FFY 17

Iowa’s SSIP Phase III Year 3 Progress Report – Part C

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Iowa Department of Education
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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.
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State Systemic Improvement Plan (SSIP) Overview

Iowa IDEA Part C Early Intervention System (Early ACCESS)

In Iowa, the system that implements Part C of the Individuals with Disabilities Education Act (IDEA) is referred to as *Early ACCESS* and is a collaborative system of four state agencies. The four agencies, known as the signatory agencies, are the Iowa Department of Education, Iowa Department of Public Health, Iowa Department of Human Services, and the University of Iowa’s Child Health Specialty Clinics. A memorandum of agreement is used to formalize their commitment to support the early intervention system. Iowa’s governor designated the Department of Education to be the lead agency among the four signatory agencies with fiscal and legal responsibilities.

Iowa established intermediate education agencies called area education agencies (AEAs) that are responsible for administration of *Early ACCESS* across the state. Currently, Iowa is divided into nine AEA regions. Each AEA is required to designate an individual who has primary responsibility for coordinating regional implementation and serves as a liaison to the Department of Education. Regional liaisons, state staff from the signatory agencies, and other early childhood stakeholders who serve infants and toddlers with disabilities and their families meet five times per year. This 32 member stakeholder group, known as the *Early ACCESS* Leadership Group, strives to create a coordinated statewide early intervention system that improves outcomes for children and families served in *Early ACCESS*.

**Highlights from SSIP Phase I, II, and III**

Six years ago, stakeholders from across the state representing all nine AEAs; Des Moines Public Schools; the state Departments of Education, Public Health, and Human Services; Child Health Specialty Clinics; Iowa Educational Services for the Blind and Visually Impaired; Iowa State University Extension; and the Iowa Council for *Early ACCESS* completed data analysis and strategic planning activities for the *Early ACCESS* system. Data from these and other activities were used to inform the SSIP Phase I.

Stakeholders overwhelmingly agreed to shift Iowa’s early intervention focus from providing direct child therapies to helping families support the development and learning of their children with disabilities. As a result, the following is Iowa’s State-identified Measureable Result (SIMR): To *increase the percentage of families reporting that Early ACCESS has helped them help their child develop and learn*, a direct connection to OSEP family outcome indicator 4C.

The Theory of Action for *Early ACCESS* was revised based on the new data analysis, and three areas of improvement were identified:

- New instructional practices: Shift instructional practice away from teaching the child to using evidence-based practices where the focus is on the caregiver.
• New implementation practices: Incorporate implementation science processes into professional development in order to build the capacity to make effective, statewide, and sustained use of evidence-based practices.

• New high quality early intervention system: Use the ECTA System Framework to develop a high-quality early intervention system that would encourage, support and require implementation of evidence-based practices.

Phase II (April 1, 2015 – March 31, 2016) included refinement of plans for all three improvement strategies. Implementation science guided the in-service trainings on the use of Family Guided Routines Based Interventions and Caregiver Coaching provided by Florida State University through the Iowa Distance Mentoring Model (IA DMM) of professional development for Early ACCESS (http://dmm.cci.fsu.edu/IADMM/index.html). Steered by data analysis, technical assistance from the National Center on Systemic Improvements (NCSI) and the Family Outcomes Cross-State Learning Collaborative, Iowa narrowed the initial focus of infrastructure improvements on two components: (1) Governance and (2) Personnel/Workforce. In 2018, the Accountability and Quality Improvement component was added. Logic models for all three improvement strategies were aligned with the evaluation plans to ensure data was available to measure progress in achieving outcomes.

Phase III Years 1 and 2 (April 1, 2016 through March 31, 2018) were spent implementing activities, collecting data, and using the results to inform continuous improvement in the implementation processes and practices. Using Iowa's AEA system, the IA DMM continued to support service providers' practice shift to using Family Guided Routines Based Intervention (FGRBI) and Caregiver Coaching. In addition, a focus on fidelity of practice and sustainability of change efforts was heightened in Phase III Year 2. New training specific to developing internal coaches began. The purpose for introducing internal coach training is to build Iowa's capacity to continue the use of FGRBI once Florida State University is no longer involved with Early ACCESS. To date, approximately 190 early intervention providers have been trained by Florida State University through the IA DMM. Of those 190, approximately 27 of the early intervention providers are in varying stages of training to become internal coaches who will support their peers in using FGRBI with fidelity, ensuring sustainability of the practice in the future.
A. Summary of Phase III, Year 3 (April 1, 2018 through March 31, 2019)

In Iowa, service providers 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 2018 activities that support progress towards helping families to help their children develop and learn (Iowa's SIMR) and the impacts of those activities are illustrated in the graphic below. Iowa's FFY 17 SSIP provides updates on the work that has been implemented, data that was collected around the work, and what that meant for infrastructure improvements and systems level change.

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**Iowa's Early ACCESS Early Intervention System Improvements 4/1/17 – 3/31/18**

<table>
<thead>
<tr>
<th>Practice</th>
<th>Professional Development</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECSE, OT, PT, SLP, SC*</td>
<td>Internal Coaches</td>
<td></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>
<td></td>
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<tr>
<td>24</td>
<td>27</td>
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**Outcomes**

**REDUCE:** Direct child teaching

**REDUCE:** Practice Drift

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

**INCREASE:** Fidelity Scale-up Sustainability

*ECSE=Early Childhood Special Educators; OT=Occupational Therapists; PT=Physical Therapists; SLP=Speech Language Pathologists; SC=Service Coordinators*
1. Theory of action for the SSIP, including the State-Identified Measurable Result (SIMR)

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>
<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>
<td></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>
<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>
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</table>

The SIMR (see blue box highlighted in the Theory of Action above):

In FGRBI, it is the parent or caregiver who promotes child learning. The early intervention service provider supports and enhances the caregiver’s consistency and effectiveness to implement learning opportunities within natural environments. Therefore, Iowa’s system 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 through service providers 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 Part C Family Outcomes Indicator 4C).

SIMR Data:

<table>
<thead>
<tr>
<th>FFY</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>87.00%</td>
<td>89.00%</td>
<td>91.00%</td>
<td>93.00%</td>
</tr>
<tr>
<td>Data</td>
<td>84.91%</td>
<td>83.25%</td>
<td>86.35%</td>
<td>85.54%</td>
<td>87.95%</td>
</tr>
</tbody>
</table>

Source: GRADS360

Reviewing Indicator 4C data 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 OSEP indicator 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 early intervention knowledge and practices; caregiver or parent practices; and, changes in the Early ACCESS infrastructure or system. The evaluation plan (SSIP Phase II) helps to monitor progress of implementation in all of these areas. Evaluation data and analysis 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.

2. The 2018 coherent improvement strategies/principal activities

Iowa remains committed to three overall improvement strategies (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 2018.

a) Strategy 1 of 3: New Instructional Practices

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Strategy 1: New Instructional Practices</strong></td>
<td></td>
</tr>
<tr>
<td>Shifting instructional practice away from teaching the child to using Family Guided Routines Based Intervention (FGRBI) where the focus is on coaching the caregiver to support the child.</td>
<td>Concluded <em>Iowa Distance Mentoring Model</em> (IA DMM) of Professional Development training for <em>Cohort 6 early intervention service providers</em> on use of FGRBI and Caregiver Coaching. Continued <em>IA DMM</em> training for internal coaches to support fidelity, scale-up and sustainability of practice.</td>
</tr>
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</table>

In 2018, Iowa built on the previous years' cohort training and support to increase early intervention providers' use of and proficiency in coaching caregivers in FGRBI through:

- Monthly expert coaching sessions between early intervention service providers, Florida State University staff (external coaches), and peer internal coaches on home visit observations using TORSH Talent online observation and data management system.
- Monthly content webinars for service providers to support understanding of practice.
- Community of Practice professional development webinars held every other month for service providers and internal coaches.
- Facebook group specific to Iowa early intervention service providers.
- Website with printed and recorded resources.
- Weekly email updates and reminders.

In 2018, Iowa built on the previous year’s internal coach training to increase the number of early intervention providers who are internal coaches which will lead to sustaining the use of FGRBI through:

- Face-to-face training with Florida State University.
- Monthly expert coaching sessions with Florida State University staff (external coaches) on peer coaching using TORSH Talent online observation and data management system.
- Monthly webinars for internal coaches to support understanding of practice.
- FGRBI Internal Coach Portal.
- Online modules.
- Community of Practice professional development webinars held every other month for service providers and internal coaches.
- Facebook group specific to Iowa early intervention service providers.
- Website with printed and recorded resources.
- Weekly email updates and reminders.

During 2018, Cohort 6 had 24 early intervention providers complete the training sequence in June. No new cohorts of early intervention service providers were started on a training sequence during 2018 in order to focus on building internal coaching capacity. Internal coach training is a multi-year training and support process. In 2018, 12 early intervention providers began their first year of internal coach training. Six providers completed their first year of training and nine providers completed their second year of training. Iowa currently has 27 internal coaches participating in various levels of coach training and support.

b. **Strategy 2 of 3: New Implementation Practices**

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2018</th>
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<tbody>
<tr>
<td><strong>Improvement Strategy 2: New Implementation Strategies</strong></td>
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<tbody>
<tr>
<td>Incorporate implementation science frameworks in order to develop the capacity to make effective, statewide, and sustained use of evidence-based practices.</td>
<td><strong>Held annual face-to-face Joint Implementation Team Meeting</strong> where regional and state teams review and reflect on progress and plan for next year. <strong>Held five 2-day stakeholder meetings</strong> (Early ACCESS Leadership Group) where updates and progress, <strong>barriers &amp; successes</strong> were discussed. <strong>Created</strong> individual agency <strong>fidelity and sustainability implementation plans</strong> with regional <strong>implementation teams</strong>. <strong>Used planned communication process</strong> to update <strong>written implementation team reports</strong>. <strong>Used written commitments from participants and administrators</strong> to provide time/resources for the service provider and internal coach training. <strong>Provided mini-grants</strong> to area education agencies to support internal coaching activities.</td>
</tr>
</tbody>
</table>
In 2018, Iowa built on the previous years' use of implementation science through:

- Accessing resources from The National Implementation Research Network's Active Implementation Hub (https://implementation.fpg.unc.edu).
- Monthly project management calls between the Iowa Department of Education and Florida State University.
- Participating in the Family Outcomes Cross-State Learning Collaborative held by the National Center for Systemic Improvement.
- Subscribing to the State Implementation and Scaling-up of Evidence-based Practices (SISEP) Center e-newsletter.
- Using existing stakeholder group meetings (Early ACCESS Leadership Group, State Work Team, Iowa Council for Early ACCESS) to discuss and support use of implementation science.

c) **Strategy 3 of 3: New High Quality System**

<table>
<thead>
<tr>
<th>Improvement Strategies</th>
<th>Principle Activities in 2018</th>
</tr>
</thead>
</table>
| **Improvement Strategy 3: New High Quality System** | **Updated evidence** in ECTA System Framework  
**Self-Assessment** for **Governance** and **Personnel/Workforce** components; added **Accountability and Quality Improvement**.  
**Continued** meeting of **family engagement task team** as part of the Iowa Council for Early ACCESS (ICEA) to increase family participation in leadership and decision-making throughout the early intervention system. Focus on creating **ICEA orientation** that is created **by families for use with everyone**.  
Held **annual State Work Team retreat** to **review, reflect and refine** work to support use of evidence-based practices.  
**Continued** to improve statewide **in-service professional development** and technical assistance system for providers **across disciplines** through the IA DMM, Community of Practice, FGRBI website, emails, webinars, YouTube, and **agency specific trainings** that support practice change.  
**Continued** to strengthen **relationships** with **institutes of higher education** (IHE) through Wednesday Wonders twice-monthly e-newsletter, having dedicated space on Early ACCESS website for IHE, meeting with IHE staff, and **initiated conversations** regarding partnering to **support FGRBI scale-up and sustainability** after FSU contract ends in 2023. |
In 2018, Iowa built on the previous years' infrastructure development through:
- Renewal of 5-year Memorandum of Agreement (MOA) between the Iowa Departments of Education, Public Health, and Human Services and the University of Iowa’s Child Health Specialty Clinics to support a statewide early intervention system.
- Using existing groups of stakeholders that meet regularly to address successes and barriers.
- Twice monthly State Work Team meetings which include staff from the Iowa Departments of Education, Human Services and Public Health, and Child Health Specialty Clinics.
- Monthly project management calls between the Iowa Department of Education and Florida State University.
- Increased involvement with institutes of higher education (IHE).
- Continuous involvement with the larger early childhood community, known as Early Childhood Iowa.
- Accessing resources from The Early Childhood Technical Assistance Center (http://ectacenter.org/).
- Participating in the Family Outcomes Cross-State Learning Collaborative held by the National Center for Systemic Improvement.
- Regular contacts with state liaisons from the Early Childhood Technical Assistance Center, The Center for IDEA Early Childhood Data Systems, IDEA Data Center, National Center for Systemic Improvement, Early Childhood Personnel Center, and Office of Special Education Programs.
- Participation in technical assistance and webinar opportunities provided by the Early Childhood Technical Assistance Center, The Center for IDEA Early Childhood Data Systems, IDEA Data Center, National Center for Systemic Improvement, Early Childhood Personnel Center, and Office of Special Education Programs.

3. The specific evidence-based practices that have been implemented to date

Iowa continues to implement three specific evidence-based practices in order to support the State-Identified Measurable Result: (a) Family Guided Routines Based Interventions for early intervention service providers; (b) internal coaching by early intervention providers who are trained to coach their peers; (c) Active Implementation Frameworks or implementation science practices.

a) Family Guided Routines Based Intervention training for service providers

In 2013, Iowa’s Early ACCESS system began to engage providers statewide in job-embedded professional development to increase their use of caregiver coaching to embed interventions in families’ daily routines. Iowa Department of Education partnered with Florida State University’s Communication and Early Childhood Research and Practice Center to use the Iowa Distance Mentoring Model of professional development to scale up and sustain their providers’ use of Family Guided Routines Based Intervention and Caregiver Coaching. The professional development sequence was designed to incorporate research that asserts educational providers learn most effectively from coaching that includes
demonstrations and explanations of effective instruction paired with sustained and active engagement, and practice in context over an extended time frame (Bransford et al., 2000; Dunst, Trivette, & Deal, 2011; Snyder, Hemmeter, & McLaughlin, 2011; Trivette et al., 2009) using a combination of learning modalities.

The Distance Mentoring Model is a process that includes all key features of evidence-based professional development (Dunst, 2015) to support providers in implementing Family Guided Routines Based Intervention through initial content-based face-to-face workshops; monthly performance-based feedback and reflective coaching sessions with regional peers and an internal coach; a follow-up coaching session with a Florida State University external expert coach; monthly webinars on related content; a second face-to-face workshop half-way through the professional development cycle; and, a Community of Practice to continue to support providers once the professional development cycle has been completed. A variety of technology supports are used to enhance the flexibility of the job-embedded professional development components. In total, approximately 190 providers in six cohorts have completed the Distance Mentoring Model professional development cycle since 2013. Evaluation on the impact of the Distance Mentoring Model as a professional development approach (Marturana & Woods, 2012), along with ongoing internal evaluation data, indicate that providers make gains in their use of key practices and efforts to bring it to scale fully statewide are under way.

b) **Internal coaching by early intervention providers who are trained to coach their peers**

Iowa continues to train and support peer internal coaches to address sustainability and internal capacity within Iowa to spread and implement FGRBI after external support from Florida State University ends. 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 2018, six additional internal coaches completed their first year of training (joining the nine originally trained group from the previous year). In the fall of 2018, an additional 12 early intervention providers began the training process to become internal coaches. This brings the pool of coaches being trained to 27.

c) **Active Implementation Frameworks**

In Active Implementation Frameworks, full implementation occurs when over half of the intended practitioners are using the innovation (i.e., FGRBI) with fidelity. Ensuring full implementation requires early intervention providers in Iowa to continue to use the practices learned during professional development beyond the length of the cohort in order to sustain and spread the innovation. Understanding and using the five frameworks continued to be part of Iowa’s work in 2018. Core elements are in place that cut across all stages of implementation and include: (1) implementation teams at multiple levels of the system (state, regional, local) that 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).
4. Brief overview of the year’s evaluation activities, measures, and outcomes

Collecting information about service providers, parent/caregivers, and system infrastructure ensures that Iowa is on the right path to improving outcomes for families and children served in Early ACCESS. Therefore, evaluation at all of these levels continues to be an essential part of Iowa's improvement efforts.

Provider Level Evaluation via Observations and Self-Assessments: How do service providers change in their abilities to implement FGRBI?

Provider level evaluation activities were carried out as planned. Outcomes of these activities are shared in Section C: Data on Implementation and Outcomes.

Observations and Self-Assessments

Videos of home visits are key tools used for observation of key components of the Family Guided Routines Based Intervention and Caregiver Coaching. The Self-Assessment Session Summary form is the collection tool used by all service providers, internal coaches and external coaches from Florida State University to capture these key measures: (1) SS-OO-PP-RR framework and Family Guided Routines Based Intervention (FGRBI) key indicators, (2) coaching strategies, and (3) family routine categories. 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.

Family Level Evaluation via Observations, Surveys, and Interviews: 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?

Family level evaluation activities were carried out as planned. Outcomes of these activities are shared in Section C: Data on Implementation and Outcomes.

Observations of Caregiver Key Indicators

This is the second year for using the Caregiver Key Indicator tool to describe and quantify the caregiver’s role in home-based intervention sessions. This tool 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, 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 caregiver-child interactions are primary in the session, the parent participates and practices embedding strategies in routines, 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 a relationship exists between the provider’s fidelity scores and the scores on the Caregiver Key Indicators.

Family Surveys
Families with providers that participate in FGRBI training receive the Early Intervention Parenting Self-Efficacy Scale (EIPSES) survey either online or a paper version through the United States Postal Service approximately 60 days after service providers complete the training sequence. The 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 providers (Guimond, Wilcox & Lamorey, 2008). Iowa uses the results of this survey as a measure to see how parents are feeling at this point in time. There continues to be 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 training and answer the same question. This would give useful information on how much the perspective of the parent has changed over time.

Family Interviews
After the professional development sequence was finished, Florida State University staff contacted families, scheduled calls, and conducted telephone interviews with parents of Cohort 6. Twenty parents voluntarily shared their experiences and provided feedback as they responded to a sequence of questions about services in the natural environment using coaching by their providers. This is an increase from the 11 interviews from the previous year and just one interview the first year that parents were contacted. The transcripts have not yet been analyzed. Results will be reported in next year’s report.
System Level Evaluation via Self-Assessments and Written Reports: How do implementation team members shift in their knowledge and use of evidence-based implementation? How did systems change to accommodate this initiative?

System level evaluation activities were carried out as planned. Outcomes of these activities are shared in Section C: Data on Implementation and Outcomes.

ECTA System Framework Self-Assessments
During 2018, Iowa added evidence to the ECTA System Framework Self-Assessments for the Governance and Personnel/Workforce Components of the framework. Stakeholders reviewed activities completed in both of these areas and recorded the evidence into the self-assessment tool. Iowa elects to score the self-assessments every other year (due again fall of 2019). In addition, Iowa started the self-assessment for the Accountability and Quality Improvement Component and will be drafting improvement activities in late spring 2019.

Regional Implementation Team Written Reports/Updates, Meeting Agendas and Notes
Regional implementation team (RIT) reports are updated via Google Docs five 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?

Agencies record on the same Google Docs in their respective sections of the form. This supports communication among agencies as they can see what each other has reported. In addition, this report helps to identify evidence-based and promising practices other than FGRBI that are being implemented by some agencies (i.e., Primary Service Provider teaming). 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 seven and eight so that appropriate actions can be taken. The information helps the state determine regional needs in order to support statewide progress on practice implementation.
5. Highlights of changes to implementation and improvement strategies

*Improvement strategies remain the same* as planned and submitted in previous SSIP reports. *Implementation*, however, *has shifted* from the previous year to a focus on training internal coaches.

The Iowa Distance Mentoring Model (IA DMM) of professional development involves a continuous improvement process driven by stakeholder input and data. Based on a survey and feedback from stakeholders, there was no Cohort 7 of early intervention service providers added in 2018. Instead, the need for increased support for internal coaches and the increase in the number of internal coaches became priorities. The addition of the new internal coaches was necessary to prevent practice drift and ensure FGRBI is delivered with fidelity and that the practice is sustained over time. Iowa has a contract with Florida State University (FSU) through September 2023. However, preparing Iowa agencies to provide coaching without FSU needed to begin now. It will take several years to develop the state's capacity to build expertise in coaching peers to use FGRBI with fidelity.

**New Professional Development Sequence**

Internal coach training was adjusted based on feedback (face-to-face meetings, coaching sessions, surveys) from stakeholders. Coaches expressed the need for continued support beyond their first and second years of training in order to better develop their skills to support their peers. At the same time, more internal coaches were needed across the state. While agencies identified potential new providers to train as coaches, FSU, with support from the Iowa Department of Education, created a system for training internal coaches who were at varying levels of knowledge and skill development. The purpose was to provide a standardized list of expectations for FGRBI Internal Coaches with differentiation that enables flexibility for the agencies' various sizes and needs. This would promote a tiered system of learning and competence favored by adult learners and provides a mechanism for each agency to achieve fidelity and sustainability of implementation.

As a result, Iowa has three tiers of FGRBI Internal Coaches (Trainee Coach, Provider Coach, and Master Coach) with a clearly defined professional development sequence (Appendix A) and roles and responsibilities for each tier (Appendix B). Internal coach training is no longer a time-bound series of activities. Each internal coach developed a written Internal Coach Competency Development Plan for 2018-2019 and submitted the document to Florida State University. This information is useful in providing support that will lead coaches to achieving their individual plans. In addition, the area education agencies have developed written FGRBI fidelity and sustainability plans unique to their agency and submitted them to the Iowa Department of Education.

**New FGRBI Provider and Coaching Competencies**

Competency based practice in early intervention is recommended. However, different disciplines and training programs have different sets of competencies (Woods, 2018, slide 4). FGRBI Provider Competencies and FGRBI Coaching Competencies (Appendix C) were developed to serve as the
foundation for the manualization of FGRBI and coaching. Internal coaches use them both as a guide for their practice and to support the practice of the team members they coach. The delineation of specific knowledge and skill competencies integral to FGRBI and coaching further describes the principles and practices to be engaged by team members supporting families in early intervention.

**New FGRBI Online Training Portal for Coaches**

A critical new piece of the training for internal coaches is the FGRBI Internal Coach Training Portal. To ensure sustainability, the early intervention work force requires relevant and easily accessible, job-embedded professional development. Online learning developed specifically for the internal coaches provides support to both achieve fidelity for early intervention service providers and new coaches, while ensuring opportunities for growth through collaboration and networking. The FGRBI Internal Coaching Training Portal provides a systematic and sequential professional development opportunity for Internal Coach Trainees and fosters continuous improvement cycles for all internal coaches.

The portal also increases access to FGRBI and coaching training materials for internal coach professional development that is essential for further increases in fidelity. The Resources section on the portal provides materials and links to videos.

**New Manualization of FGRBI and Coaching**

To promote fidelity and sustainability, the FGRBI Key Indicators Manual (Appendix D) was revised. This manual is a valuable resource to enhance understanding and application of the home visitation structure known as SS-OO-PP-RR (Setting the Stage; Observation and Opportunities to Embed; Problem Solving and Planning; Reflection and Review) and 5Q (a series of five questions that provide a framework for guiding parents to plan how they will embed interventions in daily routines and activities). The Internal Coach Manual supports Trainee Coaches in their work with team members as external coaches from Florida State University decrease time with Trainee Coaches.

**New Expanded Use of TORSH Talent for Data Collection**

In order to make data collection institutionalized and available locally, new features have been developed in TORSH. The goal is to make data easily accessible by automating the system as much as possible. Data on video-recorded home visit self-assessments and coaching sessions is now calculated through improvements in the TORSH data management system.

**New Evaluation of Internal Coaching via Institute of Education Sciences (IES) Grant**

The IES Internal Coach Evaluation Study offers us an opportunity to measure the effectiveness of *Early ACCESS*'s use of internal coaches to support early intervention providers to use Family Guided Routines Based Intervention with families in Iowa. As a field, we have data on the effectiveness of FGRBI and how it supports families and children to learn and grow. We also know that professional development models which use key features such as coaching, feedback, and video reflection help early interventionists develop new skills. But, what we haven’t been able to demonstrate is whether or not peer internal coaches can facilitate changes in early intervention provider practice. We also have the
opportunity to examine how providers are able to change parents’ use of strategies, and how that impacts their child’s development. Primary goals and potential impact are:

- Evaluate the effectiveness of the internal coaches in supporting provider use of FGRBI;
- Gain nuanced information about the change process;
- Investigate whether provider use of FGRBI is linked to family strategy use and child targets; and
- Inform how we spend limited training funds in Iowa and nationwide in Part C.

The single case experimental design study is currently in the data collection phase, which ends June 2019, and will be followed by analysis and dissemination through June 2020.

Revised Birth to Five Comprehensive System of Personnel Development

Iowa received intensive technical assistance from the Early Childhood Personnel Center a few years ago in order to develop an Early Childhood (B-5) Comprehensive System of Personnel Development (ECTA System Framework Personnel/Workforce Component). That 2016 plan was shelved for a variety of reasons; however, it was resurrected and revised in 2018. The focus was narrowed to become the Early Intervention and Early Childhood Special Education Comprehensive System for Personnel Development (EI/ECSE CSPD) plan. Stakeholders representing early intervention, early childhood special education, Iowa Association for the Education of Young Children, and Early Childhood Iowa serve on a core leadership team to ensure that an action plan moves forward.

B. Progress in Implementing the SSIP

1. Description of the State’s SSIP implementation progress

During 2018, Iowa made progress in implementing activities in all 3 areas identified for improvement: provider practice change, use of evidence-based implementation/professional development, and infrastructure development.

a) Description of extent to which the State has carried out its planned activities as intended—what has been accomplished, what milestones have been met, and whether the intended timeline has been followed.

Activities have been carried out or are in the process of being carried out as intended, according to the intended timelines.

Primary Activities Accomplished in 2018 for Early Intervention Practice Change

Iowa built on the training from the previous years to increase early intervention service providers' proficiency in and use of coaching caregivers in FGRBI with fidelity, as well as increase the number of providers who are internal coaches (intermediate outcomes from logic model submitted with SSIP Phase II). Progress towards outcomes have been made through:

- Completion of Family Guided Routines Based Intervention training for Cohort 6
- Internal coach training for continuing and new internal coaches
Completion of Cohort 6 FGRBI training took place as scheduled. Data was gathered from participants throughout the 10 month training sequence to ensure that training was being delivered as intended and meeting participants’ needs.

Internal coach training continues with the changes noted in the previous section of this report. The number of early interventionists being trained as internal coaches has increased each year as expected.

**Primary Activities Accomplished in 2018 for Implementation**

There is a continued use of implementation science and the Active Implementation Frameworks to impact change in Iowa’s early intervention system. Established structures and processes are used to support the use of evidence-based practices. Early interventionists and internal coaches report feeling supported through the training processes and activities (intermediate outcomes from logic model submitted with SSIP Phase II). State and regional implementation teams meet regularly and come together annually for a joint implementation team meeting. This helps support statewide consistency in practice while assisting with the individualized needs of each area education agency (AEA). In 2018, additional funding was provided to the AEAs specifically to support internal coach activities. Progress towards outcomes has been made through:

- Implementation team meetings
- Fidelity and sustainability planning
- Stakeholder meetings (Early ACCESS Leadership Group; State Work Team) to address barriers and successes to implementation
- Selection of internal coaches for training
- Awarded mini-grants to support internal coaches

**Primary Activities Accomplished in 2018 for Infrastructure Improvement**

Iowa continued to build the foundation for improvements in Governance and Personnel/Workforce components of the early intervention system infrastructure while adding the Accountability and Quality Improvement Component. Sharing the ECTA System Framework with multiple stakeholder groups during regular occurring meetings and having multiple state agencies involved in the System Framework Self-Assessments helps to increase staff and stakeholder knowledge of structures and partnerships needed to support an effective, efficient statewide service delivery system. As that knowledge builds, actions are implemented on plans for improvements (short-term outcomes from logic model submitted with SSIP Phase II).

The past year has had increased family engagement in system level leadership as the Family Engagement Task Team began creating new orientation materials for the Iowa Council for Early ACCESS. The orientation is scheduled to be completed for use in fall 2019. A Public Relations and Marketing Task Team has been established with multiple stakeholders to begin addressing common statewide messaging and materials for Early ACCESS. In-service training has improved this
year to accommodate the needs for internal coaches. An Early Intervention/Early Childhood Special Education Comprehensive System of Personnel Development has re-engaged and is working on improvement plans. Progress towards outcomes has been made through:

- Governance, Personnel/Workforce, and Accountability & Quality Improvement self-assessments (ECTA System Framework components) and planning
- Memorandum of Agreement between Iowa Departments of Education, Public Health, Human Services and Child Health Specialty Clinics renewed through 2023
- Family Engagement Task Team
- Public Relations and Marketing Task Team
- Continued development of in-service training system
- IHE relationship-building to impact fidelity and sustainability of FGRBI and coaching
- Developing new IDEA data system

b) Intended outputs that have been accomplished as a result of the implementation activities

In 2018, outputs as a result of the primary early intervention practice, implementation, and infrastructure activities include but are not limited to:

- Internal coach professional development sequence
- Trainee, provider, and master internal coach agreements
- FGRBI early intervention provider competencies
- FGRBI internal coach competencies
- Internal coach competency development plans
- Internal coach professional development plans
- Trainee, provider and master internal coach activity logs
- FGRBI Key Indicator Manual
- Internal Coach Manual
- FGRBI Internal Coach Training Portal
- Steps for completing a video review and feedback session for all levels of coaches
- Internal coach roles and responsibilities
- FGRBI home visiting implementation timeline
- Videos and documents for use by internal coaches
- Agency FGRBI fidelity and sustainability plans
- Mini-grants to support internal coach activities at the area education agencies
- Updated ECTA System Framework Self-Assessments
- Updated 5-year Memorandum of Agreement between 4 state agencies to support early intervention system

2. Stakeholder involvement in SSIP implementation

a) How stakeholders have been informed of the ongoing implementation of the SSIP

In Iowa, the ongoing communication about improvement activities are not couched as conversations about "the SSIP". Rather, communication is around changing the early intervention system and the use of evidence-based practices. The term "SSIP" is used only when directly connected with conversations about OSEP Indicator C11. Therefore we do not have SSIP committees or SSIP updates. Data and information about the shift to using evidence-based early intervention practices, evidence-based implementation processes, and infrastructure improvement take place in a variety of ways.
Presentations and written documents are provided to stakeholder groups that have a long history of engagement with early intervention and/or early childhood and include:

- **Early ACCESS Leadership Group (EAGL)** (32 members representing administrators, mid-management, and service providers from all nine area education agencies; Des Moines Public Schools; staff from Iowa Departments of Education, Public Health, and Human Services; Child Health Specialty Clinics; Iowa School for the Deaf; Iowa Educational Services for the Blind and Visually Impaired). Holds five two-day meetings per year.

- **Iowa Council for Early ACCESS (ICEA)** (approximately 25 members appointed by the governor and includes parents of young children with disabilities and administrators from the Iowa Departments of Education, Public Health, and Human Services and Child Health Specialty Clinics). Holds four full-day meetings per year.

- **Early ACCESS State Work Team (SWT)** (nine members from Iowa Departments of Education, Public Health, and Human Services and Child Health Specialty Clinics). Holds twice-monthly all-day meetings and an annual two-day retreat.

- **Special Education Directors** from the area education agencies (nine AEA directors and Iowa Department of Education (IDOE) staff). Hold monthly meetings. Early intervention is represented through attendance of an administrative consultant responsible for birth to age five services offered by the IDOE.

- **Early Childhood Iowa** (a statewide structure to help build a comprehensive early care, education, health, and human services system). Holds a variety of regular meetings related to the early childhood system in the state.

Long-standing relationships between and within these groups allows for smooth transitions when membership changes due to retirements, new hires, changing roles or jobs, or expiring terms for membership.

**b) How stakeholders have had a voice and been involved in decision-making regarding the ongoing implementation of the SSIP**

Existing meetings of the EAGL, ICEA, SWT and special education directors are used for data review, reflection and revision of implementation of evidence-based practices and infrastructure improvements. These are long-standing stakeholder groups who have traditionally had a voice in the decision-making process for early intervention in Iowa. In addition, implementation teams made up of early intervention providers, internal coaches, and mid-level managers meet routinely in order to engage with system change. Several area education agencies are working on adding families to the regional implementation teams. Written implementation reports are provided by the implementing agencies at the EAGL meetings where barriers and successes are identified and improvements are made. Florida State University staff routinely join the EAGL meetings via Zoom in order to hear directly from stakeholders and engage in dialog about improvements.
Surveys and interviews are also used to gather information from stakeholders. This specifically includes service providers and families directly impacted by trainings. Additionally, at every meeting of the Iowa Council for Early ACCESS, a family who has a young child in early intervention (or has recently transitioned) shares the story of their family's experience with the early intervention system. There is no shortage of lessons to learn from these stories.

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, numerous task teams (e.g., service coordinator competencies, procedure manual revisions, and public relations/marketing) formed and include diverse groups of stakeholders that volunteer to work on different aspects of the early intervention system.

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. There is always an electronic format for joining meetings so that anyone from across Iowa can participate. It is not unusual that a service provider "attends" 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.

C. Data on Implementation and Outcomes

1. How the State monitored and measured outputs to assess the effectiveness of implementation

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 primary activities' evaluation.

How evaluation measures align with the theory of action

The Theory of Action identifies three 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" in the Theory of Action, Iowa identified three 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. All outcomes on the logic models are 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 system needed to get better results for families and children in Early ACCESS. (Theory of Action, logic models and evaluation plans submitted with SSIP Phase II.)

**Face-to-Face Training Evaluation for Cohort 6 Early Intervention Service Providers**

Providers’ confidence in their ability to implement FGRBI components was assessed using a survey with a Likert Scale which ranged from “0” for Strongly Disagree to “5” for Strongly Agree. Results were analyzed using the Learning Based Assessment Tool, which attempts to examine “Net Learning” attributable to professional development.

The figures below display the results from the face-to-face workshops with Cohort 6 early intervention provider trios (groups of 3 providers from the same agency going through the training together) that took place 6 months into their training sequence. Every trio member (N=25) and eight of nine internal coaches (n=8) in attendance completed the survey. This information is critical for understanding where participants' learning was at the six month point in the training sequence.

Analysis of results offers trainers information about unmet needs of providers. This leads to shifts in future training and support to address the needs.

**Survey Results for Face-to-Face Trainings**

The chart below displays results from the post-then-pre survey completed by Cohort 6 early intervention providers at the end of the second day of face-to-face training that took place 6 months into their training sequence.

**Results from Early Intervention Provider Final Face-to-Face Training Day 2 Evaluation (N=25)**

<table>
<thead>
<tr>
<th></th>
<th>I can list 4 steps for problem solving with families on embedded intervention in THEIR routines.</th>
<th>I can describe 3 strategies to include reflection during coaching.</th>
<th>I can share 2 strategies to support others in my agency to join in and keep it going.</th>
<th>I can develop an action plan for next steps with trio.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Lag</td>
<td>13.91%</td>
<td>12.17%</td>
<td>15.65%</td>
<td>13.91%</td>
</tr>
<tr>
<td>Net Learning</td>
<td>33.04%</td>
<td>32.17%</td>
<td>27.83%</td>
<td>26.96%</td>
</tr>
<tr>
<td>Pre-Existing Learning</td>
<td>53.04%</td>
<td>55.65%</td>
<td>56.52%</td>
<td>59.13%</td>
</tr>
</tbody>
</table>

Source: Day 2 Final Face-to-Face Training Survey for Early Intervention Providers
As expected, early intervention providers came into the training with high levels of preexisting knowledge (yellow band) since they had completed six out of ten months of their FGRBI training. Every provider increased their knowledge as a result of the face-to-face training (green band). Data indicate there is some learning lag (red band) that needed to be addressed during the remaining months of their professional development activities.

The chart below displays results from the post-then-pre survey completed by Cohort 6 internal coaches at the end of the second day of face-to-face training that took place 6 months into their training sequence.

**Results from Internal Coach Final Face-to-Face Training Evaluation (n=8)**

As expected, internal coaches came into the training with high levels of preexisting knowledge since they had completed the 10 month early intervention provider training with high fidelity followed by 6 months of internal coach training. Data indicate there is some learning lag (red band) that needed attention during the remainder of the training sequence.

**Descriptive Feedback from Early Intervention Provider Trios**

Cohort 6 early intervention service providers rated their video feedback coaching sessions as the most important learning opportunity in their professional development sequence. Opportunities to problem solve with their internal and external coaches and their fellow trio members were also rated as extremely important.

The Cohort 6 trios, considered the self-assessment of their own videos and observation of other’s videos as more important to their learning than the planning for and reflecting on the feedback sessions. They ranked problem solving and planning as important for their change effort. Cohort 6 early intervention providers commented positively on having an internal coach participate in their
feedback sessions in addition to their Florida State University external coach. However, they identified redundancy between the internal and external coaching sessions and recommended combining the sessions when the internal coach was comfortable taking the lead. This change was made based on the feedback.

**Descriptive Feedback from Internal Coaches**

Eight out of nine internal coaches completed an evaluation survey describing their coaching professional development experiences and future needs. They ranked attending FGRBI training with their team members as extremely valuable. They stated it served as a review of the content, was a valuable opportunity to build relationships with team members, and helped to gain insights into the team members’ current knowledge and skills. Overall, internal coaches identified participating in the video feedback sessions with either an external or another internal coach as extremely important to their learning. They also ranked observing, completing self-assessments and problem solving with other coaches as very or extremely important to their learning. Planning for a video observation and reflecting after the video feedback were identified as important or somewhat important.

Technology was evaluated as a positive support for coaching. Using Zoom to be able to have face-to-face conversations enhanced the experience. TORSH Talent was also rated as extremely important. Support from FSU to use TORSH was rated as extremely important.

Coaches rated the networking webinars as important for learning but requested additional face-to-face training and dedicated webinars on topics that would enhance their experiences coaching their peers in the future.

“I have found the DMM to be the most meaningful training I have received in 17 years with the AEA. The expertise of FSU staff and the face-to-face opportunities in combo with the virtual opportunities to communicate have been so valuable. THANK YOU sincerely for this opportunity to improve my skills as a coach and early interventionist.”

**Internal Coach Time Study**

A crucial question for future planning and sustainability is to know how much time is needed for internal coaches to train new staff and support fidelity for current providers. To gather this information, Florida State University has completed annual time studies by collecting data from the internal coaches about what, when and for how much time they took to complete designated coaching activities.
In 2018, internal coaches were asked to choose a representative week per month to report the time spent in various coaching activities. A list of common coaching activities was provided to facilitate a comparison of time spent and to identify differences between Year 1 and Year 2 coaches. Coaches were encouraged to report time within a Qualtrics® survey monthly, however, with a few exceptions, the data collection was inconsistent and frequently forgotten despite weekly reminders. Several coaches expressed that they found the time study to be duplicative work and easy to forget. To support data submission, coaches were then encouraged to send the data in any format. The data received was then entered into the survey for them.

The utility and reliability of the sample as a reflection of Early ACCESS as a whole is severely limited due to the wide range of time available for each coach to participate in their coaching assignments and the specific plans that were made with their agency leads and Regional Implementation Team.

There were definite differences between the amount of time spent and the types of coaching activities undertaken between Year 1 and Year 2 internal coaches. However, there is such significant variability within the two coaching groups that the internal coach time study is best described as 13 individual case studies rather than a small group comparison.

**Year 1 Internal Coaches Time Study (Started with Cohort 5)**

Internal coaches (4 of 6 shared data at least for one month) reported an average of 74 hours spent in coaching activities or approximately nine hours per month. This is very similar to the 8-10 hours identified as the minimal possible to be able to produce positive outcomes. However, please note, the range of total hours reported was 6-293. A secondary source of data is provided by the time spent using TORSH Talent online observation and data management platform for commenting on videos in preparation for coaching feedback sessions. Six Year 1 coaches watched and commented on 9 videos and spent an average of 944 minutes or 15 ¾ hours doing this work.

The three top activities where the most time was spent for Year 1 coaches included:

1. Professional development for self and with trios (e.g., Face-to-Face trainings, webinars)
2. Planning for feedback sessions (e.g., observing and commenting on videos)
3. Conducting feedback sessions

**Year 2 Internal Coaches Time Study (Started with Cohort 6)**

Internal coaches who were working more independently on tasks assigned by their agencies had even greater variability in their data (8 of 9 shared data for at least one month) and reported an average of 166 hours spent in coaching activities or approximately 20 hours per month. The provider with the highest number of hours reported varied by month from 27 to 80 and averaged 50. Five of the Year 2 coaches reported an average of 8-10 hours per month ranging from 4-16 based upon the month. The secondary source of data provided by TORSH Talent for commenting in preparation of coaching feedback sessions, is also illustrative. The time spent is much less than Year 1 coaches who were assigned to watch and comment on their trio videos. Year 2 coaches spent an
average of 621 minutes or 10.2 hours with a range from 197 minutes to 1340 minutes using TORSH Talent.

The four top activities where the most time was spent for Year 2 coaches included:
1. Professional development for others (e.g., workshops, team meetings)
2. Conducting feedback sessions
3. Planning for feedback sessions (e.g., observing and commenting on videos)
4. Administrative (e.g., emails, scheduling, preparing for trainings)

**Community of Practice (CoP) Professional Development Webinars**

The Community of Practice (CoP) continued holding webinars and maintaining the IA DMM website throughout 2018. This ongoing support was requested by stakeholders. Conversations held during the Early ACCESS Leadership Group (EAGL) meetings throughout the year provided dedicated time to talk about FGRBI trainings and the continued need for supporting providers in reaching fidelity once they graduated from the training as well as continuing support for internal coaches. The CoP webinars and access to information and materials on the website are key to sustaining the use of evidence-based early intervention practices.

Through the CoP, state and national experts shared information and resources as well as led conversations on relevant topics. An average of 55 attendees participated (range 29-68) in the five sessions. This count is likely fewer than total participation as many joined in groups of team members who signed in as a single participant.

A survey was distributed once the five webinars of the series were completed. Respondents identified all topics as important and useful with three topics identified as extremely important: Application of Adult Learning to Families with Multiple Risk Factors, Connecting with Families Through Their Stories, and Linking Families to Resources and three as very useful: Feedback for Building Family Capacity, Application of Adult Learning to Families with Multiple Risk Factors, and Linking Families to Resources. All webinars were rated as including information relevant to engaging families and two webinars were rated as encouraging the participant to think critically, Feedback for Building Family Capacity and Application of Adult Learning to Families with Multiple Risk Factors.

Participants also rated the pre-webinar materials sent to support preparation as helpful, included about the right amount and types of materials, and that the practice should be continued. A monthly drawing from CoP participants for a DEC Recommended Practice Monograph was identified as valuable and also recommended for continuation.

CoP webinars are no longer considered new pieces of the Early ACCESS system infrastructure; they have become regular features. In 2018, conversations began with state institutes of higher education around strategies for how the professional development components will be continued once the Florida State University contract ends in 2023. A plan will be created over the next few years and implemented when appropriate.
Facebook for Early ACCESS Early Interventionists

In 2017-2018, there were a total of 282 Facebook posts, an average of 24 posts per month (range 18 in December to 30 in November). Facebook posts have a consistent monthly viewer response with an average of 58 views per post, range 50.3 to 66.2. August 2017 was the lowest “look” month and April the highest. With approximately 100 active group members, that is almost 60% participation for each post, which according to Facebook data reviewers is excellent. Data for 2018-2019 will be reported in next year’s SSIP report.

The most popular types of posts were on typical child development. Disabilities and routines; communication, physical development and safety followed in gaining attention. This year's most popular specific posts were the speech language strategies handouts and the Talking is Teaching: Track Your Child’s Developmental Milestones application. Our least popular posts were the CoP webinar reminders and those on nutrition, eating tips, and exercise.

2. How the State has demonstrated progress and made modifications to the SSIP as necessary

This section provides key data that provides evidence regarding progress toward achieving intended improvements to the early intervention system including (a) provider progress; (b) caregiver (parent) progress; (c) regional and state system progress.

a) Provider Progress

Cohort 6 provider progress is measured through observations and interviews. Evaluation data indicates that progress is being made in implementing evidence-based practices.

Observations: FGRBI Key Indicators

Each year, the FGRBI SS-OO-PP-RR Key Indicators are used as a primary outcome measure to assess change in provider practice across the professional development cycle. Participants in Cohort 6 performed similarly to Cohort 5, moving from 72.9% use of the FGRBI Key Indicators in their first post-training home-based session up to a mean of 82.6% in the final video recorded session. Data from Cohorts 4-6 indicate that providers are moving towards implementation fidelity at the end of the professional development cycle. Implementation fidelity means the providers are using 80% of the FGRBI Key Indicators either partially or fully during early intervention sessions as measured by the FGRBI Key Indicator Checklist. With the integration of the vision of FGRBI throughout the Early
ACCESS system, the increase of professional development available through the individual agencies, and the installation of practices by early intervention providers throughout the agencies, fidelity scores are as expected for a program ending the fifth year of implementation.

Results

Average Percentage of FGRBI Key Indicators Observed at Each Time Point, Cohorts 1-6

![Chart showing average percentage of FGRBI Key Indicators observed across different cohorts.](chart.png)

**Source:** FGRBI SS-OG-PP-RR Key Indicator Checklist from Cohorts 1-6 early intervention providers

Reliability Check
In order to provide objective, non-biased data, independent coders scored sessions for the presence of the FGRBI Key Indicators and provided data to the external coaches. Prior to independently scoring sessions, coders practiced and received feedback on multiple sessions, and reached greater than 80% agreement on three consecutive sessions with a master coder. Thereafter, one third of each coder’s sessions were coded by a second coder to ensure that they remained reliable. Then the external coach observed the video and compared coding to that of the independent observer. Most disagreements were based on clinical contexts or content not available to the coders and resulted in additional points for the early intervention provider once consensus was reached.

Key Indicator Item Analysis for Cohort 6
After analyzing the overall use of the FGRBI Key Indicators, Florida State University conducted an item by item analysis of the 12 measurable provider behaviors. This analysis enabled evaluation of areas in which providers have made the greatest change and areas in which they still need support.

In Cohort 6, sizable changes are seen in most Key Indicators. Indicators 5 (Observation) and 11 (Measuring progress) could use additional support to increase implementation.
Mean Percentage of Sessions at Each Time Point in Which Each of 12 FGRBI Key Indicators (KI) was Observed by the Blind Coders

Source: FGRBI SS-OO-PP-RR Key Indicator Checklist from Cohort 6 early intervention providers

Observations: Coaching Strategies

Early intervention providers learn to support caregivers by employing a range of caregiver coaching strategies with families. Providers should use multiple strategies during each session to match the needs of the caregiver as an adult learner, and calibrate their strategy use in the moment to build the caregiver’s capacity to support their child (Friedman, Woods, & Salisbury, 2012). Specific coaching strategies include direct teaching, demonstration with narration, caregiver practice, guided practice, general feedback, specific feedback, reflection, and problem solving. The graph below shows the mean number of specific caregiver coaching strategies used across each video probe during each cohort. On average, the providers in Cohort 6 ended the training cycle using a mean of 6.57 out of 8 coaching strategies per session. This indicates that, on average, providers are using multiple strategies to support adult caregivers as learners. What this data does not tell, though, is the frequency of coaching strategies used in a session. Rather, it tells whether the providers used the strategies at least once indicating that the provider knows and can use the strategy within a coaching session.

A deeper and more fine-grained analysis of coaching strategies could help extend what we know about which strategies are the most commonly used and which are used less often during varying components of the FGRBI SS-OO-PP-RR coaching framework. This is a topic for further stakeholder discussion during 2019.

It should be noted that all cohorts increased the numbers of coaching strategies used during their home visits from the initiation of the professional development. Cohorts 5 and 6 both started higher than previous cohorts and increased their capacity over time with professional development and coaching from internal and external coaches.
Results

![Bar chart showing average number of specific coaching strategies observed at each time point, Cohorts 1-6]

**Average Number of Specific Coaching Strategies Observed at Each Time Point, Cohorts 1-6**

Source: FGRBI SS-OO-PP-RR Session Summary Form from Cohorts 1-6 early intervention providers

**Observations: Family Routines**

Supporting families to identify and practice embedding strategies in family routines during home-based sessions are key outcomes in FGRBI. During the professional development cycle, early intervention providers learn the developmental value of diverse family routines for children as well as the importance of engaging families in the process of identifying and implementing intervention in those routines. During each recorded early intervention session, external coaches counted the number of routine categories used during the session. Routine categories include Play, Caregiving, Literacy, and Family/Community. During Cohort 6, providers reached an average of 2.17 routine categories per session. While this is an improvement from the initial 1.83 routine categories per session, further growth is needed among providers in this area. Data is consistent across all cohorts that two routine categories are integrated into home visits but increasing the number of opportunities for families to practice is an ongoing challenge.
Results

Average Number of Family Routine Categories Observed at Each Time Point
For Cohorts 1-6

Provider Progress Summary
Data collected throughout 2018 shows progress in changing provider practices for IA DMM participants. Provider practice change leads to changes in caregiver or parent behaviors which ultimately leads to changes in family and child outcomes. Work continues on improving fidelity and the scale-up of practice and sustainability.

b) Caregiver (Parent) Progress

Cohort 6 caregiver, or parent, progress is measured through observations, surveys, and interviews. Evaluation data indicates that progress is being made in caregiver use of intervention strategies within daily routines along with increased parent confidence and competence in helping their child develop and learn.

Caregiver Observations: Caregiver Key Indicators
As early intervention providers increase their use of FGRBI SS-OO-PP-RR Key Indicators, it is equally important to measure the impact of those practices on caregiver outcomes. Florida State University has developed a tool to mirror the FGRBI Key Indicators for early intervention providers, but from the perspective of the parent. This tool looks at whether the caregiver is engaged in problem solving, in implementing intervention strategies, generating ideas for routines in which to embed, and other participatory and decision-making activities. Independent coders have been trained to
rank each item on a 0-3 scale of 11 specific observable behaviors. 2018 was the second year for using the Caregiver Key Indicator Checklist during observations via the home visit videos.

Across Cohort 6, caregivers increased the mean number of items on the Caregiver Key Indicators from 42.42% before their providers participated in FGRBI professional development to 75% at the end of their providers’ participation in the professional development cycle. This provides evidence that caregivers are increasing participation with their child, in relation to their provider’s use of FGRBI.

Results

Average Percentage of Caregiver Key Indicators Observed at Each Time Point for Cohorts 5 and 6

![Graph showing percentage of Caregiver Key Indicators observed]

Source: Caregiver Key Indicator Checklist from Cohorts 5 and 6 home visits

Item by Item Analysis of the Caregiver Key Indicators

The chart below shows the results of an item by item analysis of caregiver, or parent, key indicators. The analysis indicates notable growth on Indicator 4 (Caregiver participates in 2-3 routines from different categories), Indicator 8 (Problem solving with caregiver about intervention strategies), Indicator 9 (Problem solving to generalize to new routines), Indicator 10 (Caregiver reflects on what worked) and Indicator 11 (Caregiver summarizes action plan for between sessions). On the whole, caregivers are making gains in their participation and leadership of home visits, which indicates a growth in their capacity to support their child. Providers could consider helping caregivers make gains in making caregiver-child interactions primary in the session (Indicator 1), in identifying routines, targets, and strategies for the sessions (Indicator 5), and initiating comments and questions at least three times during a session (Indicator 7). This data has been shared with stakeholders so improvements can be made.
Mean Percentage of Sessions at Each Time Point in Which Each Caregiver Key Indicator was Observed

Source: Caregiver Key Indicator Checklist from Cohort 6

Parent Survey: Early Intervention Parenting Self-Efficacy Scale (EIPSES)
Increasing caregiver's confidence and competence 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 as the extent to which parents believe that early intervention impacts child outcomes. 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 FGRBI training (using a 7 point scale from 1 "Strongly Disagree" to 7 "Strongly Agree"). Cohort 1 through Cohort 3 data are combined because the EIPSES was completed for the first time at the end of Cohort 3 training for families from the first three cohorts combined. The response rate was 45% (41 of 91 surveys). Cohort 4 (response rate 23 of 44 or 52%), Cohort 5 (response rate 24 of 44 or 55%) and Cohort 6 (response rate 25 of 59 or 42%) families each received the survey at the end of their early intervention service providers' 10 month training sequence.
RESULTS

Average Confidence and Competence of Parents in Helping Their Child Develop and Learn, Cohorts 1-6

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Confidence</th>
<th>Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohorts 1-3 (N40)</td>
<td>3.38</td>
<td>5.89</td>
</tr>
<tr>
<td>Cohort 4 (N23)</td>
<td>3.31</td>
<td>5.83</td>
</tr>
<tr>
<td>Cohort 5 (N24)</td>
<td>5.60</td>
<td>5.98</td>
</tr>
<tr>
<td>Cohort 6 (N22)</td>
<td>5.65</td>
<td>6.01</td>
</tr>
</tbody>
</table>

Source: Early Intervention Parenting Self-Efficacy Scale Survey

In 2018, Cohort 6 data on parent confidence (5.65) that what they are doing in Early ACCESS will impact their child's outcomes mirrors that of Cohort 5 (5.60). This is in contrast to the lower average confidence scores of Cohorts 1-4 (3.38, 3.31). The higher results for Cohort 5 and Cohort 6 families appears to correspond with the higher use of FGRBI Key Indicators at fidelity by Cohort 5 and Cohort 6 early intervention providers. It is noteworthy that the addition of internal coaches to support early intervention providers' use of FGRBI and caregiver coaching began with Cohort 5 and continued with Cohort 6. It appears that the better the provider is at implementing FGRBI and coaching the caregiver, the greater the parents' confidence as measured by the EIPSES. Further testing and analysis is necessary to confirm this relationship.

Caregivers from Cohort 6 feel competent in their abilities to promote their child’s development (6.01). This means that parents perceive themselves as being personally effective and capable in helping their child.

Like Cohort 5 parents, Cohort 6 parents report feeling confident in their abilities to exert control over their children’s early intervention outcomes and competent in their abilities to promote their child’s development. This is very different than Cohort 1 through Cohort 4 who were equally competent in their ability to do the interventions but less sure that the interventions would produce the outcomes wanted for their child.
Parent Interview
Twenty (20) parents from Cohort 6 voluntarily shared their experiences through phone interviews. The transcripts have not yet been analyzed. Results will be included in next year’s report.

Caregiver Progress Summary
Data collected throughout 2018 shows progress in changing caregiver’s behaviors as well as their confidence and competence to help their child develop and learn. As work continues on improving provider practice fidelity and scale up, it is expected that caregiver data will continue to improve. This will ultimately lead to better outcomes for families and children.

c) Regional and State System Progress
Regional and state system progress is measured through self-assessments and written reports.

Self-Assessments, ECTA System Framework
Iowa continues to focus on the Governance and Personnel/Workforce Components of the ECTA System Framework. In 2018, the Accountability and Quality Improvement Component was added.

Governance
The goal of the Governance 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.

In 2018, evidence was added to the elements of quality in the self-assessment. Scores for the self-assessment are calculated every other year and were last done in 2017. Scores will be calculated again in 2019 and reported next year. Quality Indicator GV5 was the focus of work completed in 2018 because it was identified a high priority item and it scored the lowest on the initial self-assessment: State and regional and/or local system entities are designed to maximize meaningful family engagement in the development and implementation of the system. Progress was made through the development and carrying out of plans for the Family Engagement Task Team to create an orientation by family members for the full council. This work will be completed in fall 2019. New plans for family engagement in early intervention system work will be built once the orientation is complete.

Personnel/Workforce
The goal of the Personnel/Workforce 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.

This year, a combined Early Intervention and Early Childhood Special Education Comprehensive System of Personnel Development (EI/ECSE CSPD) plan was created after resurrecting some previous work that had been put on hold. In August of 2018, the self-assessment for the Personnel/Workforce Component for the EI/ECSE CSPD was completed. The 2013 version of the self-assessment was no longer relevant and a new EI/ECSE CSPD Plan was created. Part C used the Personnel/Workforce self-assessment for the first time on 4/10/15 and again on 3/9/18. Below are
the results of the Part C (birth to three) March 2018 self-assessment and the Part C/Part B 619 (birth through five) EI/ECSE August 2018 self-assessment. When assessing only early intervention (birth to three), results clearly indicate that there are Quality Indicators where elements of quality are partially in place (scores 3-5; yellow bars) but are not yet in place (scores 1-2; red bars) for the birth through age five system (Quality Indicators 1, 5, 6, 11, 12). Quality Indicator 9 ranks low for both early intervention and early childhood special education. (Comprehensive recruitment and retention strategies are based on multiple data sources, and revised as necessary.) By reviewing the early intervention self-assessment alongside the EI/ECSE self-assessment, contributions of early intervention to the larger system can be identified. These would be lost by only examining the larger system self-assessment. All the evidence that is recorded in the early intervention system is incorporated into the birth through five evidence. Scores for the EI/ECSE self-assessment were determined by considering the entire birth – five age range and not just what is happening in early intervention.

Infrastructure work for early intervention 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 the self-assessment for 2018. Scores for the early intervention self-assessment are calculated every other year and were last done in March 2018. Scores will be calculated again in March 2020. Iowa expects these scores to continue to increase as state and regional processes and structures change to support the use of evidence-based practices.

Source: ECTA System Framework Self-Assessment, Personnel/Workforce Component, 0-3 and 0-5
At the end of 2018, the State Work Team (staff from the Iowa Departments of Education, Public Health, Human Services and Child Health Specialty Clinics) did a review of the remaining 4 components of the System Framework to determine what, if any, additional components the state was ready to create action plans around. Based on that review, the team selected Accountability and Quality Improvement. On February 7, 2019, a self-assessment was completed for the first time. Results are displayed below.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Rating</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing statewide planning for accountability and improvement at all levels is informed by data and reflects strong leadership and commitment to positive outcomes for children and their families</td>
<td>6</td>
<td>QI Rating</td>
</tr>
<tr>
<td>A written accountability and improvement plan includes details necessary to implement an ongoing effective statewide accountability and improvement system at all levels</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Part C and EI state staff and representatives collect adequate data to determine the quality and results of the system and services</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Leadership at all levels have sufficient information to make accountability and improvement decisions</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Leadership at all levels, as appropriate, communicate and publicly report data and information through a variety of methods to document performance and evaluation results.</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Leadership at all levels use strategies to support continuous improvement to achieve expectations, as articulated in the accountability and improvement plan.</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Leadership at all levels work to enhance capacity to use data-informed practices to implement effective accountability and improvement schemes.</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Source: ECTA System Framework Self-Assessment, Accountability and Quality Improvement Component

Even though many of the quality indicators are in place for the early intervention system, there are improvements needed. These are high stakes indicators as they impact every other component in the system. Action plans will be developed with stakeholders in late spring/summer 2019.

Written Reports

Regional system progress is measured through written reports. The reports provide valuable information on the progress that regional implementation teams have with implementing and sustaining Family Guided Routines Based Intervention and caregiver coaching. In addition, the reports identify other evidence-based or promising practices that are taking place within early intervention in individual agencies (i.e., Primary Service Provider teaming). 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 used to continually improve the work.

Of the barriers being addressed regionally, the most common are: not enough time for teaming/collaboration; not enough time for internal coaches’ responsibilities; staff turnover/shortages; difficulty engaging occupational (OT), physical (PT) and speech therapists (SLPs) in FGRBI and coaching; increase in Child Abuse Prevention and Treatment Act (CAPTA) referrals; misunderstandings of primary service provider service delivery model, FGRBI, and perceived licensing requirements for OTs and PTs.
The most common barriers brought to the state-level implementation team in 2018 were the need for: supporting internal coaches; sharing data and information about FGRBI with Special Education Directors to increase understanding and buy-in, and messaging to get OTs and PTs on board with FGRBI and coaching. The State Work Team routinely reviews the written reports and works towards addressing these systemic barriers. During this past year, mini grants were awarded to help support internal coaches; information was shared at regularly scheduled special education directors' meetings; and work moves forward to address the persistent challenge of developing OT and PT understanding of best practices for infants, toddlers, and families serviced in early intervention.

Regional and State System Progress Summary

It is vital that attention be paid to infrastructure development as well as to training early intervention service providers to use evidence-based practice. 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 action plans 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, personnel/workforce, and accountability/quality improvement, plans are underway to complete the remaining self-assessments.

3. Stakeholder involvement in the SSIP evaluation

The stakeholder groups described in Section B2: Stakeholder Involvement in SSIP Implementation (pages 17-18) are the same groups that are involved in evaluation activities described throughout this report. In addition, individual providers are involved in evaluation through their self-assessment processes that are built into the FGRBI professional development and implementation activities. Florida State University's 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 and other stakeholder groups that need to be involved.

Throughout 2018 and into 2019, State Work Team members worked with the IDEA Data Center (IDC) for support in using data with stakeholders including participating in multiple webinars. Part C lead agency staff (coordinator, research analyst, monitoring/compliance consultant) joined The Early Childhood Data System (DaSy) Center's Building a Culture of Data Use Learning Community and participated in webinars. The Early Childhood Technical Assistance (ECTA) Center and the National Center for Systemic Improvement (NCSI) have also provided resources to assist in this area. 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 and improving the Early ACCESS early intervention system. This includes evaluation and data work.
D Data Quality Issues

1. Data limitations that affected reports of SSIP progress and achieving the SIMR

There are no concerns or limitations related to quality of the data used to report progress or results. Multiple measures that are both quantitative and qualitative are collected and used at all levels of evaluation. No single piece of data is used to assess progress of the desired changes 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 FGRBI trainings is a lot; adding pretest surveys could be overwhelming for families. This is taken into consideration and explains why there is no baseline data available for family measures.

If a selected measure would not answer an evaluation question, a replacement measure would be selected. Fortunately, this did not happen.

E. Progress Toward Achieving Intended Improvements

1. Assessment of progress toward achieving intended improvements

a) Infrastructure changes that support SSIP initiatives, including how system changes support achievement of the SIMR, sustainability, and scale-up

Changes to In-Service Training (Personnel/Workforce)

In 2018, one major change to the infrastructure was with in-service training, which is a part of the Personnel/Workforce Component of the ECTA System Framework. With the shift to accommodate the increasing needs of internal coaches, new structures were created as noted in previous sections of this report (e.g., FGRBI Internal Coach Portal, provider and coach competencies, manuals).

Additionally, annual video recordings from early interventionists trained in FGRBI has become an expectation. Each agency provides the Iowa Department of Education a list of trained providers during the Spring. Providers are then randomly sampled to submit a recording of an early intervention home visit to check fidelity of practice. (See next section on fidelity for details.)

Change in Partnerships (Governance)

A new partnership was initiated with a state institute of higher education in order to plan for a local system of in-service support for 2023 and beyond. Meetings will continue and plans will be created.
New Data Work Team (Accountability & Continuous Improvement; Data System)
In May 2018, Early ACCESS staff from the Iowa Department of Education created a Data Work Team as suggested by the Building a Culture of Data Use Learning Community (hosted by The Center for IDEA Early Childhood Data Systems with 13 states participating). The Data Work Team meets weekly specifically to address Part C data collection, analysis, use and dissemination. The purpose is to help Early ACCESS effectively use data in order to positively impact outcomes for families and children served in Iowa. The Data Work Team is a subgroup of, and reports to, the State Work Team where four state agencies routinely work together to support the early intervention system.

New IDEA Data System (Accountability & Continuous Improvement; Data System)
After being on pause for a few years, Iowa is moving forward with building a new IDEA data system. One goal for the Individualized Family Services Plan (IFSP) portion of the system is to align the data entry or "paperwork" process to the work flow. Another goal is to have improved IFSP data reporting capabilities.

All of these infrastructure changes support the use, scale up and sustainability of evidence-based practices which will lead to improved outcomes for families and children.

b) Evidence that evidence-based practices are being carried out with fidelity and having the desired effects
For the second consecutive year, Iowa measured the ongoing fidelity and sustainability of FGRBI among randomly selected early intervention providers who participated in past cohorts of FGRBI training. In Active Implementation Frameworks, full implementation occurs when over half of the intended practitioners are using the innovation with fidelity. Ensuring full implementation requires providers in Iowa to continue to use the practices learned during IA DMM beyond the length of the cohort in order to sustain and spread the innovation. Beginning in 2017, Iowa’s Early ACCESS program began to require the submission of video recorded home-based sessions as part of ongoing statewide fidelity measurement. The sections below describe how past cohorts of early intervention providers continue to implement the FGRBI Key Indicators in their practice.

FGRBI Key Indicators
Twenty-four providers representing area education agency regions across all cohorts participated in the 2018 sustainability review as part of the Iowa Early ACCESS Program’s efforts to ensure ongoing implementation of FGRBI. Providers were randomly selected from a pool of providers from all past cohorts. Each session was scored by independent coders for the FGRBI Key Indicators, routines, and coaching strategies. The FGRBI Key Indicators data is displayed below in two ways: first, means were obtained for the current 12-point scale and then on an earlier version of the Key Indicators that was used in Cohorts 1-4. Sessions are scored in two ways because some providers (Cohort 1 through Cohort 4) were not trained on the current version of the measure that was initiated in Cohort 5.
While it is too early to make full conclusions about the trends in the sustainability data, it is clear that the 2018 group scored higher than the 2017 group when measured in the two ways as noted above. If these increases continue, it will likely indicate that ongoing supports like internal coaching and agency-level professional development are enhancing the sustainability of the model. A strength of the sustainability data is that it is drawn from randomly selected providers, not volunteers. Providers and agency leaders are becoming aware that sustainability data will be gathered annually and it is becoming a part of common practice in Early ACCESS early intervention services.

Results

**Average Percentage Scores on FGRBI Key Indicators for Sustainability Videos**

An item-by-item analysis indicates the percentage of sessions in which an item was present among providers in the sustainability study. Providers used FGRBI Key Indicators 1, 2, 3, 6, 7, 8, 10 and 12 at levels in over 70% of the sessions. Less commonly used items include Indicator 4 (Making a plan for the session), Indicator 5 (Observation), Indicator 9 (Generalizing to new routines), and Indicator 11 (Measuring progress). This data can be useful in helping align continued supports to current practices among providers who are using FGRBI.

**Item by Item Analysis of FGRBI Key Indicators in the 2018 Sustainability Study**

An item-by-item analysis indicates the percentage of sessions in which an item was present among providers in the sustainability study. Providers used FGRBI Key Indicators 1, 2, 3, 6, 7, 8, 10 and 12 at levels in over 70% of the sessions. Less commonly used items include Indicator 4 (Making a plan for the session), Indicator 5 (Observation), Indicator 9 (Generalizing to new routines), and Indicator 11 (Measuring progress). This data can be useful in helping align continued supports to current practices among providers who are using FGRBI.
Percentage of Sessions in Which Each FGRBI Key Indicator (KI) was Observed Partially or Fully

Source: FGRBI Key Indicator Checklist from Random Sample Cohorts 1-5 early intervention providers

c) Outcomes regarding progress toward short-term and long-term objectives that are necessary steps toward achieving the SIMR

Early intervention providers have demonstrated increased provider proficiency in and use of coaching caregivers in FGRBI with increasing degrees of fidelity. The number of internal coaches has increased. Family participation in helping their child develop and learn and being proficient in the use of Caregiver Key Indicators is improving. Additionally, they have reported and discussed barriers and successes of integrating other evidence-based practices (i.e., Primary Service Provider teaming). These are all intermediate outcomes related to practice changes that will move Iowa closer to achieving the SIMR. (Increase the percentage of families reporting that Early ACCESS has helped them help their child develop and learn.)

Progress has been made towards achieving the following intermediate outcomes related to using evidence-based implementation processes:

- Active Implementation Stages, Drivers, and Improvement Cycles are carried out by skilled individuals with the expertise to help individuals, organizations, and systems successfully use evidence-based practices;
- Increased capacity for identifying, implementing, scaling up and sustaining evidence-based practices and programs for continuous improvement of the Early ACCESS system; and
- Increase in skilled providers who feel supported at multiple levels to use evidence-based practices.

Although progress has been made in each of these implementation intermediate outcomes, there is a long way to go before the expertise is firmly embedded within regional and state agencies. Using implementation science to guide the use, scale-up, and sustainability of evidence-based practices is complicated when dealing with statewide systems change. However, Iowa is moving forward in this work in order to move closer to achieving the SIMR.
The long-term infrastructure outcomes are to have an *Early ACCESS* system that encourages, supports and requires implementation of effective practices and is self-sustaining with adequate resources to address the needs of individuals and organizations in the system. This preferred future for Iowa's early intervention system is creeping closer as the focus remains on building high quality components of the ECTA System Framework. In 2018, a third self-assessment component was added and action plans will be created mid-2019. The goal is to address all components which will move the state nearer to the long-term outcomes that are necessary in order for Iowa to improve outcomes for families and children.

**d) Measurable improvements in the SIMR in relation to targets**

<table>
<thead>
<tr>
<th></th>
<th>FFY 2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Data</strong></td>
<td>84.91%</td>
<td>83.25%</td>
<td>86.35%</td>
<td>85.54%</td>
<td>87.95%</td>
</tr>
</tbody>
</table>

Source: GRADS360

Iowa’s State-Identified Measurable Result is OSEP Indicator 4C, *percent of families in Part C who report that early intervention services have helped the family help their children develop and learn*. Indicator C4 is measured by the ECO Family Outcomes Survey-Revised. The survey is distributed to all families within a short time from having an annual IFSP review.

Even though there has been improvement since baseline, the indicator data does not accurately reflect improvements based on the work reported in the State Systemic Improvement Plan. Only a small percentage of families surveyed are being served by early intervention providers who have been trained in FGRBI and caregiver coaching. The expectation is to meet the target once FGRBI and caregiver coaching practices are implemented statewide, with fidelity, by the majority of early intervention providers.

**F. Plans for Next Year**

**1. Additional activities to be implemented next year, with timeline**

A review of the logic model inputs, activities, outputs and outcomes by multiple stakeholders will take place next year. This could lead to changes in the improvement plans, evaluation plan and timelines. This will allow time to reflect on other areas of early intervention that need attention (e.g., child find, progress monitoring, Early Childhood Outcomes) and see how to incorporate them into the improvement plans and work load. There are no anticipated major changes.

Iowa will continue: training internal coaches; supporting implementation teams and the use of implementation science; and, developing and implementing plans associated with the Governance, Personnel/Workforce, and Accountability and Quality Improvement Components of the ECTA System Framework.
2. Planned evaluation activities including data collection, measures, and expected outcomes

Planned evaluation provided by Florida State University includes: Facebook and FGRBI Community of Practice analysis; FGRBI SS-OO-PP-RR Key Indicator annual sustainability, fidelity and reliability checks of early intervention service providers; family interviews; and surveys from trainee, provider and master coaches.

Planned evaluation provided by the area education agencies includes: observations/self-assessments of FGRBI SS-OO-PP-RR Key Indicators, coaching strategies, and routines used by three early intervention providers over two to three points in time.

Planned evaluation provided by the Iowa Department of Education includes two caregiver/parent surveys (Early Intervention Parenting Self-Efficacy Scale (EIPSES) and ECO Family Outcomes Survey) along with updated self-assessment scores for Governance and Personnel/Workforce.

Regional Implementation Teams will continue providing written reports. Notes from stakeholder meetings will document other regional and state implementation activities.

3. Anticipated barriers and steps to address those barriers

In the past, Florida State University (FSU) has provided the early intervention provider observation data. The area education agencies (AEA) will be collecting that for the first time as FSU moves their focus to building internal coaching capacity. Written fidelity and sustainability plans have been submitted by the AEAs which, in part, outlines how these data will be collected. Each agency is at a different place in their ability to implement FGRBI and the State Work Team members will have to monitor the plans and provide support to enable data collection to happen.

Caregiver Key Indicators will not be collected and analyzed this year since the area education agencies are now responsible for collecting the provider home visit videos and coding them. There is no internal capacity to do this part of the evaluation at the state or regional level. However, if an opportunity for a graduate student to do this through Florida State University arises, this data will be collected and analyzed for a third year.

4. The State describes any needs for additional support and/or technical assistance

Iowa looks forward to continued support from national technical assistance centers and the Office of Special Education Programs.
References


Appendices

Appendix A  Internal Coach Professional Development Sequence (page 45)
Appendix B  Internal Coach Roles and Responsibilities (page 47)
Appendix C  FGRBI Early Interventionist Competencies and FGRBI Internal Coach Competencies (page 48)
Appendix D  FGRBI Key Indicators Manual (page 57)
Internal Coach Professional Development Sequence

FGRBI Internal Coaches participate in a systematic, competency-based professional development sequence to ensure that they have the knowledge and skills essential to: a) engage families and apply FGRBI principles and practices in their home visits, b) coach peers implementing FGRBI to achieve and maintain fidelity, and c) offer professional development to other team members on the approach within their agencies. Using an evidence-based model of professional development, internal coaches continue to expand their skills through a technology-supported, relationship-based partnership with the internal coach network in their region, across the state, and with the external coaches at Florida State University to build capacity, confidence and leadership skills that will support their team and agency within the State Systemic Implementation Plan (SSIP).

There are many considerations for selecting coaches in addition to their previous successful DMM training. Internal coaches should have time available consistently in their assignment of duties. They should have a case load of their own and be a member of an Early ACCESS IFSP team. In addition, the AEA may want to consider geographical location, commitment to the agency, previous experiences that provide insight to diversity of perspectives, and interest in being a coach with their peers. It is difficult to identify the right qualities, but certainly excellent communication skills, ability to form relationships, expertise in early intervention, and a positive outlook on learning and change are essential.

We are proposing three levels of internal coaches in Iowa DMM: Trainee Coach, Provider Coach, and Master Coach. All levels of coaches will be reviewed for fidelity annually.

Trainee Coach

Trainee Coaches begin the professional development sequence with approximately 10+ months of training, practice, and feedback. Trainee Coaches demonstrate fidelity in their own home visiting practices and begin to gain knowledge and skills to support other providers through training and guided practices with external (and/or internal) coaches as identified. Trainee Coaches will also complete the online training sequence, review their own videos and receive feedback on their home visits using the Provider Competencies and FGRBI Key Indicators. At the end of their training period, they will be fluent with the Provider and the Coach Competencies and at 80% fidelity for the FGRBI Key Indicators and Coaching Protocol. If this criterion was not accomplished or the training in DMM was not completed, then they must be willing to participate in the online training sequence and be willing to submit additional videos for review until 80% fidelity is achieved. Individualized programs can be developed to address unique needs of the AEA’s.

Once fidelity is met, Trainee Coaches will complete the coaching sequence with 2-5 team members and meet fidelity with the coaching protocol. Then, with minimal supervision, they complete coaching to 80% fidelity with additional team members. A total of five experiences coaching team members to 80% fidelity is needed to become a Provider Coach.
Provider Coach

Provider Coaches will coach five additional team members to 80% fidelity for a total of 10 and have time allocated by the AEA to participate in the Provider Coach activities. In addition to coaching individual or multiple team members to fidelity, they will support others at team meetings, participate in TA or training activities with the Master Coach and be available to review sustainability videos annually. They will maintain fidelity of implementation for both coaching with caregivers and coaching peers. Provider Coaches lead the coaching for new team members across the agency and support review of skills for others as needed. Provider Coaches assist with or provide TA and training activities as determined by the AEA plan. They also coach other team members based on request or need. They maintain fidelity and assist with sustainability data collection annually.

Master Coach

In addition to coaching providers and supporting Trainees and other Provider Coaches, the Master Coach provides support to all Early ACCESS team members in their agency through team leadership, professional development and technical assistance. Master Coaches are prepared to independently coach their own trios/pairs/individuals and mentor other internal coaches in their agencies, have achieved reliability in scoring the FGRBI Key Indicators, and only need intermittent support to avoid drift from scoring the videos reliably using the rubric.

The movement from Provider to Master Coach is competency driven, can be accomplished on a flexible schedule, and is designed to ensure the integrity of the internal coaches within their agency. Master Coaches lead sustainability data collection, feedback reviews for team members with less than 80% fidelity and are responsible for inducting new Trainee Coaches. Only Master Coaches may support training of new internal coaches as trainees.

It is not mandatory for each Provider Coach to move to Master Coach. Rather, the needs of each region should determine the numbers and types of internal coaches available and supported at each level. We do believe it is important for Trainees Coaches to complete their sequence and achieve fidelity, so they are available as a Provider Coach within their region.

However, we appreciate that the amount of time allocated in the Trainee's work assignment to coach team members and the number of team members available to coach will impact the length of time to complete the required number of coaching experiences. Therefore, no specific timeline for completion is specified.
# Internal Coach Roles & Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Trainee</th>
<th>Provider</th>
<th>Master</th>
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</thead>
<tbody>
<tr>
<td>Demonstrate provider competencies, achieve and maintain fidelity of</td>
<td>Accomplished</td>
<td>Accomplished</td>
<td>Accomplished</td>
</tr>
<tr>
<td>FGRBI Key Indicators</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Develop and apply competence in coaching</td>
<td>Learner</td>
<td>Leader</td>
<td>Leader</td>
</tr>
<tr>
<td>Coach team members</td>
<td>Contributor</td>
<td>Contributor</td>
<td>Contributor</td>
</tr>
<tr>
<td>Provide professional development for agency</td>
<td>Collaborator</td>
<td>Leader</td>
<td></td>
</tr>
<tr>
<td>Collaborate with other internal coaches in agency</td>
<td>Contributor</td>
<td>Partner</td>
<td>Leader</td>
</tr>
<tr>
<td>Engage with internal coaches state wide</td>
<td>Collaborator</td>
<td>Leader</td>
<td></td>
</tr>
<tr>
<td>Provide and utilize data to demonstrate fidelity and sustainability</td>
<td>Partner</td>
<td>Leader</td>
<td></td>
</tr>
<tr>
<td>Induct new Trainee Coaches</td>
<td></td>
<td></td>
<td>2021</td>
</tr>
</tbody>
</table>

## Terms Key

- **Accomplished**: Meets requirements (80% fidelity)
- **Collaborator**: Supporting completion of specific activity or product, limited role often related to expertise
- **Leader**: Decision-making or dominant role over others or activities
- **Partner**: Joining in common activity, sharing effort
- **Learner**: Acquiring knowledge and skills
- **Contributor**: Completing assigned role as part of larger effort

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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.
**FGRBI Early Interventionist (EI) Competencies**

### Knowledge Competencies

*Effective EIs should demonstrate knowledge of:*

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Culturally responsive and reciprocal communication strategies to engage and inform families as partners in the early intervention process.</td>
</tr>
<tr>
<td>2.</td>
<td>Family-centered, family capacity building, and family-professional collaboration practices.</td>
</tr>
<tr>
<td>3.</td>
<td>Adult learning principles and practices relevant to Family Guided Routines Based Intervention.</td>
</tr>
<tr>
<td>4.</td>
<td>An evidence-based framework for implementation and intervention in the everyday routines, activities, and places prioritized by the family for the child.</td>
</tr>
<tr>
<td>5.</td>
<td>Developmentally appropriate, culturally relevant, and functional child and family outcomes.</td>
</tr>
<tr>
<td>6.</td>
<td>Evidence-informed environmental, interactional, and instructional practices focused on embedding intervention throughout the day.</td>
</tr>
<tr>
<td>7.</td>
<td>An evidence- and practice-based coaching framework flexible for diverse caregivers that includes coaching strategies useful for teaching and supporting caregivers to embed strategies (for example, direct teaching, guided practice with feedback, problem solving).</td>
</tr>
<tr>
<td>8.</td>
<td>Teaming practices that facilitate coordinated and collaborative communication and implementation of EI.</td>
</tr>
<tr>
<td>9.</td>
<td>Technology use to support caregiver and team communication and participation.</td>
</tr>
<tr>
<td>10.</td>
<td>Assessment and progress monitoring practices that support family and team-based decision making and transition.</td>
</tr>
</tbody>
</table>

### Application Competencies

*(Details for each of the 10 Application Competencies are on the following pages.)*

*Effective EIs should be able to:*

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Facilitate positive and productive communication exchanges with families.</td>
</tr>
<tr>
<td>2.</td>
<td>Promote family-centered, capacity building, and collaboration practices.</td>
</tr>
<tr>
<td>3.</td>
<td>Integrate adult learning principles into communication and coaching practices.</td>
</tr>
<tr>
<td>4.</td>
<td>Collaborate to identify everyday routines, activities and play prioritized by the family.</td>
</tr>
<tr>
<td>5.</td>
<td>Embed intervention on functional and meaningful child and family outcomes</td>
</tr>
<tr>
<td>6.</td>
<td>Identify and coach others (caregivers and team members) to apply evidence informed and contextually matched interventions for the child and family.</td>
</tr>
<tr>
<td>7.</td>
<td>Engage in coaching matched to caregiver support needs.</td>
</tr>
<tr>
<td>8.</td>
<td>Facilitate coordinated and collaborative teaming practices.</td>
</tr>
<tr>
<td>9.</td>
<td>Use technology to support child, family and team members to communicate and participate.</td>
</tr>
<tr>
<td>10.</td>
<td>Support family and team-based assessment and progress monitoring.</td>
</tr>
</tbody>
</table>
**Application Competencies with Details**

**Effective EIs should be able to:**

1. Facilitate positive and productive communication exchanges with families.
   - a. Interact with warm, positive regard, and encouragement (e.g., facial expressions, proximity, verbal invitations) to invite caregiver participation.
   - b. Listen with genuine interest and check for understanding to clarify caregiver’s reflections (e.g., active listening, rephrasing).
   - c. Comment or asks open-ended questions with ample response time (e.g., uses declarative statements, expansions of caregiver comments, reflective questions).
   - d. Validate the caregiver’s opinions and feelings (e.g., empathic listening, affirmations, perspective taking).
   - e. Address caregivers’ questions and concerns by encouraging reflection, joint problem solving, and by sharing information.
   - f. Reflect upon own opinions and personal values and how those beliefs influence the relationship between the provider, family and child.
   - g. Describe the evidence base, purpose, and key components of an early intervention approach that supports caregivers to provide embedded learning opportunities in everyday routines and activities.
   - h. Demonstrate and provides meaningful examples of the caregivers’ role in EI supporting their children’s learning.

2. Promote family-centered, capacity building, and collaboration practices.
   - a. Develop a trusting and respectful partnership with caregivers in early intervention process.
   - b. Start with and builds on what the family does, enjoys, and believes is important for their family.
   - c. Promote family and child interactions as primary contexts for learning (e.g., focus on parent-child interactions, involve siblings, provide video clips for grandma to see).
   - d. Help caregivers figure out ways to use their own resources (formal and informal supports) or access new/different resources or referrals to increase self-efficacy skills for family.
   - e. Share up-to-date, evidenced-based, non-biased parent education/information to support the family’s informed decision-making.
   - f. Tailor parenting knowledge and skill messages in ways that are flexible, individualized and respectful of the caregiver’s experiences and expertise.
   - g. Adjust EI plan in response to and out of respect for the family’s concerns, priorities, and changing life circumstances.
   - h. Notice and comment upon what caregivers are doing to support their child’s development to build their competence and confidence.

3. Integrate adult learning principles into communication and coaching practices.
   - a. Connect current discussions and information sharing to prior knowledge and experiences of each adult.
   - b. Incorporate family history, values, and experiences throughout interactions to help the family see the connections between what they are doing and their child’s learning.
   - c. Introduce developmental information or instructional strategies and provides authentic examples in context using formats preferred by adult.
   - d. Support/scaffold caregiver’s/family’s active participation and decision making in relevant activities.
Family Guided Routines Based Intervention (FGRBI) 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.

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<tbody>
<tr>
<td>e.</td>
<td>Increase or decrease support in response to the caregiver’s skill and familiarity with a strategy or routine ensuring adequate opportunities to practice (e.g., repetition) and maintenance of skill.</td>
</tr>
<tr>
<td>f.</td>
<td>Encourage caregiver to describe/review the key components of the intervention plan using their own materials, ideas, and sequence with the 5Q or other form of visual model.</td>
</tr>
<tr>
<td>g.</td>
<td>Use multiple methods of sharing information with the caregiver (written feedback, video reflection, live coaching, etc.) based on their learning preferences.</td>
</tr>
<tr>
<td>h.</td>
<td>Provide frequent opportunities to assess and self-assess learning including use of video reflection.</td>
</tr>
</tbody>
</table>

4. Collaborate to identify everyday routines, activities and play prioritized by the family.

| a. | Explain how naturally occurring routines, play and activities support learning for children and their caregivers throughout the day. |
| b. | Describe the caregiver’s role in the routine to support the child’s learning, engagement and participation. |
| c. | Collaboratively identify with caregivers their routines and play that are going well and those that are more difficult to address functional and meaningful learning targets. |
| d. | Collaboratively plan a variety of child and family interest-based activities, play, chores, caregiving, literacy and social routines with productive roles for the child to learn developmentally sensible skills. |
| e. | Plan with caregivers to ensure opportunities to embed intervention that promotes multiple learning opportunities repeated throughout the day to ensure sufficiency of practice for learning. |
| f. | Brainstorm other routines, activities and play times for their potential to increase opportunities for learning and generalizing skills that have been acquired. |
| g. | Expand routines and play across types of routines, places, people, and expectations for the child. |
| h. | Problem solve with caregiver on how to make informed decisions on which routines are the most effective and efficient (uses expansions and subroutines to increase/decrease time and opportunities as family needs). |

5. Embed intervention on functional and meaningful child and family outcomes.

<p>| a. | Share information on typical child development, learning differences, and disability to guide caregiver’s informed decision making on priority outcomes. |
| b. | Support caregivers and other team members to jointly identify developmentally sensible and meaningful and measurable outcomes aligned with family priorities for the child and family. |
| c. | Individualize outcomes, routines, and strategies to match priorities and needs of child/family. |
| d. | Ensure inclusion of measurable, functional criteria to use to review progress toward achieving IFSP outcomes. |
| e. | Use toys, materials, and interactions that promote interest and strengths-based learning. |
| f. | Review and expand the caregiver’s understanding of what and how to embed intervention on functional outcomes to support participation in everyday routines. |
| g. | Embed targets and strategies intentionally within identified routines, activities and play with sufficient repetition for learning. |
| h. | Follow rules for efficiency of embedded intervention by: |
|   | i. Embed enough but not too much- just right amount of targets and trials to balance practice opportunities with caregiver time and interest to complete routine. |
|   | ii. Make the least amount of change in the caregiver’s typical routine (maintain sequence) for the maximum impact (increased child opportunities). |
|   | iii. Use familiar routines to teach new skills and new routines to generalize learning. |</p>
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<thead>
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<tbody>
<tr>
<td>i.</td>
<td>Incorporate the child’s natural/incidental learning opportunities in addition to targeted routines.</td>
</tr>
<tr>
<td>j.</td>
<td>Identify and implement opportunities to enhance the child’s participation in community settings.</td>
</tr>
<tr>
<td>6.</td>
<td>Identify and coach others (caregivers and team members) to apply evidence informed and contextually matched interventions for the child and family.</td>
</tr>
<tr>
<td>a.</td>
<td>Collaborate with caregivers to arrange, modify and adapt the child’s environments to promote child’s access to and participation in learning experiences in activities and routines.</td>
</tr>
<tr>
<td>b.</td>
<td>Identify and discuss with caregiver options of interaction, communication and instructional strategies that promote child engagement and learning across developmental domains (e.g., cognition, motor, social communication, problem solving, and social emotional) with family and peers.</td>
</tr>
<tr>
<td>c.</td>
<td>Describe, demonstrate, and support caregiver use of interactional strategies with fidelity that encourages responsive interactions and reciprocity including: observing, joining in and expanding on the child’s focus, modeling, responding contingently, interpreting intentions, and providing natural consequences.</td>
</tr>
<tr>
<td>d.</td>
<td>Describe, demonstrate, and support caregiver use of communication strategies with fidelity that encourage verbal and nonverbal understanding and production by using gestures and language to label and expand on the child’s requests, needs, preferences, or interests, modeling and scaffolding gestures, vocalizations, words and combinations, and by responding contingently, interpreting, providing natural consequences.</td>
</tr>
<tr>
<td>e.</td>
<td>Describe, demonstrate, and support caregiver use of instructional strategies with fidelity that encourages participation and independence including: modeling, responding contingently, providing natural consequences, using wait time and prompting.</td>
</tr>
<tr>
<td>f.</td>
<td>Describe, demonstrate, and support caregiver ability to promote the child’s exploration of the environment, self-directed learning, self-regulation, and problem solving behavior by observing, interpreting, and scaffolding in routines, activities and play.</td>
</tr>
<tr>
<td>g.</td>
<td>Apply knowledge of current research and evidenced based practices to provide and demonstrate alternative intervention strategies for caregiver to choose and apply.</td>
</tr>
<tr>
<td>h.</td>
<td>Collaborate with caregivers on the introduction and use of Augmentative Alternative Communication (AAC).</td>
</tr>
<tr>
<td>i.</td>
<td>Coach caregivers to use explicit feedback and consequences to increase child engagement, play, and skills and to maintain appropriate levels of support for learning to continue.</td>
</tr>
<tr>
<td>j.</td>
<td>Use functional assessment and related prevention, promotion, and intervention strategies across environments to prevent and address challenging behavior.</td>
</tr>
<tr>
<td>k.</td>
<td>Adapt specific instructional strategies that are effective for dual language learners when teaching English to children with disabilities.</td>
</tr>
<tr>
<td>7.</td>
<td>Engage in coaching matched to caregiver support needs.</td>
</tr>
<tr>
<td>a.</td>
<td>Use a systematic coaching framework with adults that includes practice with repetition and reflection to support their learning.</td>
</tr>
<tr>
<td>b.</td>
<td>Describe and provide concrete examples to caregivers about the key components of an evidence- and practice-based coaching framework.</td>
</tr>
<tr>
<td>c.</td>
<td>Observe caregiver’s implementation of intervention strategies and provides supportive and constructive feedback.</td>
</tr>
<tr>
<td>d.</td>
<td>Use a variety of coaching strategies (direct teaching, demonstration with narration, guided practice, caregiver practice, problem solving and reflection) with fidelity to support caregiver learning and independent practice.</td>
</tr>
<tr>
<td>e.</td>
<td>Apply knowledge of current research and evidenced based practices to provide and demonstrate alternative intervention strategies for caregiver to choose and apply.</td>
</tr>
<tr>
<td>f.</td>
<td>Coach caregiver to use identified intervention strategies with fidelity within routines and play.</td>
</tr>
<tr>
<td>g.</td>
<td>Provide multiple opportunities within each session for the caregiver to reflect on practice, interpret impact and critically evaluate use.</td>
</tr>
<tr>
<td>h.</td>
<td>Problem solve with caregiver on what works and how targets, strategies and embedding could be expanded or revised to improve outcomes.</td>
</tr>
<tr>
<td>i.</td>
<td>Support caregiver to plan intervention that will occur between sessions.</td>
</tr>
<tr>
<td>j.</td>
<td>Encourage caregiver autonomy through information sharing, practice, reflection, problem solving, and review.</td>
</tr>
</tbody>
</table>

8. Facilitate coordinated and collaborative teaming practices.

| a. | Work with providers from multiple disciplines and the family as a team to support family participation, to plan and implement supports and services that meet the unique needs of each child and family, and to ensure the role of the family as decision maker. |
| b. | Encourage providers and families to work together as a team to systematically and regularly exchange expertise, knowledge, and information to build team capacity and jointly solve problems, plan, and implement interventions in a coordinated and collaborative manner. |
| c. | Use communication and group facilitation strategies to enhance team functioning and interpersonal relationships with and among team members. |
| d. | Collaborate with team members to discover and access community-based services and other informal and formal resources to meet family-identified child or family needs. |
| e. | Collaborate with family and team members to identify one practitioner from the team who serves as the primary liaison between the family and other team members based on child and family priorities and needs if a primary provider model is appropriate. |
| f. | Coordinate consultation as needed to ensure family and child have access to all team members when appropriate or important for information and decision making. |
| g. | Support use of systematic communication and documentation procedures including use of technology to support team meetings for each child and family. |

9. Use technology to support child, family and team members to communicate and participate.

| a. | Support caregiver’s participation in team meetings with other professionals using technology. |
| b. | Integrate the use of technology to support video reflection and modeling with caregivers and extended family participants. |
| c. | Participate in and shares online resources with caregivers to support learning for the child and family. |
| d. | Use technology such as video conferencing or telepractice to support caregiver and child opportunities for assessment, intervention and peer interaction. |
| e. | Work with families and other adults to identify each child’s and/or family needs for assistive technology to promote access to and participation in learning experiences. |

10. Support family and team-based assessment and progress monitoring.

<p>| a. | Share information about typical and atypical child development across developmental domains, learning differences and disability as appropriate for the family to make decisions regarding assessment and intervention planning. |
| b. | Include family in decisions about gathering assessment information including family information and the process to be used by the team. |</p>
<table>
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<tbody>
<tr>
<td>c.</td>
<td>Use assessment materials and strategies that are appropriate for the child’s age, development, and accommodate the child’s sensory, physical, communication, cultural, linguistic, social, and emotional characteristics.</td>
</tr>
<tr>
<td>d.</td>
<td>Use a variety of methods, including observation and interviews, to gather assessment information from multiple sources, including the child’s family and other significant individuals in the child’s life.</td>
</tr>
<tr>
<td>e.</td>
<td>Obtain information about the child’s participation and skills in daily activities, routines, and environments such as home, center, and community.</td>
</tr>
<tr>
<td>f.</td>
<td>Collaborate with family to gather and use data to inform decisions about outcome development and intervention.</td>
</tr>
<tr>
<td>g.</td>
<td>Implement systematic ongoing assessment to gather information to share with the family on learning targets, to plan activities, to monitor the child’s progress and to revise instruction as needed.</td>
</tr>
<tr>
<td>h.</td>
<td>Use assessment tools, including observation and family report, with sufficient sensitivity to detect child progress, especially for the child with significant support needs.</td>
</tr>
<tr>
<td>i.</td>
<td>Use the 5Q or family preferred visual model format so that family has the ability to “know when it is working” in their intervention throughout the day.</td>
</tr>
<tr>
<td>j.</td>
<td>Collaborate with family and team to develop data based, individualized transition plan using ongoing assessment information and family input.</td>
</tr>
</tbody>
</table>
# FGRBI Internal Coach Competencies
*(Includes Trainee, Provider and Master Coaches)*

## Knowledge Competencies

**Effective internal coaches demonstrate knowledge of:**

1. Culturally responsive and reciprocal communication strategies to engage and inform EI providers as adult learners.
2. Family-centered, family capacity building, and family-professional collaboration practices.
3. Adult learning principles and practices relevant to Family Guided Routines Based Intervention.
4. An evidence-based framework for implementation and intervention in the everyday routines, activities, and places prioritized by the family for the child.
5. Developmentally appropriate, culturally relevant, and functional child and family outcomes.
6. Evidence-informed environmental, interactional, and instructional practices focused on embedding intervention throughout the day.
7. An evidence- and practice-based coaching framework flexible for diverse caregivers that includes coaching strategies useful for teaching and supporting providers as well as caregivers (for example, direct teaching, guided practice with feedback, problem solving).
8. Teaming practices that facilitate coordinated and collaborative communication and implementation of EI.
9. Technology use to support provider, caregiver and team communication and participation.
10. Assessment and progress monitoring practices that support team-based decision-making and transition.

## Application Competencies

*(Details for each of the 8 Application Competencies are on the following pages.)*

**Effective internal coaches are able to:**

1. Describe FGRBI and the coaching framework using evidence and personal experience and demonstrate the SS-OO-PP-RR and 5Q components to providers, team members and administrators.
2. Facilitate positive and productive communication exchanges with providers and team members to develop a coaching plan.
3. Integrate adult learning principles into communication and coaching practices.
4. Coach providers to implement FGRBI and use the Key Indicators with fidelity.
5. Facilitate coordinated and collaborative communication among team members and agency leaders.
6. Use technology to support provider and team members to implement FGRBI with fidelity.
7. Provide professional development and technical assistance to providers, team members, and agency.
8. Reflect upon own opinions and personal values and how those beliefs influence the relationships between the provider, family and child and the provider and other team members.
<table>
<thead>
<tr>
<th>Application Competencies with Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective internal coaches are able to:</strong></td>
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<td>1. Describe FGRBI and the coaching framework using evidence and personal experience and demonstrate the SS-OO-PP-RR and 5Q components to providers, team members and administrators.</td>
</tr>
<tr>
<td>2. Facilitate positive and productive communication exchanges with providers and team members to develop a coaching plan.</td>
</tr>
<tr>
<td>a. Listen and check for understanding to clarify provider’s reflections (e.g., active listening, rephrasing) of their coaching plan.</td>
</tr>
<tr>
<td>b. Comment or ask open-ended questions with ample response time (e.g., expansions of provider comments, reflective questions/comments, joint problem solving) to facilitate provider participation.</td>
</tr>
<tr>
<td>c. Integrate the provider’s beliefs and feelings (e.g., empathic listening, affirmations, perspective taking) to develop a coaching plan “contextual” fit.</td>
</tr>
<tr>
<td>3. Integrate adult learning principles into communication and coaching practices.</td>
</tr>
<tr>
<td>a. Encourage the provider being coached to build on previous knowledge and experiences.</td>
</tr>
<tr>
<td>b. Use multiple methods of sharing information with the provider (written feedback, video reflection, live coaching, etc.) based on their learning preferences to provide new information and resources.</td>
</tr>
<tr>
<td>c. Provide frequent opportunities to assess and self-assess learning including use of video reflection.</td>
</tr>
<tr>
<td>4. Coach providers to implement FGRBI and use the Key Indicators with fidelity.</td>
</tr>
<tr>
<td>a. Observe provider’s implementation of home visiting practices and provide supportive and constructive feedback.</td>
</tr>
<tr>
<td>b. Use a variety of coaching strategies (direct teaching, demonstration with narration, guided practice, caregiver practice, problem solving and reflection) to support learning and independent practice.</td>
</tr>
<tr>
<td>c. Provide sufficient opportunities to practice and/or observe others using the coaching targets in their plan.</td>
</tr>
<tr>
<td>d. Provide multiple opportunities within each coaching feedback session for provider to reflect on practice, interpret impact, critically evaluate use and problem solve how to increase use.</td>
</tr>
<tr>
<td>e. Identify and discuss with provider options of interaction, communication and instructional strategies that promote child engagement and learning across developmental domains (e.g., cognition, motor, social communication, problem solving, and social emotional) with family and peers.</td>
</tr>
<tr>
<td>f. Identify and coach providers and team members to apply evidence informed and contextually matched embedded intervention specific to the child and family’s everyday routines.</td>
</tr>
<tr>
<td>5. Facilitate coordinated and collaborative communication among team members and agency leaders.</td>
</tr>
<tr>
<td>a. Encourage providers to work together as a team to systematically and regularly exchange expertise, knowledge, and information to build team capacity and jointly solve problems, plan, and implement interventions in a coordinated and collaborative manner.</td>
</tr>
<tr>
<td>b. Use communication and group facilitation strategies to enhance team functioning and interpersonal relationships with and among team members.</td>
</tr>
<tr>
<td>c. Support use of systematic communication and documentation procedures including use of technology to support team meetings and professional development.</td>
</tr>
<tr>
<td>6. Use technology to support provider and team members to implement FGRBI with fidelity.</td>
</tr>
<tr>
<td>a. Reliably identify and score the FGRBI Key Indicators, comment using Torsh TALENT and complete meaningful performance based and constructive feedback to providers/trios.</td>
</tr>
<tr>
<td>b. Lead feedback sessions and coach providers/trios using FGRBI Coaching protocol with fidelity both F-2-F and virtually.</td>
</tr>
<tr>
<td>7. Provide professional development and technical assistance to providers, team members, and agency.</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>a. Lead training activities using multiple types of learning objects (e.g. You Tube, Exemplar library) to increase understanding and use of FGRBI within agency and community.</td>
</tr>
<tr>
<td>b. Mentor trainee and provider coaches within agency to achieve and maintain fidelity of implementation for coaching families and other providers.</td>
</tr>
<tr>
<td>c. Participate in agency level activities to support implementation, data collection and sustainability.</td>
</tr>
<tr>
<td>8. Reflect upon own opinions and personal values and how those beliefs influence the relationships between the provider, family and child and the provider and other team members.</td>
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FGRBI
Key Indicators Manual
Family Guided Routines Based Intervention

Key Indicators Manual

Juliann Woods, PhD

Contributors to the development and research on FGRBI from Communication and Early Childhood Research and Practice (CEC-RAP) Center

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This manual will introduce you to the coaching process developed to support implementation of Family Guided Routines Based Intervention (FGRBI) for early intervention providers. The four components, Setting the Stage, Observation and Opportunities to Embed, Problem Solving and Planning, and Reflection and Review, identified by the acronym SS-OO-PP-RR, provide a framework for integrating the principles and practices of FGRBI within home visiting with family members and other caregivers (see Figure 1 for an illustration of the framework). Each SS-OO-PP-RR component is briefly described below to introduce you to the key indicators of the process.

### Setting the Stage (SS)

Setting the Stage is an important learning strategy for both children and adults. Setting the Stage prepares the learner for what will follow in the visit while linking new information to previous experiences. Adult learning research shows that introducing material before practicing the content is associated with better outcomes (Dunst & Trivette, 2009; National Research Council, 2000). Setting the Stage builds the parents' capacity as a decision-maker by actively engaging them to discuss priorities and plan for the session (Woods, Wilcox, Friedman, & Murch, 2011). Research also tells us that giving adults input into what they are learning increases their motivation and ability to acquire new skills (Knowles, Holton, & Swanson, 2005). Setting the Stage is an opportunity to gain both the caregiver's input and to preview strategies for learning.

### Observations & Opportunities to Embed (OO)

Observation occurs when the provider actively watches the caregiver and child interact in a routine without offering coaching or feedback. By stepping back to observe, the provider reminds caregivers that the goal of intervention is to support their interactions with the child. The caregiver leads the routine/activity with the child, allowing the provider to assess how consistently and accurately the caregiver uses evidence based (EB) intervention strategies and how the child responds. The provider uses the information to build on strategies the parent is already using and to identify additional interaction and intervention strategies that will have the greatest impact on child outcomes while minimizing change to family routines.

Opportunities to Embed targets using strategies in real-world contexts with coaching from the provider are essential to the parent’s ability to independently use teaching strategies with the child. As adult learners, parents benefit from repetition, explicit feedback in the context in which they are learning, and supports that decrease as they become more comfortable and skilled using a new strategy (Kemp & Turnbull, 2014; Woods, Wilcox, Friedman & Murch, 2011). Opportunities to Embed enhance the caregiver’s competence and increase interaction with the child. In this component, the provider intentionally and systematically arranges for caregivers to embed EB strategies in routines and activities with their child. The provider also directs the caregiver’s attention to the child’s responses. The provider’s role and the coaching strategies used will vary across routines and child outcomes. However, there should be multiple opportunities for the caregiver and child to interact and receive coaching and feedback during each routine and multiple routines in each visit.
Problem Solving and Planning (PP)

Problem Solving refers to a verbal exchange between the parent and provider that serves to gather information, discuss and evaluate the ideas and options with the intention to develop or revise an action Plan. Problem Solving is not an exchange unique to a “problem” or challenging situation. It is a coaching strategy that encourages caregivers to think and talk about what they are doing and how the child is learning with the intention to improve or increase participation. When Problem Solving, caregivers share their knowledge of the child, their priorities, and their experiences of what works best for their family. The caregiver also gains new information by brainstorming options, discussing the pros and cons of the possibilities, and formulating plans with the provider. Taking the ideas generated and forming specific plans encourages caregivers to act on their decisions.

Both Problem Solving and Planning use the parent’s metacognitive skills, that is their ability to think and talk about what they are learning and doing (Knowles, Holton, & Swanson, 2005). Guiding adults use of reflection and evaluation of their child’s targets, intervention strategies, and routines or activities helps increase their ability to use, retain, and generalize new skills (Dunst & Trivette, 2009). In this component, the focus is on ensuring there is a match between the intervention strategies the caregiver is using to embed the intervention, the child’s targets, and the routines and activities. Problem Solving throughout the session, but especially at the end of each routine and prior to the provider’s departure, offers opportunities to try out the plan to ensure the caregiver is competent and confident in its feasibility. Planning provides support for deliberate and systematic practice throughout the family’s daily activities as they occur (NRC, 2000).

Reflection and Review (RR)

Reflection and Review are inter-related. We encourage the use of Reflection to inform the review process. Reflection is a useful coaching strategy to encourage caregivers to think and talk about what they are seeing and doing with their child to intentionally support learning. Reflection builds confidence and autonomy when the provider supports the caregiver through open-ended questions and encouraging comments to discuss what has worked, what is happening now, and what the caregiver wants to do next. Reflection is key to caregivers understanding of their own knowledge and skills as they build capacity for participation in both child and family outcomes.

Review is important for adult learners (Dunst & Trivette, 2009). When Reviewing, caregivers repeat what they have discussed, practiced, and experienced during the home visit. This helps them organize knowledge in their own authentic framework to facilitate retrieval and application. The provider listens carefully to the caregiver’s descriptions and provides additional support as needed. Reviewing ensures the caregiver and provider are on the “same page” about family priorities, what will occur between visits and what the plan is for the next visit. The process clarifies the plan and helps the caregiver retain and systematize what, how, when and where the intervention will occur during throughout the day.

When caregivers lead the Review process rather than the provider, they are able to relate it to their everyday experiences. They can describe how they participate and how they will know the intervention is working as their child participates. Review supports the caregivers’ retention of the information and their commitment to action (Knight, 2009).
## Implementing FGRBI using SS-OO-PP-RR Coaching

<table>
<thead>
<tr>
<th>Setting the Stage</th>
<th>Everyday Routines, Activities, and Places</th>
<th>Functional, Participation Based Outcomes</th>
<th>Embedded, Evidence-Based (EB) Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to the family as they share updates, ideas, and identify their choices and priorities for the visit.</td>
<td>Establish the value of family identified routines, activities, places, and partners to support learning.</td>
<td>Prioritize caregiver and child’s functional outcomes that support meaningful participation.</td>
<td>Discuss EB strategies that are working well, pros and cons of others to try, and how and when to embed them.</td>
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</table>

<table>
<thead>
<tr>
<th>Observation and Opportunities to Embed</th>
<th>Discuss and observe what the family does, how they do it, what they enjoy, and what they believe is important and relevant for their plan.</th>
<th>Observe the caregiver-child participating in routines and identify opportunities for embedding and repetition for practice.</th>
<th>Coach caregiver to increase participation on identified targets and measurable steps to increase engagement and independence.</th>
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<tbody>
<tr>
<td>Coach caregiver to use EB strategies which match the child's learning and promotes caregivers' ability to teach new skills and support child participation.</td>
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<tr>
<th>Problem Solving and Planning</th>
<th>Problem solve and engage in planning for the caregivers’ current priorities and the next steps between visits.</th>
<th>Brainstorm how to expand participation in current routines meaningful to the family.</th>
<th>Discuss what is working (and not) for the child and caregiver and discuss steps to revise or expand participation.</th>
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<tbody>
<tr>
<td>Promote caregiver decision-making on systematic use of EB strategies in each routine and throughout the day.</td>
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<tr>
<th>Reflection and Review</th>
<th>Reflect/Review with caregiver on strengths and possible challenges if plan matches their priorities, and additional supports needed, if any.</th>
<th>Review plan for expansion to new, diverse routines with other partners or places for generalization.</th>
<th>Reflect/Review action plan linking current targets/skills to long range outcomes. Review sufficiency of support for learning.</th>
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<tbody>
<tr>
<td>Review/Reflect on how the strategies are working and what the backup plan should be if needed.</td>
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Figure 1. Implementing FGRBI using SS-OO-PP-RR Coaching
### Setting the Stage

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<th></th>
<th>Yes</th>
<th>Partial</th>
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<tbody>
<tr>
<td>1.</td>
<td>Gathers updates on child and family - listens and encourages caregiver reflection</td>
<td></td>
<td></td>
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<tr>
<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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<tr>
<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>
<td>5.</td>
<td>Observes caregiver child interaction in routines - provides feedback and builds on dyad strengths</td>
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<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 (This indicator is repeated multiple times in 2 or more different routine categories)</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 (This indicator is repeated multiple times throughout session using both general and specific feedback for child and caregiver)</td>
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### Problem Solving and Planning

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<tbody>
<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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<td>9.</td>
<td>Supports caregiver to identify opportunities for embedding in additional contexts/ routines - plans when, where, how to embed</td>
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### Reflection and Review

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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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<tr>
<td>12.</td>
<td>Engages caregiver to lead development of a “best plan of action” for embedding intervention in multiple routines and activities throughout the day - facilitates caregiver leadership and decision making</td>
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### Provider Reflection

**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?**

*Figure 2. FGRBI Key Indicators Checklist*
Gathering child and family updates is often a comfortable and respectful starting place for a home visit. It builds or reinforces a partnership between the parent and provider. During gathering updates, general information about the family’s well-being as well as child information is shared. The parent is an active initiator and contributor leading the interaction by sharing recent and relevant information with the provider who is an active listener. The provider gains insights to guide further conversation and information sharing while establishing the caregiver’s leadership role in the relationship.

Examples of Indicator 1.

• “How was your visit to grandma’s this week?”
• “Arianna had her 15-month check-up, how did that go?”
• “I’m excited to see you. Catch me up on what’s happening.”

Considerations for Indicator 1.

For families new to the EI program, you may need to explain why you are asking questions and why they are important to support their understanding of the process and their role.

When a caregiver and child are already busy when you arrive, you may join in the interaction and start a conversation while gathering updates.

You may use the previous session notes to follow up on things that may have happened (e.g., doctor’s appointments, birthday parties, travels).

It is important to gather information each session. Providers should be flexible if the family identifies new priorities or shares concerns. Family circumstances change and it is essential to be supportive.

### Setting the Stage

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<th>Yes</th>
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<tbody>
<tr>
<td>1. Gathers updates on child and family - listens and encourages caregiver reflection</td>
<td>Score yes if provider asks and parent responds (or if parent initiates).</td>
<td>Score partial if provider asks, does not get a response and does not follow up.</td>
<td>Score no if there is not a clear request for updates.</td>
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</tbody>
</table>
Asks caregiver to update intervention implementation since last visit - listens, encourages caregiver reflection and sets up problem solving as needed

Learning more about the child and family’s participation in everyday routines and activities in the plan they developed sets the stage for deciding what to do during the current visit. The provider gathers information on the parent and child’s opportunities to embed learning targets in routines and activities, what worked, didn’t or wasn’t tried, which strategies were most helpful, and what else the family enjoyed. The provider encourages the caregiver to share ideas, questions, and ideas about what should come next as they review child and family outcomes.

Examples of Indicator 2.

- “Last week you waited before giving Carlos more apples at snack so he could ask for another one. How did you use wait time this week?”
- “You said you wanted to create more opportunities for Arianna to practice rolling. What did you try? How did it go?”
- “I am watching Carlos help you pick up the blocks. That’s new! How did you manage that?”
- “How’s the new stroller? Did you try any community outings? How did it work to use the blanket rolls to stabilize his seating?”
- “How did Sebastian amaze you this week?”
- “I’m listening to the list of routines you tried this week. Are there any that you want to talk about?”

Looks Like

Sharing a story about bath time with big sister when Abby watched and imitated everything Sissy did including splashing water out of the tub! Provider smiles and asks Mom, “What do you think made it go so well?”

Problem solving with dad on how to use place favorite toys in the environment to encourage Arianna to increase the frequency of her rolling.

Holding Carlos in her lap while Mom plays a pat-a-cake game and tells you what they have been working on this week.

Doesn’t Look Like

Asking for updates on homework or asking rapid-fire yes/no questions (e.g., “Did you try the new bottle?” “Did you go to the park everyday like you planned?” “Did you remember to visit the day care?”) to get your notes taken.

Listening to the caregiver share the new words Abby said and responding with “That’s nice, now let’s read this book” rather than encouraging mom to talk about what strategies she used to help.

Responding with comments that close a conversation rather than showing respect for caregiver’s efforts (e.g., “Maybe next week you’ll have more time.”)
Considerations for Indicator 2.

Building a relationship takes time. Sometimes simply asking how the strategy or plan went from last week may be enough to start a conversation. Other times follow-up comments or questions can encourage the caregiver to share more or give examples. Sometimes when a parent is tired or busy, it is simply hard to remember. Offer support or suggestions to trigger the caregiver’s memory.

Asking the family about intervention implementation sends the message you believe in them and it reaffirms their role in supporting their child. Providers who assume the family is “too overwhelmed” to help their child do not give the family opportunities to build their capacity. It is important for the family to decide what information they want to share with you. Respect their decision, but always ask.

Sharing personal or family information may be uncomfortable for some caregivers. Others may not be sure what they should share. Asking general questions and following up with ones more focused to the intervention may increase the caregivers’ comfort and help them decide what they want to share. The providers be conversational and non-confrontational in the requests and comments.

Life happens for all of us; family or friends may visit unexpectedly, the car breaks down, and kids get sick. Plans change. It is important to use this time during the visit reflecting with caregivers on what they did do rather than pointing out what they didn’t. Following up with reflection questions and problem solving gives caregivers an opportunity to identify strategies to use the next time when plans do not go as anticipated.

Listening about what worked or didn’t as the caregiver shares the updates informs providers about possible places, times, or materials to adapt in the environment to increase participation. It is also a good time to discuss or brainstorm ideas for any environmental arrangements or adaptations that could support learning.

Updates may lead to ideas for new family and child outcomes. Be sure to listen closely to the caregiver and capture their interests, wishes, or ideas that come from the discussion. The information can be valuable for future planning.

Updates may also lead to opportunities to share additional information or resources enabling the provider to move the exchange from update to the discussion of priorities naturally.

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<tr>
<td>2. Asks caregiver to update intervention implementation since last visit - listens, encourages caregiver reflection and sets up problem solving as needed</td>
<td>Score yes if provider asks or makes comments and parent responds with update on targets, routines, or strategies.</td>
<td>Score partial if provider asks, and follows up with another prompt but still does not get a response OR if parent’s response is not specific and provider does not follow-up.</td>
<td>Score no if there is not a clear request for updates related to intervention implementation.</td>
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</table>
Shares information related to development and family interests - connects learning targets to functional outcomes and IFSP priorities to increase caregiver knowledge and resources

The provider and caregiver discuss the family priorities and why they are important. Sharing specific developmental information, making connections to the child’s current learning targets, talking about where he/she started, and discussing next steps provides important information to the family in the moment. Revisiting the child outcomes on the IFSP and encouraging reflection on his/her current status can help to maintain focus for the intervention and identify specific learning targets for the session. Reviewing previous plans also reinforces the connections between what should happen during the visit to support the family’s priorities.

Examples of Indicator 3.

- “At the last IFSP meeting, you mentioned wanting Arianna to communicate so that her needs are met. How do you think her new gestures are helping her do that?”
- “You said that Caleb had a great time picking up beans off his high chair tray and feeding himself. Are you ready to try foods with more texture?”
- “Can you see how the sounds and signs are helping him get his needs met? When Carlos reaches and vocalizes, he lets you know he wants more. He’s communicating! With more practice, his sounds will become words.”
- “Bayley’s IFSP outcome is to help out with morning routines so she gets ready for child care in a good mood. You shared she helps with getting dressed and packing her diaper bag, but eating breakfast ruins the good start. Can you tell me more? Would you like to focus on just breakfast?”

Looks Like

Encouraging the caregiver to understand and interpret the child’s skills as they develop (e.g., “Did you notice how Arianna looked to see if you were watching her drop her cookie on the floor? That tells you she is interested in getting your attention, an important part of being able to communicate with others! What do you think about that?”)

Supporting the teaching and learning relationship between the child and caregiver by offering developmental information, materials, or suggestions related to the routine that link to long-term outcomes and priorities (e.g., “You mentioned that the tooth brushing routine can be a challenge. If we focus on that and make some progress, it could help make getting ready for bed much less stressful. What do you think?”)

Doesn’t Look Like

Giving developmental information that contains jargon, overly technical terms, or is delivered in an “expert” way that does not connect to the family’s goals (e.g., “CP kids often have trouble with abduction and are not as likely to crawl with alternating arm and leg movements.”)

Asking general questions that are difficult to answer or appear to not encourage the caregiver to respond (e.g., “Do you have any questions about Ricardo’s development before we get started?”)
Considerations for Indicator 3.

Knowledge of child development varies widely in families based on experience, interest, and education. Informal and formal information supports also vary. A key role for the provider is offering “just enough” information for caregivers at the “right time” and encouraging them to think about it and use it in ways that support the child and family.

Caregivers are adult learners. Providers should be prepared to scaffold for families to support their ability to make choices and decisions. Sharing developmental checklists to illustrate the child’s learning or sharing a video of the child using new skills can help the caregiver understand what the child is doing now and what is coming next. Adult learners benefit from having information shared in multiple formats like written materials, videos, or other media.

Many families identify walking and talking as priorities without knowing the sequence or steps of development that their child will need to reach this outcome. Providing developmental information helps families celebrate learning specific targets that will help achieve the child’s bigger outcomes. Little steps mean so much! Sharing information frequently helps families plan their next steps.

Family priorities change and should be checked regularly to enhance the family’s active participation and ensure the provider is in tune with the family’s interests. The more meaningful and relevant the learning targets and routines are, the more the child and family can engage and participate in their typical day.

Sharing information about high impact developmental outcomes (i.e., those learning targets that promote child engagement and learning overall) helps families make informed decisions about their priorities. Sharing information on social-emotional development, self-regulation, communication, problem solving, and adaptive skills gives caregivers opportunities to understand their child now and how to plan for the future.

Functional, meaningful child and family outcomes are developed in partnership as caregivers gain knowledge and skills to make informed decisions. Opportunities to discuss “why” targets, strategies, and routines are important to increase the family member’s ability to make choices about priorities and next steps.

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<tbody>
<tr>
<td>3. Shares information related to development and family interests - connects learning targets to functional outcomes and IFSP priorities to increase caregiver knowledge and resources</td>
<td>Score yes if provider expands on what parent describes in update by sharing developmental information and initiates a connection about a target to functional outcomes or to IFSP or long-term goals.</td>
<td>Score partial if provider refers to the IFSP or long-term goals but does not specifically add developmental information or rationale for the targets, routines, or strategies OR if the provider provides developmental information not linked to IFSP priorities/session targets.</td>
<td>Score no if IFSP, functional outcomes, or long-term goals are not discussed and related to current targets, routines, strategies.</td>
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</table>
Building consensus on the session plan at the outset focuses the intervention on the family priorities. The provider and caregiver summarize or restate the targets and strategies for each routine or activity to ensure they are on the same page. Developing a clear “game plan” helps preview what will happen for the parent as a learner and primes them to think about how they will use the identified strategies in their routines. This is an opportunity for the provider to ensure the parent’s understanding of the specific learning targets and strategies to embed in the routines during the visit.

Examples of Indicator 4.

- Mom says, “I want to have her finish breakfast and then get dressed without a meltdown. I’ll describe what we are doing and show her the pictures. Then she can pick what she wants to play and we can take turns.”

- Provider says, “I think I heard you say that you want to start with her favorite books so she uses her new words. Then she will walk to the sink with you using one handed support to wash her hands and back to the high chair for snack. You are going to give her choices to label in both routines.”

- “Rolling the ball back and forth, putting the toys in the bucket, pulling the clothes out of the dryer are the times you expect him to participate by taking turns with you, picking up objects and putting them somewhere else, right?”

- “Today we will go outside in the yard with his brothers and play in the sandbox, share, scoop, talk and just have fun. We’re going to play too. Yay!”

Looks Like

Helping caregivers make decisions about what takes place and when in the session (e.g., “You mentioned wanting to help Arianna pick up and hold objects in her hands more when you are playing. What do you want to do first, play or have lunch? What materials do we need?”)

Specifying the how and what as well as where and when to embed it so the caregiver is ready for the routine (e.g., “Hank will choose the book. You will ask him what he wants and expect him to respond you start. After he names it, add a word so he hears two words back.”)

Doesn’t Look Like

Asking questions that confirm the provider’s agenda (e.g., “How about we play in the living room and work with his puzzles? That worked well last week and they are laying right over there.”)

Engaging in provider led discussions that focus on child skills or therapeutic interventions that do not occur in the context of a routine (e.g., “Billie will walk with 2 handed support for 3 feet on 2 of 3 trials.”)
Considerations for Indicator 4.

Embedding intervention includes the targets, strategies, routines, and repetitions necessary for learning. Caregivers must have this information to be able to participate and gain competence. Broad outcomes like learning to talk or walking with balance hide the many smaller skills the child usually needs to learn prior to mastering the goal. Family members benefit from identifying specific learning targets that they can see, support, and then identify when the child is using them functionally. Rather than working on multiple gestures, signs, and words at the same time, the caregiver can learn the one or two specific learning targets to use in actual routines and activities to increase participation. For example, the child names milk and cookie at snack rather than colors or animals.

When getting started, it may be easiest to focus on one or two features of the embedded intervention until the caregiver is comfortable. Always start with the child or caregiver’s target(s). What the child or caregiver is supposed to do must be clear. Be specific. “Cara is going to grasp her sock at the toes and pull it off.” “Juan is going to raise his arms to signal he wants to be picked up.” Once the target is clear, you can add the intervention strategy. “You are going to look right at Juan and wait for him to reach up to you to be picked up.” New strategies or routines can be added as the caregiver practices the routines during the session.

It may be helpful for some caregivers to break the information down by steps in the routine sequence. Others may want to identify the what (target), when (times), where (routine location), and how (teaching strategy).

Using reflection and problem solving during or immediately following each routine provides an opportunity to review the specific targets and strategies, to expand or adapt their use, and to increase the frequency of opportunities to embed if appropriate.

It may feel obvious to the caregiver and provider what is going to happen during practice and not necessary to name the specific features to embed, especially when it is a familiar activity. However, clarifying only takes a few seconds and is a great reminder to be intentional and deliberate when embedding the intervention into functional routines. Taking it for granted may decrease the feedback that the child or caregiver receives that is essential for maintenance and generalization.

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<tr>
<td>4. Clarifies session targets, strategies, and routines jointly - facilitates caregiver participation and decision making in the discussion</td>
<td>Score yes if parent and provider discuss what, when, and how to embed intervention (must have at least target and routines to count).</td>
<td>Score partial if provider leads the discussion of what, when/where, and how OR only some of the specifics are discussed by parent and provider.</td>
<td>Score no if it does not occur OR if the provider makes the statements without parent input.</td>
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Observation and Opportunities to Embed

5

Observes caregiver child interaction in routines - provides feedback and builds on dyad strengths

The provider observes a routine or activity that the caregiver has identified as important or interesting to learn what the caregiver and child are doing and to build on what is working well for the child and caregiver. The provider sets up the observation with the parent (“Why don’t I just watch to see what happens while Sammy gets dressed?”) and watches without interruption. The provider offers feedback on the child’s use of target skills, parent’s use of strategies that make the interaction positive, or the potential for learning in the routine. Observation should always occur before coaching a new routine or a new target in a familiar routine to identify potential strategies and opportunities to embed.

Examples of Indicator 5.

- “Let me watch to learn how you wash his hands at the sink. I don’t want to make suggestions without knowing what you do.
- “I’m going to see how she responds when you try helping her roll half way over. I can learn by watching what she does and how you help her.”
- “Show me how you have snack. Then we can chat about what else you might want to try.”
- “You mentioned a fun tickle game you do with her. Can you show me what that looks like?”
- “When I watch a routine or play time, I learn what Jing Mei is doing with your help. That helps me learn about what’s working and what we can consider next.”

looks like

Positioning self for easy observation—without interrupting or intruding upon the dyad’s interactions or participation (e.g., “I’ll watch while you help him get dressed and then we can talk about what you think he could learn.”)

Helping the caregiver identify current routines, activities, and preferred play times that have potential to be meaningful opportunities for embedding intervention and then observing them.

Observing naturally occurring routines, making note of key components such as the beginning and ending of the activity, opportunities for repetition, opportunities for joint attention, the outcome/purpose of routine, and then sharing the information with the caregiver as feedback.

Doesn’t Look Like

Playing or practicing with the child while the parent observes you (e.g., child directed intervention.)

Telling the caregiver you want to watch snack, dressing, etc., so you can make recommendations about how the routine could be improved.

Observing without connecting child and family behaviors to goals/outcomes (e.g., just watching the family) or family strengths and child interests (e.g., not providing feedback on what the caregiver is doing well.)
Considerations for Indicator 5.

It is important to explain the purpose of observation to caregivers before you begin. Caregivers may feel a bit uncomfortable being watched and may even change how they would typically interact without an understanding of the purpose and the value. It may be helpful to have a few explanations ready like, “I’m just going to watch you wash hands to see how the routine typically happens” or “Let me watch and see what he does when you give him a choice.”

Observations can be brief, such as when the parent picks the child up from the floor or during a diaper change, but should always include feedback. Feedback on what the provider saw the parent do that supported the interaction helps to build the caregiver’s confidence and can decrease concerns about being observed.

For example, a caregiver who seems shy or reluctant to participate can be observed holding the child and playing with him when the provider enters the home. Commenting on how Dad held Dion upright so he could see who was coming and how Dad gave Dion a turn to say “Hi!”, can be an example of the importance of observation. The provider gave Dad feedback on what he was doing, explained why it was important, how it helped him, and then was ready to explore where else holding Dion upright and taking turns could be incorporated into their day. Dad also heard what he was doing that was helping his son and how to expand it to teach more skills.

Incidental observations may offer more information about family routines. For instance, a child’s sticky hands may lead to another observation, this time with hand washing. It provides opportunities for feedback, problem solving, and planning.

Using previous examples of observation can encourage caregivers to try new or more challenging routines. For example, “Remember when I watched you with dressing and then we brainstormed ideas to help make it easier for him to do it himself? How about I step back and watch you get him into the car seat so we can brainstorm again.”

Observation helps the provider shift leadership to the caregiver. It gives the provider time to learn about the child’s engagement and participation. It keeps the provider in the background to listen and learn about what strategies the caregiver uses and how the child responds.

For routines that are not easy to observe, you can ask for a video that you can watch together and discuss.

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<thead>
<tr>
<th>Observation &amp; Opportunities</th>
<th>Yes</th>
<th>Partial</th>
<th>Not Observed</th>
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<tbody>
<tr>
<td>5. Observes caregiver child interaction in routines - provides feedback and builds on dyad strengths</td>
<td>Score yes if provider intentionally observes routine(s) identified by parent AND provides strengths-based feedback.</td>
<td>Score partial is provider observes but does not provide strengths-based feedback OR observes only non-targeted routines OR observes for less than 20 seconds.</td>
<td>Score no if intentional observation with feedback is not observed for at least 20 seconds.</td>
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Coaching is individualized to the learning preferences of the caregiver and the outcomes of the child. The provider engages the caregiver using a variety of adult learning strategies in coaching. The provider seeks to build on the caregiver’s strengths and the child’s interests. Expanding on the caregiver’s ideas can increase competence and confidence and expand opportunities for the child. Anytime that a strategy is suggested or used by the caregiver, the provider considers if and how it can be incorporated to support the child’s learning. Just as intervention is systematic for the child, coaching must support the caregiver’s acquisition of knowledge and skills in a systematic approach with sufficient repetition.

**Examples of Indicator 6.**

- “Malik seems to really like this ball when you roll it back and forth. See his smile and the way he leans forward into the action. Let’s move it over here, just out of his reach, to see if he will reach or even crawl for it.” *(Guided Practice)*

- “Do you think you could try picking him up and waiting until he looks at you, lifts his arms in the air, or vocalizes?” *(Direct Teaching)*

- “Watch me help Harper roll over. First, I position her on her side and bring her leg over just a little so gravity helps. Then I wait and talk to her to encourage her to finish the job. See, here she comes. Are you ready to try?” *(Demonstration with Narration & Caregiver Practice)*

**Looks Like**

Demonstrating and explaining a strategy and then asking the parent to join you to practice (e.g., showing Mom the right distance to hold the toy for the child to be successful in reaching to grasp, and then giving Mom an opportunity to try.)

Using a variety of strategies matched to the caregiver’s learning preferences (e.g., demonstrating first and then explaining step by step as the parent tries it with the child; observing the parent first and then using guided practice to help fine tune what the caregiver does; starting with reflection on what the caregiver has tried before and brainstorming what to try next before engaging the child.)

Incorporating coaching strategies, then gradually reducing the support to the caregivers so they can practice and gain confidence in their ability.

**Doesn’t Look Like**

Providing a list of opportunities the caregiver could use between visits to work with the child (e.g., “You can work on making choices at snack, getting dressed, at bath time, and with blocks or puzzles.”)

Demonstrating a strategy for the caregiver, but then forgetting to turn the interaction back over to them to practice and see if it works for the caregiver.

Only offering feedback about the child’s behaviors, and not pointing out how the caregiver’s strategy relates to the child’s response, building caregiver confidence.
Considerations for Indicator 6.

Adults have different learning preferences and use various strategies to support their learning. The provider’s coaching must address the individual needs of each caregiver and recognize that the caregiver’s rate of learning will vary. Some caregivers will be anxious to learn to support their child and engage immediately while others will be unaware of their role or feel insecure in their abilities. The provider must meet caregivers where they are and be ready to support them.

Coaching strategies should be used that promote caregiver leadership and mastery. The goal in coaching is for the caregivers to be independent and fluent in their use of strategies. In order to do that, they need multiple practice opportunities in a variety of routines that increases their ability to use strategies.

Because caregivers learn through active participation, the majority of the home visit should be spent coaching caregivers in various routines, problem solving, and reflecting on the best strategies setting the stage to set up routines to observe and practice throughout the visit.

To support the caregiver’s learning, the use of a systematic learning cycle can be helpful. Teach the caregiver about the strategy, demonstrate and explain, guide the caregiver’s practice to support them taking over, and gaining skill and then pull back for the caregiver to practice independently. The provider should start in the cycle at the parents level and reduce support as the caregiver gains confidence and competence. Using reflection and problem solving throughout the teaching cycle enhances the family’s active participation and ownership in the routines based intervention.

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<tr>
<td>6. Uses coaching strategies, matched to caregiver and child behaviors as caregiver embeds intervention in routine - scaffolds and repeats to build competence and confidence (This indicator is repeated multiple times in 2 or more different routine categories)</td>
<td>Score yes if provider matches coaching strategy caregiver (using teaching cycle) AND decreases support to promote caregiver independence in the routine AND uses coaching strategies at least twice during each of 2 routine categories.</td>
<td>Score partial if coaching on specific child or family targets occurs in the context of family identified routine(s) with the parent participating but does not use coaching strategies that promote caregiver independence (i.e., if the provider uses direct teaching but rarely offers caregiver a chance to practice) OR if coaching occurs multiple times but only in 1 routine.</td>
<td>Score no if coaching on specific child or family targets does not occur in the context of family identified routine(s) with the parent participating.</td>
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General and specific feedback serve important roles in the coaching process. General feedback helps keep the coaching positive and respectful while enhancing the caregiver’s confidence. General feedback to the parent and child can also keep the momentum going during an activity that is more challenging. The provider offers positive comments and general encouragement to the caregiver and child about the interactions (e.g., “That was great!” “Way to go!” “Look at you two having fun.”) However, specific feedback focuses on building the caregiver’s competence in addition to confidence. The provider gives feedback to the caregiver specific to the child’s participation, commenting on strategies the caregiver used, the accuracy or frequency of the child’s targets, and/or giving constructive suggestions for further refining the strategy and target use.

**Examples of Indicator 7.**

- “He ate five bites in a row! That’s a record. You have the right amount of food and good timing.”
- “You waited for Jaelyn to lift her foot. When she imitated the word ‘shoe’ after you named it, she was telling you that she knows it is her shoe.”
- “Tyree seems to like the ball when you roll it back and forth. See his smile and the way he leans forward into the action. He is responding to you.”
- “Do you realize you are both smiling right now? You really helped her do it!”

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<th>Looks Like</th>
<th>Doesn’t Look Like</th>
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<td>Describing specific examples of the target, activity, materials, strategies, or the outcome of the behavior (e.g., “Toby got what he asked for when he pointed to his toothbrush.” “Making a chair out of pillows on the floor is ingenious. Julia can sit up and reach her toys.”)</td>
<td>Offering general feedback only without intentionally connecting to the child’s target, caregiver’s strategy use, or their engagement and participation (e.g., “Nice job.”)</td>
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<td>Sharing information about the focus on the caregiver’s attention on child behaviors (e.g., “Did you see how excited he was when you put a block on the tower… and how he added more blocks? He showed you how much fun he was having and how skilled he was releasing objects.”)</td>
<td>Offering only feedback about the child’s behaviors, and not pointing out how the caregiver’s support relates to the child’s response (e.g., “Good talking.”)</td>
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<td>Encouraging interactions that promote a positive relationship (e.g., “It looks like you both are having fun.”)</td>
<td>Offering more suggestions or corrective feedback for the situation than the caregiver can implement efficiently.</td>
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Considerations for Indicator 7.

Adult learners value input that is functional for the child and relevant for the family. Caregivers are more likely to use feedback that helps them help their child with the targets and in the activities that are most important to them.

Feedback is important for building and sustaining relationships, and should be supportive and honest. Constructive feedback that helps the caregiver learn what to do is not the same as corrective feedback that points out what did not work. Feedback should contain more constructive and positive than corrective comments, especially when sharing new information and building the confidence of the caregiver. Providers often feel comfortable giving feedback on what the child did in the routine, but it is equally important to give specific feedback to the caregiver. Telling the caregivers what they did and how it supported their child encourages them to continue to use the strategy and it builds caregiver confidence.

Feedback is also most useful in the moment when it is situated in the context of a routine, rather than delayed. Consider feedback that leads to reflection and/or problem solving as a strategy to build caregiver capacity. For instance, you may say, “When you named the toy and paused, she imitated you! What else do you think you did that helped her?”

Affirmations and encouragers are important to sustain the interactions and build confidence.

Caregivers need to provide feedback to the child too. Help caregivers identify and use interest-based activities with natural reinforcers. Another turn of a favorite game, a big smile from a parent, or a choice of the next song are logical “feedback” or consequences for the child that supports more learning. Statements like “good talking” do not teach words or encourage another response. It can even interrupt the flow of the activity.

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<tr>
<td>7. Provides general and specific feedback on caregiver and child behaviors and interactions - teaches and encourages caregiver to participate (This indicator is repeated multiple times throughout session using both general and specific feedback for child and caregiver)</td>
<td>Score yes if at least 6 examples of feedback related to the child or family targets, routines, or strategies are provided and at least 3 of those examples are specific feedback.</td>
<td>Score partial if fewer than 6 examples of feedback or less than 3 specific feedback examples related to the child or family targets, routines, or strategies are provided OR if only specific or only general feedback occur.</td>
<td>Score no if general or specific feedback related to the child or family targets, routines, or strategies is not given.</td>
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Problem solving refers to an exchange of ideas between the provider and parent that serves to build the parent’s capacity to identify, use, and modify intervention strategies that supports the child’s learning and/or the family’s outcomes. Problem solving is not always about a problem; it can be an exchange of ideas or brainstorming about new intervention strategies, other places to embed the targets, or how other family members can learn how to use the strategies. Problem solving expands caregivers’ capacity by building on their knowledge and experiences with various intervention strategies. Providers listen and learn from the family while offering other perspectives or strategies to incorporate into the best plan. As the caregivers gain confidence embedding intervention and supporting the child’s learning, they will begin to initiate problem solving exchanges and application of intervention strategies in other routines and places.

**Examples of Indicator 8.**

- “What do you think would happen if you used wait time before you opened the door to go outside to play?”
- “Let’s make a list of what you have tried so far so we can see if we can figure out what works.”
- “Do you feel like waiting for him to take a step will work or would another strategy feel more natural to you?”
- “You mentioned that the strategies you tried didn’t work, why do you think that may be? Let’s see if we can figure it out.”
- “He is responding well to your directions. What’s next? Should we add a new strategy to help him take the lead?”

**Looks Like**

Posing open-ended questions or offering prompts that facilitate the parent’s contribution (e.g., “I noticed Maddy didn’t reach that time when you offered her a choice. What do you think might have worked before? Tell me what you do to help her when she gets frustrated.”)

Modeling alternatives while describing the thought process or scaffolding suggestions for the caregiver to consider (e.g., “I wonder if the choices aren’t motivating to her, or maybe she can’t quite see them. What do you think? Do you think that using books or blocks would interest her longer?”)

Building consensus on the most useful ideas and strategies for all involved in the plan.

** Doesn’t Look Like**

Listing formal recommendations from books or experts without integrating the family’s priorities and beliefs.

Identifying the activities, routines, and strategies that will be used without including caregivers’ ideas or addressing their concerns.

Directing the agenda or providing only the options the provider is most comfortable using.
Considerations for Indicator 8.

Brainstorming or problem solving is a skill that is natural for many adults, but certainly not everyone. It is a more advanced cognitive skill that builds on previous experiences and available information. Think about the caregivers’ experiences as adult learners and provide adequate scaffolding to increase their ability to join in the problem solving and planning. Engaging in problem solving also lets caregivers know that they possess valuable knowledge and experiences that they can use to help their child.

Starting small and building the caregivers’ confidence will increase their comfort and capacity to use brainstorming and problem solving to determine what works best for them.

Ideas can be shared verbally or can be observed and included in the plan. Learning how the caregiver communicates most comfortably helps their participation. Encouraging the caregiver to share ideas and strategies promotes participation and increases the likelihood they will use the ideas in the intervention independently.

Not all intervention strategies are natural to parents and they do not work in all routines for every target. The provider must coach caregivers on evidence-based (EB) interventions that are appropriate for the child, acceptable to the caregiver, and can accomplish the level of support necessary. EB instructional strategies that caregivers can use in routines include arranging their environment, responding contingently, modeling, expanding, taking turns, wait time, prompting, and hand over hand support. Assistive technology may also be important to assess for need and utility. Brainstorming about what to use and when gives the family ideas to choose from and opportunities embed.

Problem solving is more difficult when the topic is unfamiliar or when the individual is tired, stressed, or unsure of the situation. These are all conditions that many family members experience at different times while participating in early intervention (and providers do too!). Because it is so important for the adult learners to participate, don’t give up. Try expanding things that are working and introduce the tough stuff slowly.

### Problem Solving and Planning

Problem solves with the caregiver about appropriate intervention strategies to embed - coaches caregiver on evidence-based interventions for identified targets and routines

| 8. Problem solves with the caregiver about appropriate intervention strategies to embed - coaches caregiver on evidence based interventions for identified targets and routines |
|---|---|---|
| **Yes** | Score yes if at least 4 comments or questions promoting problem solving on strategies, targets, routines, or what worked in the session. There should be at least 2 separate exchanges with at least 2 turns each. |
| **Partial** | Score partial if there are 1-2 comments or questions that prompt or support problem solving with the caregiver on the strategies for targets, specific routines, or what worked or didn’t in the session OR if exchanges did not last a minimum of 2 turns. |
| **Not Observed** | Score no if the provider does not ask questions/make comments to engage caregiver in brainstorming or exchanging information about intervention for targets or routines. |
Expanding the child’s functional use of targets into additional routines promotes learning. Family members know what they do and what they want their child to learn. Engaging them in the process of identification of what targets fit best in which routines, how many times the learning targets can be embedded, and how often the routines will be repeated during the day and week gives them the information needed to become the decision maker and leader for their child’s and family’s intervention. Starting small, building on success, and using the everyday routines and activities the family already have can increase learning opportunities without taking over the family’s life. The child is fully included as a member and active participant with the family. Involving siblings and extended family members not only promotes family participation, but also helps to teach the importance of learning with others.

Examples of Indicator 9.

- “Where and when do you think Sonje could pick up objects and use them to help you?”
- “Let’s look at the different types of routines (routine categories) and see what you are doing already.”
- “Who else in the family would be a good partner for Aaron?”
- “What routines happen on a regular basis and provide multiple opportunities for Amiyah to practice?”
- “Bath time works well for Diego and big brother Antonio because he gets so many opportunities for repetition of both targets. What other activities do you think they can do together?”

Looks Like

Brainstorming when and where to expand opportunities to embed intervention strategies into other routines (e.g., “Chen responded to the small portions at snack by requesting more. What other routines might you be able to use the same strategy – small portions or piece by piece to encourage him to request?”)

Helping families become aware of the natural learning opportunities and routines that they already participate in for intervention without adding more (e.g., “Let’s walk around the kitchen and family room and look for places Tori could safely pull herself up and stand while you are there doing chores.”)

Using problem solving and planning for caregiver-child interactions that use the caregiver’s ideas (e.g., “I heard you say that Sophia looks for the cat when she is playing on the floor. What can you do to help Sophia play with the kitty as a new routine?”)

Doesn’t Look Like

Bringing a toy bag or using the child’s toys primarily for play interventions without expanding to other types of routines and activities the family identifies that occur throughout the day.

Providing activities for the family to use rather than engaging them in the identification and planning of those that are most natural and will occur with sufficient repetition for learning to occur.

Giving the family a list of materials and planned activities the caregiver and child should use for therapy or intervention at special activity times and not including the siblings.
Considerations for Indicator 9.

Caregivers may not realize how many opportunities children have to learn naturally in their everyday routines and activities or know that practice when the learning target is useful and meaningful can accelerate the child learning the skill. Families may need you to share how opportunities in everyday routines and activities are as effective or even more so than therapist or teacher delivered trials because they are repeated throughout the day as they naturally occur. Information is very important. Offering examples of embedding in daily routines could help a caregiver understand why routines are valuable learning contexts.

Caregivers may not fully understand exactly what a routine is and may need your support in “building” a meaningful and predictable sequence so that targets and strategies can be embedded.

Embedding intervention in routines and activities will require systematic expansion by the family with support by the provider to ensure generalization for both the child and the caregiver. Using different types and categories of activities, involving different partners and family members, and including new or different materials or locations are all ways to increase frequency and support generalization.

More isn’t always better, especially for busy families. Having enough opportunities to develop learning targets in naturally occurring activities is important. Contriving activities or routines for caregivers to practice can cause family members stress and result in decreased rather than increased motivation by the child. Caregivers should decide on the routines and activities that fit them best. Siblings and other family members often provide interest and motivation as well as extra hands.

Maintaining the family’s sequence or structure and embedding into their routines rather than following the plan of the provider makes it easier for the family to remember and apply the strategies. They own their routines. Providers just help make adaptations where needed to increase the child’s and caregiver’s participation.

Repetition is important. Every routine with embedded intervention repeated consistently everyday or multiple times in the day can make a difference. When intervention is embedded throughout the day in different routines, like caregiving, play, chores, stories, and errands the practice adds up. When it is repeated frequently, learning occurs naturally.

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<thead>
<tr>
<th>Problem Solving &amp; Planning</th>
<th>Yes</th>
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<tr>
<td>9. Supports caregiver to identify opportunities for embedding in additional contexts/routines - plans when, where, how to embed</td>
<td>Score yes if provider prompts or supports the caregiver opportunities multiple times (3+) in the session to identify new opportunities, routines, locations, or partners for practice.</td>
<td>Score partial if there are 1-2 comments or questions that prompt or support identification and discussion of new or different routines, locations or partners for practice OR if provider tries and parent does not respond.</td>
<td>Score no if a discussion does not occur OR if the provider gives the parent a list of other routines and times to embed.</td>
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Asks questions, comments to promote caregiver reflection and review of a routine or the session - identifies what works for caregiver and child

By asking the parent to reflect on what worked and what didn’t in the session, the provider offers the parent an opportunity to think critically about and share what the child is learning and what supports are needed. Reflecting on the use of the strategies helps parents “self-assess” how accurately they used the strategies, and helps them think about how the child responded. Reflection is also the key to the caregiver’s recognition of their contributions to their child’s learning.

Examples of Indicator 10.

• “Let’s review for a minute. How did you help Evie practice sitting today.”
• “What will you say to Grandma to explain the best ways to support Rose sitting on the floor? Which strategies do you want her to use this week during bath time?”
• “Today you positioned Teresa with a Boppy to lean on. It gave her a place to bear some weight while interacting with the toy. How do you think that went?”
• “It looked to me like he was able to pick up the cheerios from the tray and out of your hand as well. What did you see happening? Why do you think that worked for him and you?”

Looks Like

Asking/answering questions to focus on the caregiver’s attention on child behaviors (e.g., “Did you see how excited he was when you put a block on the tower… and how he added more blocks independently? He showed you how much fun he was having and how skilled he was becoming releasing objects. What did you think worked best?”)

Helping the family to see what the next developmental step is and how to “up the ante” to encourage the child’s participation in the routine (e.g., “See how she is using the brush on her own hair and looking at you? She might reach over and want you to brush your hair! What else do you think she might do?”)

Doesn’t Look Like

Asking vague or general reflection questions that do not support the caregiver’s participation (e.g., “What do you think about that?” “How do you think that went?” “What do you want to do next?”)

Using handouts from assessments or curriculum, books, or the Internet to describe intervention without demonstrating and comparing to what the child is doing in everyday activities.
Considerations for Indicator 10.

Reflection is an advanced communication skill that requires some time and practice for many caregivers and providers. To support the caregivers’ reflection, you should be genuinely interested in what they believe. Asking questions that demonstrate your interest in ideas beyond your own helps to increase the exchange of ideas.

Participation is increased when caregivers feel that their responses and comments are welcomed. Keeping questions and comments nonjudgmental requires you to listen without jumping to conclusions before you have really heard what the caregiver is saying. You may also need to ask follow-up questions to clarify and understand the caregivers’ point of view.

Questions that have an obvious or expected answer do not support caregiver reflection. True reflective questions do not lead the parent to the answer you are looking for. Rather, an authentic reflective question results in the parent’s ideas, impressions, worries, thoughts, or questions.

You can also support the caregivers’ reflection by reflecting on what you saw and why you think that it works for the child or the parent. Building on what works is very important to ensure that the caregiver’s confidence expands along with their competence.

Questions that use “What”, “What if”, and “How” are open-ended questions that spark creativity and new ideas. Examples include:

- “What if you moved the pillow. What could he do?”
- “How do you think that went?”
- “What did you see Jason do when he was helping you stir the cookie dough that showed you he was having fun?”

It’s often best to review after each routine or activity rather than waiting until the end when you are writing the plan. The teachable moment is relevant and immediately useful. After review, you may decide to try the routine again.

Review is an opportunity to listen to what the caregiver believes is working, why, and how they can increase opportunities, decrease supports, up-the-ante, or just stay right where they are to ensure the target/skill is fully mastered.

**Reflection and Review**

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<tr>
<td>10. Asks questions, comments to promote caregiver reflection and review of a routine or the session - identifies what works for caregiver and child</td>
<td>Score yes if there are 3+ comments or questions that prompt or support reflection from the caregiver on the target, strategies, or routines AND at least 1 comment/question relates to what occurred during the current session.</td>
<td>Score partial if there are 1-2 comments or questions that prompt or support reflection from the caregiver or if there are multiple reflection questions but none are related to current session targets, strategies, or routines.</td>
<td>Score no if there is not at least 1 comment or question to prompt reflection from the caregiver on strategies, specific routines, or what worked in the session.</td>
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Encourages the caregiver to describe what it will look like when the intervention is working - specifies measurable targets, strategies, and routines for the plan

Caregivers learn best how to help their child participate when the expectations are clear and reasonable for both the child and themselves. Examples should be concrete and relevant to the family’s priorities. All jargon needs to be carefully defined so caregivers can make informed decisions about what to do, when to do it, and how much participation is just right for their child in each of the routines and activities. It helps the caregiver to talk through exactly how they can support the child and in return, what they should expect the child to do. Making connections to the family’s priorities also keeps the focus on the “larger” learning outcomes when the targets for the child are small.

### Examples of Indicator 11.
- “You said things were going ok with sitting. What does ‘ok’ look like? Sitting longer? Fussing less? Sitting more frequently?”
- “Walking down the aisle at your wedding in May is your outcome. What do you think you can do this week that will tell you he’s getting closer?”
- “Grandma’s coming to visit this week; how will you describe to her what Anna is learning when she helps you fold the clothes and put them away?”
- “Tell me what bedtime will look like when the routine is working.”

### Looks Like
Emphasizing the connection between the child’s practice of learning targets in routines and activities and their progress toward broader goals (e.g., “Pulling to stand by the couch will help him walk with support which is a small step toward walking. What will you look for this week to get close?”

Directing the caregiver’s attention to the child’s behaviors that she has learned to illustrate development and to look to where they will go next (e.g., “Peggy looked at you and reached for the cookies. What can she do next?”)

Celebrating a successful interaction or activity and helping the family connect their actions to the child’s outcomes (e.g., “Frankie walked to the table carrying his cup at lunchtime because you waited for him and encouraged his help.”)

### Doesn’t Look Like
Giving the family specific skills that the child should be doing (e.g., stacking four blocks, walking 10 feet, and naming 10 body parts) without including how those skills can be used in a functional context.

Using jargon or specific discipline terminology to measure progress that does not fit in the family activity and/or increase participation.

Telling the family what the targets in the routine should be, and assigning how many times to practice.
Considerations for Indicator 11.

It can take lots of practice for some caregivers to understand what embedding intervention into everyday routines and activities is all about. Some caregivers have an “aha” moment while others need the provider to share more examples and offer choices of options that could work for the family. Like children, adults need input in different formats, frequency, and varying types of support. Provide examples of what it could be like and ask for input from caregivers initially. Brainstorm options or choices. For instance, for a child who is working on pulling to stand, you could offer options like, “Will you want to see him pulling up more often or maybe in new places in the house this week?”

Watching videos of the child and parent practicing is very helpful to support the caregiver’s understanding of what the target is and looks like when it is working. Pausing the video and talking it through is a great strategy. A picture is worth a thousand words, and can provide great contexts to talk about whether or not there are changes in participation.

Back up plans are very helpful. Talking about what it looks like when it is working often identifies some possible complications that haven’t been discussed and could lead to breakdowns. Take time to talk through these and problem solve “worst case scenarios” (e.g., “If he doesn’t pull up on his own, what will you do next?”)

Talking about what it will look like when it’s working also leads to discussions of adequacy or sufficiency of opportunities to embed. As you prepare to develop the plan, it is imperative to include “enough” opportunities for the caregiver and child to learn within and across routines. Knowing when it is working teaches caregivers to measure and evaluate the effectiveness of their supports and the degree to which the strategies are helping their child.

For children with significant delays or disabilities, learning to identify small targets that can increase participation can support the family’s motivation and persistence. Helping caregivers reflect on positive changes increases understanding of their child’s development.

<table>
<thead>
<tr>
<th>Reflection &amp; Review</th>
<th>Yes</th>
<th>Partial</th>
<th>Not Observed</th>
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<tbody>
<tr>
<td>11. 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>
<td>Score yes if provider comments/asks questions that promotes the caregiver to describe what the functional measures of the target will be in their routines.</td>
<td>Score partial if the provider takes the lead suggesting what the functional measures of the target will be in their routines with minimal parent problem solving or reflection.</td>
<td>Score no if a discussion does not occur OR if the provider describes how to measure without parent input.</td>
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Engages caregivers to lead development of a “best plan of action” for embedding intervention in multiple routines and activities throughout the day - facilitates caregiver leadership and decision making

Engaging caregivers in the review of their plan is essential; it is their action plan. Not only do they know what will and will not work for them, they will be best at figuring out how to address any changes that may need to occur if their plans are interrupted. Plans developed by the caregivers are far more likely to be implemented than those provided to them. Clearly and succinctly summarizing the action plan offers the caregiver an opportunity to share the jointly created game plan for the upcoming time period.

Examples of Indicator 12.

• “After today’s session, do you think working on pointing at the object she wants and imitating your words are still your top priorities for her this week?”

• “Let’s look at your plan and you can show me what you want to keep and what you want to change for this month.”

• “Do you want to jot down Natalee’s new words on the white board or should I?”

• “Your snack time video can help Grandma see how well Johnathan eats when he feeds himself.”

• Mom says, “I emailed the pictures of Sharon helping hold Taylor’s bottle so you can see what a helper she is during feeding.”

• “Let’s walk through the 5Qs and make sure we’ve covered all the basics.”

Looks Like

Summarizing together (e.g., verbally, in writing, via email, an activity matrix, or any method preferred by caregiver) what the action plan could include for the coming period based on what happened in this session and the discussion on what next steps the caregiver wants to take.

Asking the caregiver open-ended questions followed by choices as needed to develop a flexible plan with options that match the child and family needs (e.g., “Knowing you have doctor’s appointments next week and your schedule is different, what do you want to try to help her pull to stand at home? Can you think of ways to do that at the doctor’s office or at Grandma’s?”)

Reviewing together (e.g., verbally, in writing, via email, or any method preferred by caregiver) the action plan to ensure it is clear and the roles are assigned (e.g., “I’ll bring you new snack pictures next week while you work on the picture choices at bedtime this week.”)

Doesn’t Look Like

Assuming the caregiver is too busy or overwhelmed to complete any intervention with the child during the daily routines and activities.

Offering a plan or “homework” to the caregiver that the provider believes is best for the child and family.

Assuming that the caregiver knows what the plan should be even though it hasn’t been discussed during the session.
Considerations for Indicator 12.

Checklists, white boards, text messages, activity matrices, and sticky notes on the mirror in the bathroom are all strategies that can help caregivers remember the specific targets, strategies, and expectations important for the child’s learning. It is too much to expect caregivers will learn only from hearing or watching a brief demonstration. Adults need a variety of formats to master new skills.

Life happens. Supporting parents to learn to problem solve and reflect gives them the power to substitute routines and activities that might fit better into the schedule when a change occurs because of visitors, illness, or appointments. Planning for change in advance (e.g., how to have a snack in the car instead of at the table, how to use wipes to wash hands instead of the sink at home) gives the caregiver the power to make things happen no matter what occurs.

Not all caregivers will be comfortable taking the lead writing or reviewing the plan or making a video, but some will when given the chance. Ensuring the caregiver’s ideas lead the plan development is more important than who writes it! Take turns, change up the format, involve the siblings, but do support the caregiver with a plan.

Include all of the 5-Qs during the plan of action as a reminder to the caregiver.

And watch your use of jargon! The plan belongs to the family - encouraging them to use their words, even for the intervention strategies. One provider noticed that a mom referred to strategies as “tricks” and continued to use mom’s language when making a plan. Sometimes providers feel like caregivers know what they are working on without saying it explicitly. Without discussing the action plan, the caregiver may not actually be as confident in what to do and when. Jointly creating a plan keeps everyone on the same page. Knowing how to embed intervention is better than knowing what the jargon means. Help the family make it their own.

**Reflection and Review**

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<td>12. Engages caregiver to lead development of a “best plan of action” for embedding intervention in multiple routines and activities throughout the day - facilitates caregiver leadership and decision making</td>
<td>Score if provider supports the caregiver to take the lead to identify caregiver strategies (how), specific routines (where/who), and targets (what) for embedding (when) throughout the day.</td>
<td>Score partial if the provider takes the lead suggesting the plan to embed targets throughout the day with minimal parent problem solving or reflection.</td>
<td>Score no if there is not a clear plan with action steps with caregiver input.</td>
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References


We would like to thank all of the families and collaborators who have contributed to the production of this manual. Your wisdom, experience, and perspective was vital to the development of the manual, and it will help others provide stronger services to families.

For more information and resources, please visit the Communication and Early Childhood Research and Practice Center’s website at: http://cec-rap.fsu.edu