td>
</tr>
<tr>
<td>Video 3</td>
<td>62.5</td>
<td>25-91.7</td>
</tr>
</tbody>
</table>

The ranges are too large for meaningful analysis. This is affected by the skill of the provider, the engagement of the caregiver, and the situation of the day with any of the three altering the score for the visit significantly.
Caregiver Progress, continued

Caregiver Key Indicator Item Analysis

This checklist shows specific indicators. Items 8-10 are yes/no rather than yes, partial or no and include a minimum number of exemplars for credit to be given. These items will be reanalyzed to tease out how to make them more meaningful. They were intended to show “leadership” on the part of the caregiver.

Caregiver Progress Summary

Provider practice change leads to supporting and sustaining caregiver knowledge and behavior changes which ultimately leads to changes in family and child outcomes. As Early ACCESS early intervention providers improve their use of FGRBI and Caregiver Coaching, caregivers will also improve on implementing intervention strategies into their child’s everyday routines and activities. Quantitative and qualitative data will continue to be helpful in evaluating caregiver progress.

Caregiver Key Indicators Cohort 5

<table>
<thead>
<tr>
<th>Caregiver Key Indicators</th>
<th>Yes</th>
<th>Partial</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Caregiver child interaction is primary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes if more than 50% of time. Partial of 25-49% of time, No if 24% or less.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Caregiver participates in 2-3 typical/preferred routines from different routines categories?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If they only do one type of routine but talk to others, score as partial.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Caregiver uses family’s typical materials?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 3-5 times but only one routine, score as partial. If 3-5 times in 2 or more routines, then yes. If 2 trials in one routine and three in another, then yes. If less than three times in only one routine, then no.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Caregiver embeds the child’s functional targets 3-5x in routines?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 3-5 times but only one routine, score as partial. If 3-5 times in 2 or more routines, then yes. If 2 trials in one routine and three in another, then yes. If less than three times in only one routine, then no.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Caregiver practices intervention strategies 3-5x in routines?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 3-5 times but only one routine, score as partial. If 3-5 times in 2 or more routines, then yes. If 2 trials in one routine and three in another, then yes. If less than three times in only one routine, then no.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Caregiver responds to feedback with comments or more practice at least three times per session?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Caregiver requests or responds to information and ideas at least three per session?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Caregiver problem solving with interventionist on what is and is not working regarding intervention strategies at least two times per session?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Caregiver problem solving with interventionist about general family priorities at least two times per session</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Caregiver reflects on current session at least one time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Caregiver reflects on child/family progress at least once per session</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Caregiver summarizes action plan for intervention between visits?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average Percentage of Sessions in Which Each Caregiver Key Indicator was Observed at Each Time Point
Regional System Progress—Moving Towards Improved Family & Child Outcomes

Regional system progress is measured through written reports and focus groups. Evaluation data indicates that progress is being made in the use of regional implementation teams across Iowa.

Written Reports

Written reports provide valuable information on the progress that regional implementation teams are having with implementing and sustaining use of evidence-based early intervention practices. The State Work Team is able to monitor who is attending meetings, how often meetings are taking place and successes and barriers that the regional teams experience. In addition, the reports identify barriers that need to be addressed by the state level team and indicate what topics need to be discussed at the statewide stakeholder meeting (Early ACCESS Leadership Group meeting). The following are examples of information reported and then used to continually improve the work.

<table>
<thead>
<tr>
<th>Who has attended the meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid level management staff, IA DMM graduates, internal coaches, agency administrators, regional liaisons, instructor of early childhood college courses, community partner health providers, providers who are ECSE teachers, occupational therapists, physical therapists, speech language pathologists, social workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you engaged disciplines other than ECSE teachers in the work of scaling-up FGRBI? If so, what disciplines did you engage? How did you engage them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All agencies are engaging the following disciplines in addition to their early childhood special educators: speech pathologists, occupational therapists, physical therapists, social workers, audiologists, hearing and vision specialists, autism consultants, nurses, service coordinators, orientation and mobility specialist.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What data do you review routinely in meetings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGRBI, coaching strategies and self-assessment data; locally collected data on coaching practice indicators; outcome writing; OAT/FLOAT to score outcomes; Early ACCESS year end report data; primary service provider teaming; review job descriptions to reflect FGRBI; practice and home visit videos; numbers of people attending IA DMM trainings; referral numbers; number of joint visits; evaluation and eligibility data; ECO and exit data; local needs assessment; frequency of service data; workload data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What data would you like to review in meetings (but you do not have)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broader use of video recordings and fidelity to practice checks; increase use of 5Q document (embedding interventions) to collect data; use of OAT/FLOAT to review outcomes; child progress monitoring; local measures of parent competence and child participation; comparison data with other agencies on average amount of services per discipline/average number of visits per year.</td>
</tr>
</tbody>
</table>
### Regional System Progress, *continued*

#### Highlights from the meetings:
- Following OAT/FLOAT when writing outcomes
- Implementation plans for Primary Service Provider (PSP) teaming
- Continued discussions on embedding interventions into routines
- Generate ideas for professional development for the year
- Reviewed IFSP rights and manual and how to improve practices regarding rights and safeguards with parents
- Reviewing intake processes
- Using DEC practices by putting coaching, FGRBI and PSP together to provide services to families
- Focus on 4 things: building sustainability, fidelity of practice, outcome writing, growing Autism Navigator
- Cross disciplinary PD planning

#### Barriers or problems addressed or working on at regional level:
- Change in personnel
- Time for team meetings
- Educating administrators on change in practice
- Competing demands on caseload for staff working with ages birth – 21 years
- Making FGRBI a priority for all EA providers
- Ensuring time for coaches to fulfill their roles
- Figuring out PSP teaming
- More buy in from support disciplines other than early childhood special educators

#### Help or support needed from the State-level Implementation Team/State Work Team:
- Training for writing outcomes
- Opportunities to discuss and learn from other agencies
- Partnering across agency boundaries to learn from each other
- Continued support in communicating with special education directors

#### What would you like to discuss at Early ACCESS Leadership Group meetings:
- IFSP team meetings
- Data on transition from Early ACCESS to early childhood special education
- Family outcomes
- Update/changes on SS-OO-PP-RR data collection
- Value of more practice time using coaching in routines and reflection to improve

### Focus Groups
Focus groups were video recorded and will be transcribed and analyzed in 2018. Results will be used to further support the successful use of implementation teams to sustain the changes to the Early ACCESS system. Results will be shared in the next SSIP report.
State System Progress: Moving Towards Improved Family & Child Outcomes

State system progress is measured through the **ECTA System Framework self-assessment** and meeting documentation. Evaluation data indicates that improvements are being made to the early intervention system/infrastructure.

**ECTA System Framework**

DaSy and ECTA Frameworks Self-Assessment Comparison Tool is an Excel-based instrument that provides a structure for states to record the current status of the state system and set priorities for improvement. It is a companion to the ECTA and DaSy System Frameworks and was developed with extensive input from Part C and Section 619 staff from partner states (http://ectacenter.org/sysframe/selfassessment.asp). Stakeholders in Iowa, including state staff, updated the self-assessments for the Governance (GV) and Personnel/Workforce (PN) components.

**RESULTS: Governance Component (GV)**

The goal of the GV component is to *ensure that there is an established enforceable decision-making authority to effectively implement the statewide system and leadership advocates for and leverages sufficient fiscal and human resources to support quality services throughout the state.* It consists of 8 Quality Indicators, each with corresponding elements of quality.

The self-assessment was updated, rescored, and results compared between Time 1 (3-21-16) to Time 2 (1-23-18) to evaluate systems change.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>GV (Governance)</th>
<th>3-21-16 Time 1</th>
<th>1-23-18 Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Vision, mission and/or purpose guide decisions and provide direction for quality comprehensive and coordinated Part C and Section 619 statewide systems.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>2 Legal foundations (e.g. statutes, regulations, interagency agreements and/or policies) provide the authority and direction to effectively implement the Part C and 619 statewide systems.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>3 Administrative structures such as state and regional and/or local system entities are designed to carry out IDEA and related federal and state mandates to ensure statewide implementation of the system including provision of services.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>4 State and regional and/or local entities enforce rules and responsibilities for implementing IDEA and other federal and state mandates.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>5 State and regional and/or local system entities are designed to maximize meaningful family engagement in the development and implementation of the system.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>6 State leadership advocates for and leverages fiscal and human resources to meet the needs for implementation and oversight of the statewide system and services.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>7 Leaders use written priorities with corresponding strategic plan(s) and evaluate to drive ongoing system improvement.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>8 Part C and 619 state staff or representatives use and promote strategies that facilitate clear communication and collaboration, and build and maintain relationships between and among Part C and Section 619 stakeholders and partners.</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

Quality Indicator GV5 was the focus of work completed in 2017 because it was identified a high priority item and it scored the lowest on the initial self-assess: **State and regional and/or local system entities are designed to maximize meaningful family engagement in the development and implementation of the system.**
### Iowa’s Change in Governance, Quality Indicator GV5: Family Engagement

<table>
<thead>
<tr>
<th>QI 5</th>
<th>State and regional and/or local system entities are designed to maximize meaningful family engagement in the development and implementation of the system.</th>
<th>QI Rating</th>
<th>Element of Quality Rating (EQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Decisions about system structures support equitable representation of families on the state Interagency Coordinating Council (ICC), local ICCs, task forces, and committees.</td>
<td>2</td>
<td>Element Rating 2 3 H H</td>
</tr>
<tr>
<td>b</td>
<td>Part C and 619 state staff or representatives support (e.g. through stipends, transportation, information and preparation, convenient time and location, mentoring, FTE, consulting fee) family members’ active roles on councils, committees, and task forces to allow their full participation and input into system decisions related to areas such as policies, training and TA, monitoring, and program improvement.</td>
<td>2</td>
<td>Element Rating 2 3 H H</td>
</tr>
<tr>
<td>c</td>
<td>There are ongoing system wide efforts to recruit families that are representative of the demographics of the state and local communities and support their leadership development.</td>
<td>2</td>
<td>Element Rating 2 3 H H</td>
</tr>
<tr>
<td>d</td>
<td>There is an ongoing process for evaluating and improving meaningful family engagement in the system.</td>
<td>2</td>
<td>Element Rating 2 3 H H</td>
</tr>
</tbody>
</table>

The above information shows that ratings for all four elements of quality (a-d) increased from 2 to 3 and the priority level remains high. In 2017, the Family Engagement Task Team created activities that align with each element of quality to ensure active partnerships with families are found throughout the early intervention system. The expectation is for the current rating to remain the same over a couple of years. Scores will not increase to a 4 rating until activities under each element of quality are fully implemented.

The intent is to increase the amount of evidence recorded for each element by fully implementing improvement activities. Examples of future activities include:

<table>
<thead>
<tr>
<th>Strategies to Meet Elements of Quality: Results of activities become evidence for rating the elements of quality on self-assessment.</th>
<th>Activity or Action</th>
<th>Elements of Quality</th>
<th>High Priority</th>
<th>Lead</th>
<th>Start Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop protocols and/or policies that support family partnership within ICEA, local ICCs, task forces, and committees so that family partnership is embedded within the system.</td>
<td>GV5a</td>
<td>X</td>
<td>Weigel, Mash</td>
<td>Summer 2018</td>
<td></td>
</tr>
<tr>
<td>Train and support providers, agency staff, leaders, administrators, and families to understand family involvement, family engagement, and family partnership.</td>
<td>GV5b</td>
<td>X</td>
<td>Weigel, Mash</td>
<td>Summer 2018</td>
<td></td>
</tr>
<tr>
<td>Identify what other agencies are already doing in the area of partnering with diverse families.</td>
<td>GV5c</td>
<td>X</td>
<td>Weigel, Mash</td>
<td>Summer 2018</td>
<td></td>
</tr>
<tr>
<td>Develop and implement two way communication plan for feedback on family partnership in ICEA, local ICCs, task forces, and committees. (Leading by Convening)</td>
<td>GV5d</td>
<td>X</td>
<td>Weigel, Mash</td>
<td>Summer 2018</td>
<td></td>
</tr>
</tbody>
</table>
RESULTS: Personnel/Workforce (PN)

The goal of the PN component is to guide states in the planning, development, implementation and evaluation of a comprehensive system of personnel development (CSPD). It consists of 12 Quality Indicators, each with corresponding elements of quality.

The self-assessment was updated, rescored, and results compared between Time 1 (4-10-15) to Time 2 (3-9-18) to evaluate systems change.

Infrastructure work has been demonstrated throughout this report in multiple sections. Using evidence-based professional development and implementation practices has produced evidence which has been recorded in self-assessment elements of quality within quality indicators 2, 7, 9, 11 and 12 in particular. New scores reflect rating increases for these quality indicators. Quality indicator 4 and 9 experienced decreased ratings. Quality indicator 4 decreased as discussions emerged about creating early intervention and service coordination certifications in the state, which was not a consideration when the self-assessment was first scored. Upon deeper reflection of the evidence on recruitment and retention, quality indicator 9 was reduced to reflect the fact that work has not moved along as first thought. Iowa expects these scores to continue to increase as state and regional processes and structures change to support the use of evidence-based practices.

Meeting Documentation

The State Work Team (SWT) is made up of staff from the Iowa Departments of Education, Public Health, and Human Services and University of Iowa's Child Health Specialty Clinics. The team meets twice a month with regular and frequent contact between meetings. The SWT is responsible for overall functions of the Early
State System Progress, continued

ACCESS system and perform the roles and responsibilities for supporting statewide implementation of the State Systemic Improvement Plan (SSIP). Iowa has another larger group of early childhood stakeholders and meets as needed. Google Drive is used to manage the meeting agendas and notes.

As a result of frequent meetings and contacts between multiple state-level agency stakeholders, implementation of the improvement plans and evaluation continues to be on target for the SSIP.

Regional and State System Progress Summary

It is vital that equal or greater attention be paid to infrastructure development as there is to training of service providers. A high quality infrastructure means a more effective and efficient system that supports implementation of evidence-based practices. Iowa's investment in professional development is intimately tied to using implementation practices that contribute to building the infrastructure to sustain progress. Having the MOA Action Plan aligned to the ECTA System Framework ensures that attention is given to all parts of the system. Even though the focus to date has been on governance and personnel/workforce, plans are to complete the remaining self assessments beginning in 2018.

C3: Stakeholder Involvement in Evaluation

The stakeholder groups described in Section B2: Stakeholder Involvement in SSIP Implementation (pages 24-25) are the same groups that are involved in evaluation activities that have described throughout this report. In addition, individual providers are involved in evaluation through their self-assessment processes that are built into the IA DMM professional development and implementation activities. Florida State University's DMM staff are critical partners in gathering and disseminating data back to providers, implementation teams, and the State Work Team. It is the State Work Team that then brings data and evaluation activities to the Iowa Council for Early ACCESS, Early ACCESS Leadership Group, and any task teams or other stakeholder groups that need to be involved.

Throughout 2017, the Part C Coordinator worked with the IDEA Data Center (IDC) for support in using data with stakeholders including the use of info graphics and data meeting protocols. The Early Childhood Technical Assistance (ECTA) Center and the Early Childhood Data System (DaSy) Center have also provided materials to assist in this area. Iowa was asked to preview the draft of the video Converting COS Data to OSEP Progress Categories/Summary Statements and offer feedback before final release. Several State Work Team members completed the preview with comments. When the final product was released, the team was pleased to see their feedback had been taken into consideration and improvements made. This video was well received by the Iowa Council for Early ACCESS and Early ACCESS Leadership Group. The video provided information that made looking at Iowa's data more meaningful and understandable to stakeholders.

Working with stakeholder groups is "business as usual" for Early ACCESS. There is a long history of the stakeholder engagement for the purpose of supporting the Early ACCESS early intervention system. This includes both evaluation and data work.
SECTION D: Data Quality Issues

D1: Data Limitations and Concerns

There are no concerns or limitations related to quality of the data used to report progress or results. Multiple measures, and both quantitative and qualitative data are collected. Multiple measures are used at all levels of evaluation. No single piece of data is used to assess progress of the desired changes that will lead to the SiMR.

Collecting data from families means being aware of and sensitive to all that is going on in their lives. Balancing that with the required paperwork for participating in Early ACCESS, and the consents to participate in the IA DMM trainings; adding pretest surveys could be overwhelming for families. This is taken into consideration when no baseline data is available for a family measure.

If a selected measure would not answer an evaluation question, a replacement measure would be selected. Fortunately, this did not happen. Future plans include increased family engagement in evaluation of the Early ACCESS improvement and evaluation plans. This is addressed in the plans created by the Family Engagement Task Team.

Section E: Progress Toward Achieving the Intended Improvements

E1: Progress Toward Achieving Intended Improvements

Early ACCESS is on track for SSIP implementation. The three high-level improvement strategies are all underway and interrelated so that one cannot change without having an impact on the others. Data shows evidence that providers are making progress towards using FGRBI and Caregiver Coaching practices with fidelity. Caregiver behavior change is more difficult to assess; however, parents are giving positive feedback on their experiences with service providers who are using FGRBI and Caregiver Coaching.

By the end of Federal Fiscal Year 2017, Cohort 6 trio members are expected to complete their training sequence and 9 internal coaches will have completed 2 years of training and 6 will have completed their first year of training. Another round of the professional development survey will be completed to determine the regional needs for more cohort and internal coach trainings.

Changes to the infrastructure are evident. Between specific infrastructure activities based on the MOA Action Plan and the activities generated by using evidence-based PD and implementation; there is a large number of activities happening to provide permanent, lasting impacts on components of the ECTA System Framework.

Evaluation has been built into the system change plans since the beginning of the planning process. It is a critical and essential ingredient for success of changing the culture of how early intervention is done in Iowa. Early ACCESS will continue to monitor the evaluation data and adjust its implementation activities to address concerns and improve outcomes.

Given there is a direct relationship between the Theory of Action, improvement strategies, logic models and evaluation plan; Early ACCESS considers the 3 improvement strategies—new instructional practices, new implementation strategies, and new high quality system—to all be supportive of the SiMR, helping families to help their children develop and learn. However, there is no expectation to see change in the OSEP Indicator
4C data until practice is used statewide with fidelity, within a high quality system that supports the use of evidence-based practices.

SECTION F: Plans for Next Year

In 2017, a new Request for Proposal was created by the Iowa Department of Education in order to expand and sustain the work of the past 5 years. The competitive grant process resulted in several proposals being received, reviewed, and scored. In November 2017, Florida State University was awarded the contract through 2023.

Stakeholders will be surveyed in the spring to determine the need for another cohort of providers to be trained. Cohort 6 will graduate in May/June 2018. The annual Joint Implementation Team meeting has been moved from June to August in order to give more time to analyze Cohort 6 data for use in the meeting. This meeting will help determine some next steps for the trainings.

Implementation science research makes clear that systems change requires specific planning for sustainability and scale-up if changes in practice are to endure. Iowa is taking a 3-pronged approach to ensuring sustainability of FGRBI:

1. Support internal coaches to high fidelity so that they can continue to provide meaningful and goal directed peer coaching within their agencies;
2. Develop, pilot, and evaluate online professional development modules to increase new providers' knowledge of FGRBI and recommended practices; and
3. Partner with institutes of higher education (IHEs) in Iowa to develop linkages from preservice training to workforce expectations.

In 2018, stakeholders will be providing input to the development of online modules that FSU will be creating. By combining the expertise of FSU with the knowledge of providers, agency staff, and families; the expectation is that the modules will be highly effective in training new providers or providers who need follow-up training. These modules will impact the early intervention infrastructure by improving Iowa's ability to provide in-service professional development and technical support beyond the current contract period. The capacity of state staff to incorporate new structures and duties will be built as everyone learns together what is necessary to shift Iowa's early intervention system to support better results for children and families.
Acronyms

AEA ..................... Area Education Agency
EA ...................... Early ACCESS
EAGL .................... Early ACCESS Leadership Group (Liaisons from all Area Education Agencies, Departments of Education, Public Health, and Human Services, Child Health Specialty Clinics, Special Education Directors, Iowa School for the Deaf, Iowa Educational Services for the Blind and Visually Impaired, Autism)
ECSE ..................... Early Childhood Special Educator/Education
FGRBI .................... Family Guided Routines Based Intervention from Florida State University
FSU ...................... Florida State University
GV ....................... Governance (component of the ECTA System Framework)
ICEA ..................... Iowa Council for Early ACCESS (Iowa's interagency coordinating council)
IA DMM ................. Iowa Distance Mentoring Model of Professional Development for Early ACCESS
OSEP ..................... Office of Special Education Programs, US Department of Education
OT ......................... Occupational Therapist
PD ....................... Professional Development
PN ......................... Personnel/Workforce (component of the ECTA System Framework)
PT ......................... Physical Therapist
RIT ....................... Regional implementation teams (at each AEA and Des Moines Public Schools)
SC ....................... Service Coordinator/Coordination
SiMR ..................... State-identified Measurable Result
SLP ....................... Speech Language Pathologist
SS-OO-PP-RR .......... Setting the Stage, Observation and Opportunities to practice, Problem solving and Planning, Reflection and Review
SSIP ..................... State Systemic Improvement Plan
SWT ..................... State Work Team (Departments of Education, Public Health, and Human Services, and Child Health Specialty Clinics)
References


## Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>Public Awareness</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
<th>Who participates?</th>
<th>Priority?</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Awareness</strong></td>
<td></td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>o Physician</td>
<td>Comprehensive plan to inform public regularly is developed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Referral agencies</td>
<td>Early ACCESS is branded with multiple formats of messaging available.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>o Policy makers</td>
<td>Messages are available for various audiences (e.g., tailored messaging).</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>o General population</td>
<td>The importance of family is clear in messages and materials about early intervention.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Family Members</strong></td>
<td>Services are described as supports to family to enhance child’s development and participation.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Role of family is described and illustrated with examples congruent with FGRBI.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rationale for and examples of everyday routines, activities, and places as teaching and learning contexts are provided.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Messaging emphasizes informational resources and informal supports for family as well as formal services.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Materials are available in multiple formats (e.g., print, video/audio) and languages.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

*Appendix A: Needs Assessment*

---


*DMM is a project within the Communication and Early Childhood Research and Practice (CEC-RAP) Center. CEC-RAP is a collaborative center within the College of Communication and Information in the School of Communication Science and Disorders at Florida State University.*
## Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>First Contacts</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
<th>Who participates?</th>
<th>Priority?</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warm Welcome</strong></td>
<td>Providers engage in dialogue that are consistent with cultural and individual beliefs and learning styles of the family.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Program is described as support to families within the context of their everyday routines, activities and places.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td><strong>Introduction to Program &amp; Services</strong></td>
<td>Programs provide families with a primary contact person and easiest ways to contact that person.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Families receive a written statement of program philosophy regarding family participation in assessment planning and activities emphasizing their role on the team.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Family Conversations</strong>&lt;br&gt; o Concerns&lt;br&gt; o Priorities&lt;br&gt; o Resources&lt;br&gt; o Interests</td>
<td>The family is encouraged to ask about what they want to know about their child and program.</td>
<td></td>
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</tr>
<tr>
<td><strong>Screening, if appropriate</strong></td>
<td>Providers engage family members in a conversation about their child’s interests, abilities, and needs. They demonstrate to the families that this information is critical and useful to develop the child’s program using natural learning opportunities.</td>
<td></td>
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<tr>
<td><strong>Next Steps</strong></td>
<td>Providers review, with parental consent, agency information about the child’s family.</td>
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<td>1 2 3</td>
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</tbody>
</table>
Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>Evaluation and Assessment</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
<th>Who participates?</th>
<th>Priority?</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Assessment Plan</td>
<td>The family and other team members identify and address relevant individual, cultural, and linguistic characteristics that may influence the assessment process.</td>
<td></td>
<td></td>
<td>1 2 3</td>
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</tr>
<tr>
<td>Eligibility Evaluation</td>
<td>Scheduling occurs at the convenience of family in location of their choice.</td>
<td></td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td>Family and team members share observations and information to complete a developmental assessment in the child’s daily routines and activities.</td>
<td></td>
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<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Assessment for Program Planning</td>
<td>Providers observe caregivers with children in contexts that are familiar to the child (e.g., home, childcare activities) relying on materials that capture the child’s interests and behaviors in routine circumstances (e.g., playing, eating, dressing).</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Routines Based Conversation</td>
<td>Providers, families and other caregivers work as team members for purposes of assessment (i.e., give priority to family/caregivers’ observations and reports, discuss assessment results, reach consensus about the child’s needs and programs).</td>
<td></td>
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</tbody>
</table>
## Integrating FGRBI into Program Practices

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<tr>
<th>Evaluation and Assessment</th>
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<th>What do we do now?</th>
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<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Sharing</strong></td>
<td>Throughout the assessment process, the family is encouraged to share their priorities and concerns and ask questions.</td>
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<tr>
<td></td>
<td>In preparation for sharing and discussing assessment results, families are encouraged to share information with team (i.e., to bring a photo album, to think of a meaningful story, etc.).</td>
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<tr>
<td></td>
<td>All information is shared in easy to understand language.</td>
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<tr>
<td></td>
<td>Family members discuss routines while providers ask questions and listen.</td>
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<td></td>
<td>Providers report strengths within natural learning opportunities. They may also identify challenging times, routines or situations.</td>
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<td></td>
<td>The child’s performance is not reported separately by each discipline but is integrated, resulting in a holistic and functional profile of the child.</td>
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<tr>
<td></td>
<td>Recommendations are made within context of everyday routines, places and activities as requested by family.</td>
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</tbody>
</table>
## Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>IFSP</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
<th>Who participates?</th>
<th>Priority?</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-planning</strong></td>
<td>The information sharing process after assessment is explained as collaborative brainstorming and problem-solving discussion in which family input is actively sought and valued.</td>
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<td></td>
<td>Team members assure the family that they will not be making decisions for the child or family, but will provide information about the child and community resources.</td>
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</tr>
<tr>
<td><strong>Sharing (or reviewing) evaluation/assessment information</strong></td>
<td>Initiation of the conversation is guided by the observations, thoughts and questions of family members. The other team members offer their insights and observations in a conversation about the child.</td>
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<tr>
<td><strong>Identifying outcomes and strategies</strong></td>
<td>Providers report assessment results in a manner that is immediately useful for planning program outcomes and strategies (in that the reporting identifies strengths and opportunities for learning that are functional and developmentally sensible).</td>
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<td></td>
<td>Family members and providers jointly develop appropriate family-identified outcomes within routines for both child and family.</td>
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<td></td>
<td>Purpose of outcome is clear (everyone knows why it is an outcome) and accomplishment is measurable.</td>
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</table>
### Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>IFSP (continued)</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
<th>Who participates?</th>
<th>Priority? 1-no; 2-maybe; 3-yes</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Determination of services/service providers provided</td>
<td>Meaningful outcomes for the child that build upon the current skills and behaviors and promote membership with others are identified by family and serve as the foundation for identification of services and supports.</td>
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<td></td>
<td>Family outcomes are included in IFSP.</td>
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<td></td>
<td>Planning that considers the situation (e.g., class, home, etc.) in which the intervention will be applied occurs prior to implementation.</td>
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<tr>
<td></td>
<td>Supports, and resources provide families with participatory experiences (i.e., opportunities that promote parents’ sense of competency as a parent) and opportunities to make choices and decisions.</td>
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<tr>
<td></td>
<td>Resources support family participation, strengthen parenting competence and confidence, and match each family members identified priorities.</td>
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</table>
# Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>Intervention</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
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<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service provision</td>
<td>Supports and resources are mobilized in ways that are supportive and do not disrupt family and community life (i.e., scheduling and location of services are convenient to the family and match family preferences). Providers use helping styles (i.e., ways of communicating or providing services or supports) that promote shared family/professional responsibility in achieving family-identified outcomes. Family and child strengths and assets are used as basis for engaging families in participatory experiences supporting parenting competence and confidence.</td>
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<tr>
<td>Implementation</td>
<td>Intervention is implemented by caregivers between visits of providers in their everyday activities and routines. Caregivers actively participate in planning sessions based on their priorities. Interventions involve as minor a modification of existing routine, sequence, materials as necessary for outcome achievement.</td>
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</table>
## Integrating FGRBI into Program Practices

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<th>Priority?</th>
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<tbody>
<tr>
<td></td>
<td>Providers support caregivers use of their family’s naturally occurring routines, activities, and events as the context for learning.</td>
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<td></td>
<td>Caregivers have opportunities to reflect on what works for them supporting their child in each visit and to problem solve options for next steps.</td>
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<td></td>
<td>Providers match caregiver’s learning style and strength to enhance their participation in routines and natural learning opportunities.</td>
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<td></td>
<td>Providers demonstrate to caregiver’s ways to promote interaction, communication, and learning by being responsive to child behavior, using naturalistic teaching procedures and environmentally adaptations as requested by and appropriate for family.</td>
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<td></td>
<td>Providers support caregiver’s interaction, communication, and learning in play, promoting engagement and friendship activities using appropriate coaching strategies.</td>
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<tr>
<td></td>
<td>Only specialized equipment necessary for successful functioning in everyday routines is used.</td>
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</tbody>
</table>

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DMM is a project within the Communication and Early Childhood Research and Practice (CEC-RAP) Center. CEC-RAP is a collaborative center within the College of Communication and Information in the School of Communication Science and Disorders at Florida State University.

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## Integrating FGRBI into Program Practices

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<thead>
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<th>Intervention (continued)</th>
<th>FGRBI Practices</th>
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<tbody>
<tr>
<td></td>
<td>Instructional strategies are embedded and distributed within and across activities and routines with caregiver input on what works.</td>
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<tr>
<td></td>
<td>Practices are used systematically, frequently, and consistently within and across environments (e.g., home, center, community) and across people (i.e., those who care for and interact regularly with the child).</td>
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<tr>
<td></td>
<td>Practices used are evidence based, useful across environments, respectful, and not stigmatizing of the child and family and are sensitive to linguistic and cultural issues.</td>
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<tr>
<td></td>
<td>Providers and caregivers review what is working to ensure measurable and meaningful participation for the child and family.</td>
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</tbody>
</table>
## Integrating FGRBI into Program Practices

<table>
<thead>
<tr>
<th>Monitoring Progress</th>
<th>FGRBI Practices</th>
<th>What do we do now?</th>
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<th>Priority? 1-no; 2-maybe; 3-yes</th>
<th>What’s our next step?</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Team input</td>
<td>Family and providers work together, share information each visit, and collaboratively address (i.e., respectfully, as equal partners) family identified goals.</td>
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<tr>
<td>● Formative input</td>
<td>Practices and outcomes are individualized for each child based on: (a) the child’s current behavior and abilities across relevant domains; (b) the family’s view of what the child needs to learn; (c) interventionist view of the child’s strengths and strategies to enhance participation; and (d) the demands and requirements of the environments. Data-based decisions are used to make modifications in practices with functional and meaningful data collected by caregivers and providers.</td>
<td></td>
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<tr>
<td>● Annual review</td>
<td>Providers and families assess and redesign targets and outcomes to meet the ever-changing needs of the child and family. Providers and families assess the child’s progress on a yearly (summative) basis to modify the child’s goal plan (e.g., IFSP).</td>
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</table>
Dear IA-DMM Year 1 Internal Coach,

Welcome to the Cohort 6 Internal Coach team training! This letter outlines the qualifications and activities for participation in this 10-month professional development project.

**Qualifications of Internal Coach**

1. Completed IA-DMM training with a minimum of 80% on SS-OO-PP-RR fidelity checklist and participated in five feedback sessions. Coaches may be chosen from graduates of C1-C5 who meet the listed qualifications.
2. Interested in becoming an internal coach.
3. Able to spend a **minimum of four hours per week** in internal coaching activities.
4. Willing to participate in Community of Practice coaching activities as well as C6 monthly feedback sessions.

**Internal Coaches Professional Development Activities**

**Online training**

1. Reach reliability on scoring Key Indicators.
   - Read Key Indicators Manual and coding rubric
   - Complete online training
   - Watch practice videos online using coding rubric
   - Review at least five brief videos for initial reliability

   Videos should be at 80% with FSU coders. This step should be completed prior to the October face-to-face training.

2. Participate in Cohort 6 monthly webinars to support trio.
3. Participate in Internal Coach Webinars during the year specific to mastery of coaching skills.

**Video and Self-Reflection**

1. Collect, code, and reflect on two of your own videos to share with other internal coaches (Video 1 due October 2nd, Video 2 due December 1st).
2. Use TALENT to share and compare videos with other internal coaches.
3. Pair with another internal coach to reflect on the second video as practice feedback to provider by January 2nd.
**Trio Coaching Activities and Assignments**
1. Complete preparatory phone calls or emails with the FSU external coach to plan for feedback sessions. Participate in nine trio sessions with your FSU external coach.
2. Plan for and participate in leading two coaching sessions with trio members before June 2018 and receive FSU feedback.

**Expectations Following the Training Sequence**
1. Provide on-going coaching support within the AEA.
2. Support development of future internal coaches.
3. Support fidelity of implementation of FGRBI.

________________________________________
Print Name

__________________________
Signature

________________________________________
Date

__________________________
Region

**General professional development sequence for Year 1 Internal Coaches**

- Using online materials, reach fidelity using the Key Indicators SS-OO-PP-RR coding rubric
- Self-assessment and reflection on own videos
- Face-to-Face training and webinars for internal coaches
- Observation and increased leadership in C6 trio feedback sessions
- Submission of independent coaching sessions with trio members for review

Distance Mentoring Model is a project within The Communication and Early Childhood Research and Practice Center (CEC-RAP). CEC-RAP is a collaborative center within the College of Communication and Information, School of Communication Science and Disorders at Florida State University.

2017
Welcome to the Early ACCESS (EA) Wednesday Wonders! The purpose of this newsletter is to have a consistent, predictable way for EA stakeholders to stay current on happenings as well as share information with other stakeholders such as practical advice, training announcements, video clips, and/or success stories. It is a newsletter for stakeholders, by stakeholders. Please let me know if you have something you would like to contribute or have suggestions or comments at: melissa.schnurr@iowa.gov

To view archived Wednesday Wonders, visit the Iowa Family Support Network website.

The past cannot be changed. The future is yet in your power. –Mary Pickford

Wondering about FGRBI?

ATTENTION HIGHER ED! New, free online resource about early intervention designed with your students in mind! Last winter, you may recall the Early Intervention Field Experience Guidance release. The work on this guidance prompted a task team of higher ed and community college faculty as well as Early ACCESS liaisons and providers to design the Foundations of Early Intervention online module. The module was designed to provide students with foundational information prior to doing any type of field experience in early intervention (e.g. shadowing, practicum, student teaching). The module can be used by students in its entirety (with built in activities, quizzes, and a certificate of completion) or use portions as the basis for class discussion.

Contact Melissa Schnurr via e-mail (melissa.schnurr@iowa.gov) if you would like access to the modules without the need to create a log-in and complete the quizzes (students must create a log-in; however, this is optional for instructors). Additional information about starting a career in early intervention can be found on the Iowa Family Support Network website.

Another Resource for Instructors – Videos of What EI in Iowa Looks Like:
Over the past three years, Early ACCESS (early intervention in Iowa) has worked with Larry Edelman to produce a variety of videos that illustrate what early intervention (EI) in Iowa looks like. The videos range from a couple of minutes to 35 minutes, and include interviews with families, clips of Early ACCESS providers coaching families, and reflections from providers. What videos will you use in your classes this fall?

Early ACCESS Vision: Every infant and toddler with or at risk for a developmental delay and their families will be supported and included in their communities so that the children will be healthy and successful.
In case you were wondering....

Resource for Families of Infants and Toddlers:
The Little Voices for Healthy Choices (LVHC) is a national initiative for Early Head Start (EHS) and Migrant and Seasonal Head Start (MSHS) programs. It was developed to promote wellness in infants, toddlers, and expectant families. The initiative includes training and resources with strategies designed to help families and communities address healthy nutrition, physical activity, brain development, and sleep for children birth to 3.

Resource for Families – Making Bedtimes and Naptimes Easier:
Many families find bedtime and naptime to be a challenge for them and their children. Sleep problems can make infants and young children moody, short tempered, and unable to engage well in interactions with others. Sleep problems can also impact learning. Parents also need to feel rested in order to be nurturing and responsive to their growing and active young children. This first installment of the Making Life Easier series, developed by the Technical Assistance Center on Social Emotional Intervention for Young Children, provides a few proven tips for making bedtimes and naptimes easier for both parents and children.

Something wonderful is happening....

Iowa Early Care & Education 2017 Institute - Registration Now Open!
Iowa AEYC is pleased to announce registration is now open for the Iowa Early Care & Education Fall Institute, Power to the Profession. Discounted registration rates are available for members and for those who register before the end of August. Visit the Iowa AEYC website for registration information, updates on special events, and more information over the next seven weeks.

For more information about Early Childhood Iowa, visit: www.earlychildhoodiowa.org

For more information about Early ACCESS, visit: www.iafamilysupportnetwork.org or contact:

Cindy Weigel, Early ACCESS State Coordinator  
Iowa Department of Education  
Bureau of Learner Strategies & Supports  
Des Moines, IA 50319  
Phone 515-281-8634  
Email cindy.weigel@iowa.gov

or  
Melissa Schnurr, CSPD Consultant  
Iowa Department of Education  
Bureau of Educator Quality  
Des Moines, IA 50319  
Phone 515-281-5751  
Email melissa.schnurr@iowa.gov
### Self Assessment – Session Summary

Provider:  
Date:  
Agency:  

**Previous Coaching Goals:**

<table>
<thead>
<tr>
<th>Functional Outcomes</th>
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<tbody>
<tr>
<td>Child outcome:</td>
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<tr>
<td>Targets for the session:</td>
</tr>
<tr>
<td>Family outcome:</td>
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<tr>
<td>Focus for the session:</td>
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</table>

<table>
<thead>
<tr>
<th>Routines</th>
<th>Caregiver Coaching Strategies</th>
<th>General Coaching Strategies</th>
<th>Specific Coaching Strategies</th>
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<tbody>
<tr>
<td><strong>Play:</strong></td>
<td></td>
<td>Information Sharing</td>
<td>Direct Teaching</td>
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<td>Play w/objects</td>
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<td>Observation</td>
<td>Demonstration with Narration</td>
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<tr>
<td>Physical play</td>
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<td>Joint Interaction</td>
<td>Guided Practice</td>
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<td>Pretend play</td>
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<td>Caregiver Practice</td>
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<tr>
<td>Social games</td>
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<td></td>
<td>Specific Feedback</td>
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<tr>
<td><strong>Pre-Academic:</strong></td>
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<td>General Feedback</td>
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<td>Reading with books</td>
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<td>Problem Solving</td>
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<td>Songs/rhymes</td>
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<td>Reflection</td>
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<td>Writing/drawing</td>
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<td>Computer/T.V./video</td>
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<td><strong>Caregiving:</strong></td>
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<td>Food/drink</td>
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<td>Hygiene</td>
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<td>Dressing</td>
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<td>Comfort/disability</td>
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<td><strong>Community &amp; Family:</strong></td>
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<td>Errands</td>
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<td>Chores</td>
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<td>Socialization</td>
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<td>Recreation</td>
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</table>

**Comments:**

**Intervention Strategies for the Child’s Targets**

**Responsive Strategies:**

**Individualized and Specific Supports for Participation:**
## Setting the Stage

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Partial</th>
<th>Not Observed</th>
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<tbody>
<tr>
<td>1.</td>
<td>Gathers updates on child and family - listens and encourages caregiver reflection</td>
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<td>2.</td>
<td>Asks caregiver to update intervention implementation since last visit- listens, encourages caregiver reflection and sets up problem solving as needed</td>
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<td>3.</td>
<td>Shares information related to development and family interests - connects learning targets to functional outcomes and IFSP priorities to increase caregiver knowledge and resources</td>
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<td>4.</td>
<td>Clarifies session targets, strategies, and routines jointly - facilitates caregiver participation and decision making in the discussion</td>
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## Observation and Opportunities to Embed

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<tr>
<th></th>
<th>Yes</th>
<th>Partial</th>
<th>Not Observed</th>
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<tbody>
<tr>
<td>5.</td>
<td>Observes caregiver child interaction in routines - provides feedback and builds on dyad strengths</td>
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<tr>
<td>6.</td>
<td>Uses coaching strategies, matched to caregiver and child behaviors as caregiver embeds intervention in routine - scaffolds and repeats to build competence and confidence <em>(This indicator is repeated multiple times in 2 or more different routine categories)</em></td>
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<td>7.</td>
<td>Provides general and specific feedback on caregiver and child behaviors and interactions- teaches and encourages caregiver to participate <em>(This indicator is repeated multiple times throughout the session using both general and specific feedback for child and caregiver.)</em></td>
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## Problem Solving and Planning Intervention

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<th>Yes</th>
<th>Partial</th>
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<tr>
<td>8.</td>
<td>Problem solves with the caregiver about appropriate intervention strategies to embed - coaches caregiver on evidence based interventions for identified targets and routines</td>
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<tr>
<td>9.</td>
<td>Supports caregiver to identify opportunities for practice in additional contexts/routines - plans when, where, how to embed</td>
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## Reflection and Review

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<th>Yes</th>
<th>Partial</th>
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<tr>
<td>10.</td>
<td>Asks questions, comments to promote caregiver reflection and review of a routine or the session - identifies what works for caregiver and child</td>
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<tr>
<td>11.</td>
<td>Encourages the caregiver to describe what it will look like when the intervention is working - specifies measurable targets, strategies, and routines for the plan</td>
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<td>12.</td>
<td>Engages caregiver to lead development of a &quot;best plan of action&quot; for embedding intervention in multiple routines and activities throughout the day - facilitates caregiver leadership and decision making</td>
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What specific strategies did you use to build the caregiver’s confidence and competence?

How did you support the caregiver’s decision-making and leadership in identifying routines and activities for embedding learning?

How did you support the caregiver to embed intervention strategies on identified learning targets?

How did you ensure the caregiver and child had sufficient time to practice and prepare to embed intervention (e.g. strategies, routines, targets) between visits?
STAKEHOLDER INVOLVEMENT IN EARLY ACCESS

The success of the Early ACCESS system depends on the knowledge and skills the following permanent, stakeholder groups:

**Early ACCESS State Work Team (SWT) (9 members)**

Staff from Iowa Department of Education, Iowa Department of Public Health, Department of Human Services, and University of Iowa's Child Health Specialty Clinic.

Two full-day meetings per month; two-day summer retreat; contact between meetings to get work done. This multi-state agency group is the core team that is responsible for the day-to-day operations of Early ACCESS and supporting the work of the SSIP. This includes ensuring implementation of improvement plans and evaluation.

**Early ACCESS Leadership Group (EAGL) (30-34 members)**

Area education agencies (AEA) (liaisons/providers/service coordinators, special education director as liaison to all AEA special education directors, mid-level management)

Des Moines Public Schools
Department of Education
Department of Human Services
Autism Consultant

Iowa School for the Deaf
Department of Public Health
Child Health Specialty Clinics
Iowa Educational Services for the Blind & Visually Impaired

Five 2-day meetings per year. Statewide stakeholders come together to address early intervention issues such as: practice implementation; data reviews; procedures; policies; IFSP development; system capacity; child find; quality assurance and compliance; service coordination; eligibility; public relations; and any current topics of interests. The agenda is built by the group with input from the State Work Team. Google documents are used for easy access by all. Technology is used to bring in out of state guests and experts in the field of early intervention.
Iowa Council for Early ACCESS (ICEA) (18-25 members)

Parents of young children with disabilities.

Multi-Agency Stakeholders from public and private entities.

Department of Education  Department of Public Health
Department of Human Services  Child Health Specialty Clinics

Four full-day meetings per year. Always has a parent of child with a disability as the chair and vice-chair. Agenda is set by executive committee of the ICEA. Participates in data reviews and evaluation activities of the statewide system. Provides leadership and support for system-level activities. Most recently added a new emphasis on engaging parent members in other parts of the Early ACCESS system.

Signatory Agency Leadership Team (4 members)

Administrators from Iowa Departments of Education, Public Health and Human Services, and Child Health Specialty Clinic who are bound by a written Memorandum of Agreement (MOA) to ensure the Early ACCESS system functions successfully. MOA is executed every 5 years. New MOA takes effect in 2018.

Team meets 4 times a year on the months that the full Council does not meet. State Work Team members also attend the Signatory Agency Leadership Team meetings.

Regional Implementation Teams (RIT) (10 teams, 5-13 members per team, approximately 80 individuals statewide)

Personnel Preparation/Higher Education
AEA Administrators, Supervisors, Coordinators, Liaisons
Service providers (SLP, ECSE teachers, OT, PT, deaf/hard of hearing teachers, vision teachers, social workers, autism consultant, service coordinators)
Internal coaches for FGRBI and Caregiver Coaching
Media specialists

Each team meets within their region to support their agency in use of evidence-based practices in early intervention. Determine their agenda items and what data they will review. Reports in writing to the State Work Team at the Early ACCESS Leadership Group meetings.
State Advisory Team (10-15 members)

State Work Team members (Staff from Iowa Department of Education, Iowa Department of Public Health, Department of Human Services, and Child Health Specialty Clinic)

Area Education Agencies (Special Education Directors, EA Liaisons)

Early Childhood Iowa (Early Head Start, Head Start; Child Care; Maternal Infant Early Childhood Home Visitation; Iowa Association for the Education of Young Children)

Child Care Resource and Referral

Personnel Preparation/Higher Education

Meets as needed to share information on implantation and system change activities for Early ACCESS. Networking opportunities to learn about other agency activities.

Iowa Distance Mentoring Model for Early ACCESS Project Administration Team (5-7 members)

Florida State University, College of Communication and Information, School of Communication Science and Disorders

Iowa Department of Education

Meets monthly via Zoom to monitor and adjust implementation plans for using evidence-based practices as well as evidence-based professional development and implementation practices.

Evaluation Team (5-7 members)

Department of Education

Florida State University IA DMM project staff

External evaluator

2017 was the final meeting of this team as the external evaluation ended due to end of the contract period for external evaluation activities. As of late 2017, State Work Team members have assumed responsibilities that were previously done by the external evaluator. For example, the regional implementation team focus groups were conducted by the SWT in October 2017 and are being transcribed and analyzed with the assistance of graduate students at a university.

IFSP/IEP Data System Core Team (3-5 members)

Department of Education (for IFSP & IEP input)

Department of Public Health (for IFSP input)

Area Education Agencies (for IFSP & IEP input)

Meet as needed to help develop specifications for new IFSP/IEP data system.
National Groups that State Work Team members are active participants where information is both shared and gathered to support Early ACCESS improvement plans:

Division of Early Childhood, Early Intervention Special Interest Group

Infant Toddler Coordinator Association

Early Intervention-Early Childhood Professional Development Community of Practice (EI-EC PD CoP)

Service Coordination Training Workgroup (sub-group of EI-EC PD CoP)

Service Coordination Leadership Institute
Appendix F

Family Interviews—Cohort 5, Iowa Distance Mentoring Model for Early ACCESS

The following information includes details from each of the questions which are in bold. Answers are summarized with examples provided for context to enhance the reader’s understanding.

**What did you see as the advantages of you working together with your provider to support your child’s learning and everyday routines, activities, and places using your own materials and toys?**

Parents responded positively to the coaching approach when working together to incorporate their child’s learning in their everyday routines such as bath time, mealtime, and play time. Most parents explained that the environment was familiar so it was easy for them to adapt the new routines to their lifestyle. One parent reported that the coaching strategy was very helpful so that she could help her son, “I didn’t know what I was working with, she taught me a bunch of techniques to work with him, stuff I never would’ve thought of.”

Parents seemed to value how the intervention was at their home so that they had access to their own materials and toys. One parent mentions how helpful it was for them to not have to purchase new toys, but rather use existing materials already in their home to achieve their child’s target outcomes. Many of the advantages that parents described had to do with their ability to use the strategies that they learned, incorporating them in their day-to-day routines.

- “Well it teaches me how to be hands on with my own kiddo and not to only rely on other physical therapists, but I can learn what I need to do daily to help him develop and I can take a bigger, um, I don’t know, a bigger... position in helping him I guess. I can be more of a help and not just be on the sidelines” (J.B., personal communication, June 15, 2017).
- “They [Sarah and Michelle] taught me how I could come up with things on my own and what I could use in my house to... foster those skills” (E.D., personal communication, May 31, 2017).
- “It was something that was easy to implement because it used what we already had, it used kind of our regular routines... it fit into our life and it wasn’t something that we had to adapt our life to” (K.L., personal communication, June 18, 2017).

**What did you see as the disadvantages of working together with your provider to support your child’s learning and everyday routines, activities, and places using your own materials and toys?**

Most parents reported no disadvantages to the coaching approach in daily routines while others found the strategy to have a few disadvantages. One parent reported having difficulty identifying more routines than what they already were doing in their daily life. She did not feel the need to do more when the ones they were using worked. Another parent replied, “a disadvantage as well because it was her own surrounding and sometimes she would lose focus.” It is interesting how this parent found that using the same toys resulted in the child’s decreased
Family Interviews—Cohort 5, Iowa Distance Mentoring Model for Early ACCESS

attention. This parent had a contrasting view to the many other parents who found that the same environment was an advantage. Another parent responded to the question “I feel like we just kinda repeated stuff every time she was here. Um, sometimes there wasn’t really anything new she was able to bring to the table.”

- “Part of it’s just because my son didn’t progress like with his speech and stuff quite as much as we hoped so we’re doing private speech now. Um, but otherwise, um, for the most part, things have been pretty positive” (A.B., personal communication, July 6, 2017).

Did you see any differences between coaching and any other early intervention services you’re receiving in or outside of Early ACCESS?

Many parents responded to not having received any other style of early intervention services while other families received services from physical therapists, occupational therapists, and speech pathologists that were more clinic based. One parent responded “there’s more of a wide range of things she looks at instead of like when I brought him to physical therapy or occupational, they would just do those specific areas and also, with her being able to come to my house and she could see like, how he is in his own environment.” This parent gave insight to how the coaching approach in a natural environment lead to a positive impact on their family’s outcomes. This parent also thought that the approach contributed to the child being their “normal self” during therapy because they were familiar with the environment. Coaching led to the parents feeling more independent and not having to strictly rely on professionals alone to be able to impact their children’s lives. They reported that they felt they could embed the new acquired skills from the providers into their day-to-day routines.

- “She [Jenny] definitely gives more advice on things we could do that’s helpful-um where at Ryan’s other speech that she goes to, it’s more like drills, it’s more like in her face like, you know, getting her to say stuff where Jenny gives us, ideas and helpful tips on ways to get her to talk and what not” (J.B., personal communication, July 5, 2017).
- “The difference I would say would be it’s more, there’s more of a wide range of things she [Gail] looks at instead of like when I brought him to physical therapy or occupational, they would just do those specific areas. And also, with her being able to come to my house and she could see how he is in his own environment so, it’s more like how he really is instead of if I brought him somewhere, he doesn’t act like his normal self because he’s not used to the place. So he doesn’t do what he normally would do at home” (J.M., personal communication, June 15, 2017).

What kind of routines, meaning snacks, getting dressed, and play activities, and places did you use that worked best for you and why?

Most of the parents responded to specific routines such as bath time, brushing teeth, and going outside. Parents recognized the importance of routines and how they embed them throughout the day. A parent answered, “she could see us kinda what we normally do and what we
Family Interviews—Cohort 5, Iowa Distance Mentoring Model for Early ACCESS

normally struggle with, then that would give her better ideas of ways to help us and maybe give him ways to kinda focus and, um, engage more in the activities.” Parents explained how the providers embedded the new strategies in their everyday routines from going to the park or getting into the car. A parent said that their provider gave ideas of routines they could incorporate into their day to day that would support their goals and the provider would follow up to see if they were successful. Another family explained the places that worked best, “Like with us, from his bedroom to the bathroom to take a bath. Or playing in different rooms learning, um, newer atmospheres and different toys in different rooms.” Generally, the parents responded well to the question explaining many routines, activities, and places that worked well for them. Largely parents felt that the intervention benefited from being at their home environments.

- “There’s talk about maybe being a slightly autistic kid, um, so his routine is just everything, altering it all is difficult and so that’s what she [Shawna] taught us do ... dealing with those changing ... she helped out in every aspect from eating to going to sleep to color matching” (P., personal communication, June 15, 2017).
- “He definitely likes being outside, so any time we could be outside, that was helpful because he likes to interact more and show more and be more, just outgoing” (A.B., personal communication, July 6, 2017).

Your provider gave you feedback on how you used your intervention strategies or what your child did in response to your help. How useful did you find the feedback?

All of the parents felt that the feedback from the provider was useful and gave them insight to what was and was not working with their intervention. One parent responded, “It was really good. We just want the best for him so she, um, she was very open and upfront with what was going on”. Another parent reported that the feedback was encouraging and caused her to keep a positive outlook. Parents felt that the feedback supported their ability to focus on how their child is improving and reaching their outcomes. Another parent praised the provider for her ability to keep feedback simple so that the spouse, a non-English speaking parent, could easily understand the translation. Parents felt that the feedback reassured them that the strategies they are using are causing a positive impact when supporting their children. Feedback from the providers enabled the parents to reflect on the success of their improvements and gain confidence.

- “But, she [Mariel] was very helpful...even emotional support for me, you know, her seeing kids like Liam before and talking to me and reassuring that I’m doing okay and it was really - she was great” (L.S., personal communication, June 15, 2017).
- “She [Christy] made it as simple as she could and it was honestly, honestly I could easily translate it over to my wife pretty quickly, pretty quickly. You know, in a way where she understood it and
like she got to it really quick. So, I couldn’t be like ‘Oh how am I going to explain it to my wife’, you know” (Z., personal communication, July 5, 2017)?

- “Oh, it’s really good. Yeah, it was really good. We just want the best for him so she [Carol], um, she was very open and upfront with what was going on and, and yeah, it was, it was very good” (J.H., personal communication, July 7, 2017).

Your provider encouraged you to participate, to problem solve, and to make decisions about what you wanted to do. To what extent did these discussions help you know what and how to teach your child?

Problem solving allows for parents to embed strategies based on what is helping or is not helping the child and their parent during intervention. During the phone interviews one parent referred to problem solving as “trial and error”. Parents explained that the provider helped them to find a solution to what is not working within intervention and to brainstorm and find strategies that do work. For example, one parent shared their concern of how they suspected their child was developing ADHD. The provider reassured the parent explaining that the behavior was completely normal and they worked together to find a solution to the concern. Another parent explained that when their child was having a temper tantrum they use problem solving during their intervention to find new approaches. One parent summarized the importance of problem solving as essential to the intervention so that they as a team could bounce off ideas and think critically about what did and did not work.

- “It taught us where he needs to be developmentally and when and what we need to know. Different ways to do the things that we were already doing ... You know, we might have been doing one way and she [Kelly] said that might lead to this so here try this” (T. & K., personal communication, June 19, 2017).

- “I believe that was mainly the base around the whole intervention, uh, just teaching me to work with him, what to look for, how to reinforce the good behaviors and how to teach him to learn in a way that he could learn... I guess learning how to teach Abel. That was the base around, kinda, the whole thing learning, learning how Abel learns then teaching me how to teach him in a way that he’s going to comprehend it” (P., personal communication, June 15, 2017).

- “Well, they [Sarah and Michelle] were pivotal actually. Um, just to bounce ideas off to see what worked, what didn’t work, to tweak things. I mean, if I didn’t have that back and forth, to go between, between all of us, then I just don’t think that we’d be as far as we are today” (E.D., personal communication, May 31, 2017).

- “He’s our oldest and our first kid so we’re all, we were just learning as we went so we, you know. She [Carol] showed us how to like, give him choices like what kind of snack he wants, which is good for us because we want him to be independent and things. Little things like that that we just weren’t doing. Now he’s making his own decisions and becoming more independent and things like that, which she was showing us, which is great, you know, little things that we were just kinda missing” (J H., personal communication, July 7, 2017).
Family Interviews—Cohort 5, Iowa Distance Mentoring Model for Early ACCESS

- “Yeah, absolutely. Um, a lot of it was like, certain positions. Um, for a time, we were trying to get him to look to the left more and he’d only look to the right and so helping me figuring out things to put in front of him or things that would help motivate him. She [Beth] was a big help there because I wasn’t seeing the progress I wanted to see and so she was really helpful in first of all, encouraging me and then, um, thinking of new ways and new, new toys or new things we can give him to help motivate him, um, to improve faster. So yeah, she was really helpful there” (J.B., personal communication, June 15, 2017).

Planning and review was also included in the home visit to what extent did these discussions help you to know what to do in between visits with your provider?

Many of the parents explained that the planning and review discussed with their provider was helpful. It was important to have the reminder throughout the week of the strategies and goals they had thought of using during their day-to-day routines. One parent felt planning and review allowed her and their provider to discuss a different routine if the one they were working on was not successful. Another parent discussed how the provider did not leave homework but gave suggestions of strategies that they can work on. One parent reflected on how their provider left a paper that had all of the goals for the week that they needed to work on. The parent liked how she could reflect and look back at past goal sheets and see how many of the skills the child had mastered over time. Parents explained how planning and review allowed them to go over what they accomplished in the past session and discuss the new focus of what to work on for the upcoming weeks.

- “You’re always concerned about your kids if they are kinda growing and hitting the milestone like they should, especially if they were a premature baby like Sam, or maybe they have a sibling like his older sister that maybe was ahead of milestones, so kinda having them go through the reviews each time was kinda helpful to see, like okay, he is on track, like, our efforts are working and then maybe it helps us identify areas that are maybe slower progressing, or um, you know, we don’t have to worry about this area so much because he is ahead here, so that kinda helps to, like, see that review” (K.L., personal communication, June 18, 2017).
- “So I think it was helpful because, um, she [Jenny] would follow up with it and kinda go a different route if she didn’t respond to it” (J.B., personal communication, July 5, 2017).
- “They [Christy] explained it to her even though she doesn’t know English, I mean they were patient, they were really patient” (Z., personal communication, July 5, 2017).
- “Laminated sheet that we have on our refrigerator that we write on with, um, a dry erase. It has what we’re working on this week and what we wanna work on, um, just things that, like tools that can help him or ways that we can encourage him to do things differently so we have on our fridge as a reminder every day” (J.B., personal communication, June 15, 2017).

This next section is about self-efficacy, how confident do you feel about working with your child in your routines throughout the day and how has that changed over time?
All of the parents reported that they felt more confident in their routines due to their provider coaching them. Many parents reported feeling empowered and at ease because of the intervention. One parent shared that this was her first child with a disability and felt lost compared to how she felt about raising her other children. The parent explained that if a provider told her exactly what to do she felt she would have struggled. However, she reported that, “They come in and we talk and we collaborate and we come up with ideas and bounce ideas off of each other and that’s what makes it work.” A different parent explained that without the provider’s coaching strategies they did not think that her child would have progressed as much. Several parents explained they felt more confident trying strategies with their children than they initially did. A parent also mentioned that they felt more and more confident after their child reached a different milestone.

- “It’s very helpful, I feel a lot more confident” (L.S., personal communication, June 15, 2017).
- “I definitely feel more, like, at ease with her, like throughout the day to just kinda understand her needs better” (J.B., personal communication, July 5, 2017).
- “I think that just by gaining the confidence that, you know, you’re not failing your child, and like they’re not falling behind, and having Bobbi come in and acknowledge the good things that are happening and she’s noticing, and then reassuring us that he’s progressing and he might be progressing on his own time schedule but, um, I think overtime you build that confidence, so when you see the results that boosts your confidence for sure” (K.L., personal communication, June 18, 2017).
- “Oh, a whole lot better. I wasn’t a bad mom before but I understand a whole lot more now. I understand where his barriers are and how to work through them, um, like the joint attention was a big one. I had no idea what that was a year ago. Now I know how to work through it and how to make him ask for it before he gets what he wants.” (P., personal communication, June 15, 2017).
- “I do actually feel that because I went into this having absolutely, I mean, I have five children and my other four children are quote unquote normal. They developed normally and have had no issues, but I, just, so, I was kinda lost when Paisley came into the world and I was like, ‘Oh my gosh’. We started noticing things were going on. I just didn’t know what to do. So I don’t think that she would be where she’s at today if I wouldn’t have this change and if we did things differently. Like if somebody just came in and said, ‘Here. Do this, do this, do this’, I don’t think I’d be anywhere, any further than we were when we started. They [Sarah and Michelle] come in and we talk and we collaborate and we come up with ideas and bounce ideas off of each other and that’s what makes it work” (E.D., personal communication, May 31, 2017).

How is the coaching approach similar to or different from any other early intervention services you’ve experienced or participated in?

This question allowed for parents to compare and contrast early intervention services different to the coaching approach. Some parents only had experience with the coaching approach
alone while others went to different therapists. All of the parents that participated in different interventions found that the coaching approach and other services were different. One parent explained that she found that the therapies other than Early ACCESS early intervention, did not allow the parent to be incorporated. The parent gave an example of how the physical therapist only exercises her child. In contrast, the coaching approach allows for the parent to be involved and learn how to help the child every day. Parents felt that the coaching approach was more personalized to fit their child’s needs. A different parent felt that the speech pathologist made the child stick to the focused areas while the coaching approach went “from one activity to the next and never really finish.”

- “It’s more personal. It’s more tailored to fit Paisley and what she needs, whereas the doctors just tell me a general idea of what should be happening and what I should do. It’s just more personal and more tailored and it’s for her” (E.D., personal communication, May 31, 2017).

Would you encourage another family to participate in using this coaching approach?

All of the parents reported that they would encourage a different family to participate in the coaching approach. Parents felt that the coaching approach provided the families with a support system and constant encouragement. One parent responded, “I think it’s helpful because I think any encouragement that we can get definitely makes a difference...any help, you know, coming in, different approaches, different ideas, anything is great.” Several parents know families with children that were born premature as well as children that have a trach and tube. These parents responded to the question explaining how they would share their story of their success with the coaching approach to these families and let them know how it made a great impact on their children’s lives. Overall, the parents had many positive comments about their providers and would encourage other families to use the coaching approach.

- “Oh yes, I, um, I would definitely, yes. Me and my husband, we didn’t know what to do and they [Mariel and Lauren] came in, it was wonderful, I looked forward to seeing them every week” (L.S., personal communication, June 15, 2017).

- “I would. I think it’s helpful because I think any encouragement, um, that we can get definitely makes a difference to know that we’re not failing as parents” (A.B., personal communication, July 6, 2017).