

Evaluation of Quality Early Intervention Home Visitation in Nebraska

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Abstract

A group of planning region teams (PRTs) in the state participated in a pilot project as part of Nebraska's Results Driven Accountability plan. In professional development that rolled out in three phases, these PRTs received training and technical assistance to (a) utilize Routines-Based Interviews (RBI; McWilliam, 2010) for assessing child and family strengths and concerns, (b) apply information gained from RBIs to write high quality, functional Individualized Family Service Plan (IFSP) outcomes, and (c) use the *Getting Ready* approach as a framework for partnering with families and delivering high quality routines-based home visits. The current study explored the influence of this third phase of professional development on home visiting practices in the pilot PRTs. The research team conducted interviews with family members ($n = 22$), Early Intervention (EI) service providers ($n = 12$), and service coordinators ($n = 7$). In addition, copies of written plans from both EI provider and service coordinator home visits ($n = 11$) were collected. Findings from a qualitative data analysis inform the profession's understanding of effective family-professional partnerships, data-driven decision making processes in EI, and collaborative development of routines-based interventions to achieve child/family IFSP outcomes.

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Introduction

In Nebraska, the Early Intervention Co-Lead Agencies (Departments of Education and Health and Human Services) designed a Results-Driven Accountability (RDA) plan to improve child/family assessment, the functionality of IFSP outcomes, and the quality of home visits for infants and toddlers with delays/disabilities and their families. Seven planning region teams (PRTs) across the state participated as pilot sites for professional development and technical assistance focusing on three evidence-based strategies that address the above areas of need. Strategies included (a) the use of RBI for assessment of child and family needs and priorities, (b) translating RBI results into functional IFSP outcomes, and (c) the use of the *Getting Ready* (Sheridan, Marvin, Knoche, & Edwards, 2008) framework for quality routines-based home visits. An evaluation of the first two RDA strategies, pilot PRT sites' implementation of RBI and the development of functional IFSP outcomes, was conducted in 2017 by Kuhn and Boise.

The 2017 evaluation revealed consistent, wide-spread use of RBI for child/family assessment across the pilot site PRTs, resulting in accelerated development of positive family-professional relationships and rich descriptions of family priorities for family members and their children. Information from the RBI was reported to yield IFSP child and family outcomes that were meaningful to the families. In addition, the study found the number of child and family outcomes was significantly greater in PRTs that had completed the functional IFSP outcome training when compared to PRTs who had not yet received this phase of training. Several indicators of child outcome quality were also significantly improved. These included emphasizing child participation in a routine, including observable behavior in the outcome, and having criteria for completion that was reasonable and linked to the outcome (Kuhn & Boise, 2018).

These promising findings revealed that state-led efforts to provide training and technical assistance in the first two strategies outlined in the RDA plan were achieving the desired impacts across the pilot PRTs. The 2017 study also explored “business as usual” practices in non-pilot site PRTs. A notable feature of the sample of non-pilot site PRTs was that some practitioners had received training in the first two RDA strategies and some had not. Inquiry into EI service delivery practices in both pilot and non-pilot PRTs revealed a number of similarities in approaches. For example, families were valued as partners in the evaluation and assessment process; however, they were less likely to be included in the IFSP decision-making step regarding who would deliver EI services to their child and family. Home visits often reportedly began with the professional obtaining updates from families on current skills of or concerns about the child and/or family. Participants in the 2017 study mentioned coaching activities such as giving feedback, modeling, giving suggestions, and planning for use of strategies when the provider was not present. References to other key coaching behaviors were missing. For example, no participants mentioned reflection, defined by Rush & Shelden (2005) as questioning that prompts caregivers to analyze current strategies in light of their intentions, for the purposes of refining one’s knowledge or skills. Practice (repeating a skill to achieve confidence or fluency) was not mentioned, nor was goal-setting (Stormont, Reinke, Newcomer, Marchese, & Lewis, 2015).

Across pilot and non-pilot PRTs, there seemed to be a preponderance of professional-child interactions reported by parents during home visits as compared to professional-parent, or triadic, professional-parent-child interactions. In addition, discussion or trial of strategies was rarely reported to occur within routines, and when routines were mentioned these were limited in number. Playtime and mealtime were most commonly mentioned.

Finally, data collection regarding family implementation of strategies “between home visits” was not mentioned by participants in the 2017 study. Many professionals lacked clarity regarding the family’s implementation of strategies between home visits, and none reported gathering data on this, although across the PRTs their sense was that this varied. Families often reported that if they had difficulty using a strategy discussed with their service provider they waited until the next home visit to attempt to resolve the problem. For many families, next visits were two weeks or more in the future (Kuhn & Boise, 2018).

Thus, the initial trainings in RBI and functional, quality outcome writing did not seemingly translate into trials of strategies immediately within the home visit to focus families on intervening with their children to improve skills within the context of valued family routines. In addition, the degree to which families implemented planned interventions with the children in between home visits was unknown. These findings underscored the importance of training and technical assistance for the third RDA strategy—use of the *Getting Ready* framework to strengthen the quality of home visitation practices.

Literature Review

Current literature addressing the effectiveness of training home visitors of families of young children with disabilities in EI reports mixed results. Researchers have demonstrated that EI professionals can be trained to teach caregivers to embed strategies within daily routines (Krick Oborn, & Johnson, 2015; Marturana & Woods, 2012; Salisbury et al., 2018). Caregivers have reported this routines-based approach as meaningful (Salisbury et al., 2018). Marturana and Woods (2012) taught 18 EI providers to use home visiting practices that focused on actively coaching the caregiver to include strategies within family/community routines through a Distance Mentoring Model (DMM). The training program, consisting of performance-based

feedback and technology support, resulted in providers that spent more time “actively” coaching the caregiver and integrated more (and a variety of) family routines into the EI services.

Similarly, Krick Oborn and Johnson (2015) evaluated a multi-part, nine-week, professional development intervention to train three practitioners to use coaching with parents that incorporated strategies into daily child/caregiver routines in the home. The providers attended a workshop followed by six weeks of coaching via email feedback. Although the frequency of coaching strategies used increased after providers were trained, daily routines were rarely incorporated, and providers spent similar percentages of time discussing strategies not associated with a specific daily routine. The authors suggested that a future direction for research may be to examine ways for providers to learn to expand the number of routines discussed within coaching sessions.

More recently, Salisbury and colleagues (2018) studied 11 EI professionals and 19 caregivers using the Embedded Practices and Interventions with Caregivers (EPIC) approach. EPIC included coaching with specific questions to guide instruction and interaction between provider and caregiver leading to embedding strategies within daily routines. With the use of this approach, caregivers reported an increase in use of strategies outside of the home visits and within daily routines. Due to the small sample size in this study, researchers recommended investigating similar approaches to training with larger groups.

With regard to embedded strategies, it is widely accepted as best practice to create a plan with the caregiver identifying strategies to be used when the EI professional is not present. However, few studies have examined how frequently such plans are used and the content included. Salisbury, Woods, and Copeland (2010) explored professionals’ perspectives as they participated in the Chicago Early Intervention Project (CEIP), a collaborative consultation

approach, funded to evaluate the Family-Guided-Routines-Based Intervention (FGRBI; Woods, 2005). CEIP asked providers and families to develop a plan that identified learning targets and the routines in which interventions would be implemented between home visits and monitor progress frequently.

Salisbury, Cambray-Engstrom, and Woods (2012) continued this line of inquiry by exploring the use of “contact notes” by 6 providers and 21 caregivers using the FGRBI approach. Home visit videotapes were reviewed to determine if the strategies providers used during visits were reported on the contact note. Results showed the providers underreported their use of coaching strategies indicating contact notes may not be a complete representation of what occurs during sessions. Additional exploration of notes needs to be conducted with larger groups implementing FGRBI or similar routines-based approaches. Furthermore, the use of notes to support caregiver implementation when providers are not present and the use of notes to support caregiver-provider communication between sessions warrants more examination.

It appears that communication between visits may be a crucial aspect of EI services needed for the caregiver to implement strategies with fidelity when the provider is not present. Although methods of communication between visits have been examined in other fields (Ye, Rust, Fry-Johnson, & Strothers, 2010), literature regarding caregiver and EI service provider communication between visits appears to be almost non-existent. This project aimed to provide important information to the field about current practices in Nebraska and have implications for strengthening this aspect of family-professional partnerships.

The literature examining home visiting training and practice that is reported above focuses on approaches utilized with EI service providers. While EI providers play a critical role in the implementation of EI services, it is believed effective service coordination is needed for

optimal family and child outcomes (Dunst & Bruder, 2002). Assessing effective service coordination training and practice has, however, proven challenging due to the complex nature of this resource (Childress, Raver, Michalek, & Wilson, 2013). For example, there are few tools to effectively measure service coordination outcomes (Bruder & Dunst, 2008; Trute, Heibert-Murphy, & Wright, 2008), and there is little known regarding the preservice or in-service training of service coordinators (SCs) specifically serving the field of EI (Bruder, 2010; Bruder & Dunst, 2005; Park & Turnbull, 2003; Roberts & Akers, 1996).

Childress and colleagues (2013) found a significant and positive change in knowledge for 17 EI service coordinators who attended a two-day introductory training. An item analysis of the posttest indicated the greatest percentage increases on items addressing the role of the SC, eligibility determination, IFSP development, family-centered practices, and communication. However, three items on the posttest were answered correctly by fewer than 75% of the participants. These items addressed active listening skills and effective practices for working with families.

A qualitative study examining collaboration among medical professionals, EI SCs, and families of young children with significant health challenges reported frustrated parents often found themselves in the middle of the groups of professionals, attempting to “ensure smooth communication between the providers from the health or medical setting and those from...EI settings” (O’Neil, Ideishi, Nixon-Cave, & Kohrt, 2008, p. 128). O’Neil and colleagues recommended communication training for professional providers as well as use of technology to improve both communication and collaboration.

Outside of the field of EI, there are interesting initiatives regarding training of professionals who must work across disciplines to effectively deliver supports in the fields of

medicine, social work, and mental health. Such interdisciplinary supports, by nature, require a high level of communication and collaboration. This has led to the emergence of interprofessional training. A review of literature on this topic indicated there is still much to explore regarding the outcomes and limitations of such training and what constitutes effective training formats and curriculum (Pecukonis, Doyle, & Bliss, 2008; Reeves et al., 2010).

For professional development in this third strategy of the Nebraska RDA process, both SCs and EI service providers received training and follow-up coaching to use *Getting Ready* approaches as a framework for quality home visits, while acknowledging that the focus of their respective visits may differ. There was a great deal of symmetry in the training format, although the EI providers were trained on all eight *Getting Ready* strategies, while SCs trained on seven strategies (see Table 1). The SCs did not receive training on facilitating parent-child interactions as this is not an integral part of the SC role. Thus, this study has the potential to inform the state co-lead agencies, as well as the field of EI, regarding promising training practices for SCs.

Table 1

Getting Ready Strategies

Strategies to Strengthen Relationships	Strategies to Build Competencies
Communicate openly and clearly	Focus parent's attention on child's strengths
*Encourage parent-child interaction	Share developmental information/resources
Affirm parent competencies	Use observations and data
Make mutual/joint decisions	Model and/or suggest

* SCs were not trained on this strategy

Purpose of the Study

The focus of the current study was to better understand family, SC, and EI service

provider experiences with the third RDA strategy—the *Getting Ready* framework for quality EI home visits. In particular, we were interested in exploring the influence of training in and implementation of *Getting Ready* on the provision of high quality routines-based home visits. Such home visits would enable EI service providers and SCs to focus on supporting child and family progress toward achieving IFSP outcomes through the development of effective plans within home visits and attention to implementation of plans between home visits. There were two research questions:

1. How do family members and EI service providers describe the influences of the *Getting Ready* framework on (a) establishment of the home visit agenda in partnership with the family, (b) identification and practice of strategies within family routines during visits, (c) development of a home visit plan to support families' use of strategies with their children, (d) use of and fidelity to the strategy steps outlined by the home visit plans in family routines/activities with their children between visits, (e) family-provider communication between visits, and (f) family-professional collaborations to monitor child and family progress on IFSP outcomes?
2. How do family members and SCs describe the influences of the *Getting Ready* framework on (a) establishment of the home visit agenda in partnership with the family, (b) development of a home visit plan to support families' access to desired services and resources, (c) implementation of the home visit plan between visits, (d) family-provider communication between visits, and (e) family-professional collaborations to monitor child and family progress on IFSP outcomes?

Method

An exploratory qualitative design was implemented for this evaluation study. A variety of

data sources were tapped to allow the research team to triangulate findings, thus increasing the validity of the results (Creswell, 2013).

Setting and Participants

PRTs from Pilot 1 of Nebraska's RDA roll-out were contacted by the Co-Lead Agencies and invited to participate in this study as these regions had participated in all three installments of training in evidence-based practices. Pilot 1 PRTs received training in the *Getting Ready* framework for quality home visits in the summer of 2017 and teams participated in technical assistance to achieve fidelity of implementation during the 2017-2018 service year. A purposeful sample of EI providers (e.g., early childhood special educators, speech/language pathologists, occupational or physical therapists), SCs, and family members whose children receive EI from trained and approved Pilot 1 PRT providers were recruited to participate in the study.

Procedure

Description of professional development for quality home visitation. The Co-Lead agencies contracted with faculty from the University of Nebraska-Lincoln and independent EI specialists familiar with previous applications of the *Getting Ready* framework to adapt the model, as well as design training and support, for pilot site participants to implement *Getting Ready* strategies within EI home visits.

As part of this process, EI providers were trained in evidence-based practices for focusing on parent-child interactions and strengthening parent-professional partnerships. The parent-professional collaborative practice of developing an effective action plan was highlighted. For example, the EI provider "Guide for Interactions" from the *Getting Ready* model training prompted providers to include several components while visiting and developing an action plan with families. These included gathering information about child and family interactions and

progress since the previous visit, establishing a purpose for the current home visit, choosing an IFSP outcome as the focus of the visit, brainstorming routines, skills, or strategies applicable to the selected outcome, practicing skills/strategies, developing a specific plan for continued practice after the professional has gone, setting a target for the child to reach by the next visit, and planning communication between visits. A home visit plan template was recommended to pilot site teams, however, the teams were free to modify this template as desired. There was a similar guide used by SCs to prompt valued components of their role, for example, establishing the home visit purpose, exploring the effectiveness of resources/supports, listing steps to be taken by whom and when to access needed services/supports, and planning for communication between visits. While a full description of this training is outside the realm of this report, a succinct portrayal of the application of *Getting Ready* in early childhood special education home visiting has recently been published (Marvin, Moen, Knoche, & Sheridan, 2020).

Data collection. Twelve EI service providers, seven SCs, and 22 family members of 20 children identified for EI services were recruited from the Pilot 1 PRTs and invited to participate in semi-structured interviews about their experiences with EI services utilizing the *Getting Ready* framework of home visiting. The participants were asked to complete a demographic survey prior to the interviews. See Table 2 for demographic results. Each participant was assigned a numerical identifier to protect the confidentiality of the subject. The de-identified data and the list of participants were kept separately in a locked file cabinet in the researcher's office.

Interviews were conducted in person or via Zoom. Family members were offered a stipend of \$75 for participating to offset any expenses or inconvenience. See Appendix A for the family, EI service provider, and SC versions of the interview protocol. The interviews were

transcribed verbatim and uploaded into NVivo software (Castleberry, 2014) for data management and qualitative analysis by two independent coders.

Table 2

Interview Participant Demographic Data

Characteristic	Parents (<i>n</i> = 22)	Children (<i>n</i> = 20)	Professionals (<i>n</i> = 19)
Age	<i>x</i> = 30.91 years <i>SD</i> = 5.45	<i>x</i> = 33.55 months <i>SD</i> = 7.72	<i>x</i> = 37.21 years <i>SD</i> = 9.85
Gender			
Male	22.73%	60.00%	---
Female	77.27%	40.00%	100.00%
Race/Ethnicity			
Black/AA	---	---	---
American Indian	---	---	---
Asian	---	---	---
Caucasian	95.45%	85.00%	94.74%
Two or more races	4.55%	15.00%	5.26%
Hispanic ethnicity	9.09%	10.00%	10.53%
Non-Hispanic ethnicity	90.91%	90.00%	89.47%
Highest Level of Education Completed			
Less than high school	4.55%		---

9 th – 12 Grade, no diploma	4.55%	---
High school diploma/ GED	18.18%	---
Some training beyond HS	45.45%	5.56%
Two-year degree	9.09%	5.56%
Four-year degree	4.55%	38.89%
Graduate degree	13.64%	50.00%
Years Employed in Current EC Position		$x = 7.86$ $SD = 8.06$
Years Employed in Early Childhood (Birth – Age 8)		$x = 11.86$ $SD = 9.43$

The research team coordinated with the Co-Lead Agencies and Pilot 1 PRT leadership to obtain copies of 11 completed home visit plans from across the Pilot 1 PRTs. The sample, chosen by the providers as representative of usual home visit plans, included documents completed by EI service providers ($n = 7$) and SCs ($n = 4$). Identifying information from the plans, such as names of children, family members, or professionals, was removed by PRT staff prior to being given to the research team. Each home visit plan was assigned an identifying number, and subsequently uploaded into NVivo for data management and coding by two independent coders. These documents were analyzed for descriptions of EI services, and evidence of planning for use of strategies when the professional is not present, as well as planning for family-professional communication across the Pilot 1 PRTs.

Data analysis. A basic qualitative approach was applied to analyze the two sources of data (Merriam, 2009), in an effort to thoroughly describe and better understand how participants experience home visitation within the *Getting Ready* framework. Interview transcripts and home

visit plans were uploaded to NVivo software for data storage and organization, efficient coding, and thematic development. Trained members of the research team performed a constant comparative method of analysis (Merriam, 2009). In an iterative and inductive process, transcripts and documents were read, and meaningful segments of the text identified and labeled with initial codes by two independent coders. Coders then met to compare identified codes and reach consensus on these (Hodges, 2011; Kisely & Kendall, 2011). Next, categories of codes were aggregated to identify patterns or establish themes. Links between themes were documented, with an aim of developing a thick, rich description of the participants' experiences.

Validation and reliability strategies. Several strategies were implemented in an effort to ensure the credibility, integrity, and stability of study findings. First, the analysis of multiple sources of data provided an opportunity to triangulate data and corroborate evidence (Merriam, 2009.) Next, two coders independently coded the interview data, compared identified segments, and resolved differences through consensus, bringing interrater agreement to the process of coding and thematic development (Armstrong, Gosling, Weinman, & Marteau, 1997). An expert reviewer who is a member of the research team then reviewed the codes assigned to the meaningful segments and the themes generated from the data and offered feedback regarding the codes and themes. Finally, after analysis of interview transcripts and home visit plans, as well as integration of findings from both, preliminary results of the analysis were mailed or sent electronically to interview participants who consented to review these results and provide feedback regarding the accuracy of the findings (Creswell, 2013). This member check is considered by some scholars to be “the most critical technique for establishing credibility” (Lincoln & Guba, 1985, p. 314).

Results

Three major themes emerged from the analysis of the qualitative data. Each of these major themes as well as related subthemes will be explicated below. This will be followed by the results of the member check of the validity of these findings.

Theme 1: Engaging families to achieve IFSP outcomes. Professional participants made numerous references to utilizing family-centered, participatory-building practices to build effective partnerships with parents. In turn, family participants in the study described their engagement in EI services. This theme may be further subdivided into four sub-themes that are highly pertinent to such engagement: coaching, practice, home visit action plans, and communication between visits.

Coaching. Families and professionals alike mentioned a variety of coaching strategies such as offering suggestions, modeling, and providing feedback were used during home visits. Commonly mentioned contexts for coaching included family routines and activities, such as “snack,” “bath time,” “cleaning,” “shopping,” “playtime,” “reading books,” “diaper changes,” “dressing,” and “lunch.” One EI provider explained: *“A lot of times it’s me coaching, you know, verbally coaching or modeling some things, and then having the parent try it.”*

Practice. As demonstrated in the participant quote above, modeling and demonstration is most effective when followed by the coachee “trying” the strategy. Importantly, there were numerous and widespread reports that “practice” occurred within the routines during the home visits as EI professionals set the stage for families to try strategies and interventions in the moment to ensure family competence and confidence in mutually agreed-upon strategies. This EI provider stated: *“I like to always have them...try it out obviously while I’m there, just so I see them actually do it because hearing about it and seeing me do it is different than...them having to*

actually do it.” Another provider believed such practice was more valuable to families than the written home visit plan: “Really the important thing I feel...is the practice that happens at home visits, the repetition. I mean, the parents are going to remember what you tell them repeatedly more than what you write down.”

Participants readily described a variety of supportive ideas and strategies that emerged during home visits. It was more difficult, however, for most of them to specifically outline the “steps” of a strategy.

Home visit action plans. Action plans were consistently used by EI professionals to further the impact of EI support between home visits. This was accomplished in some key ways. First, the plan usually named the IFSP goal that was the focus of the visit, and often the goal was broken down into a manageable chunk allowing families to take incremental and positive steps toward meeting goals. An EI provider stated:

There's a little portion at the bottom [where] we...write out what they're going to do between visits, and that's something that the family normally decides on. It's not necessarily like something I wrote. I always call it...a mini goal. "What do you want your mini goal to be for next time?" And they come up with it on their own which I do think helps buy in. But I would say that's the most consistent way that we...help them to try and get some of that follow through.

A parent described how the home visit plan provided support for her: *“This is what we talked about, and this is what we're going to try, and we'll talk more about it on the next visit, like what worked, and what did not work. So, that kind of helps.”* Another parent said: *“At the end of our visit she'll write goals...down on a piece of paper for us. So, we can always go back to that and reflect, like what do we need to work on, what do we need to do.”*

Next, most plans stated the routines in which the family agreed to try the strategy. One EI provider used the following strategy: *“A lot of times I'll have my families pick a routine that they feel like they have time to be with their child or time to give their child attention.”* Another EI provider shared:

Sometimes, we'll tie it to a specific... time of day. So, instead of it being an intervention that you have to apply on your own, to all these different parts of the day, we actually kind of break it down and start to apply it to a specific part first. And then, maybe on subsequent visits, we might try to even expand that to other parts.

A family member expressed appreciation for the linkage of the process to daily family life:

It's...on that sheet we talked about...it's listed out. So just whatever the activity is that we need to be working on or the goal that we're working -- you know, the skill. Then she'll give me ideas of... usually three or four different parts of the day or different kinds of activities ...to incorporate that into. But none of it's stuff that we would never do. It's all part of how we would normally do our day and all that. She knows us... really well, and she's been here where we talk about a typical day and all that with the service coordinator. So it's all very applicable.

The plans were handwritten on carbon paper so that a copy could be left with the family.

A format for the home visit action plan was suggested to teams during the *Getting Ready* training, but teams were able to adapt the plan to meet local needs, thus sections included in the plans varied from team to team. All plans analyzed for this project reported family updates on child progress and described strategies or ideas that were the focus of the visit. However, plans adhering closely to training recommendations additionally included sections for naming the outcome of focus, identifying routines in which the family agreed to try strategies/ideas, and

specifications for between-visit communication should the family have questions. Supportive features of the action plan format such as these were absent in a small number of plans analyzed for this project.

An additional issue found in the language used in some actions plans was the presence of jargon specific to a particular EI provider role. On the “Family” line for “What will happen in between visits?” one plan stated: *“Practice ‘squatting’ activity 1x a day—looking for less falling and squatting more.”* Another stated: *“Continue to simplify words for [the child] to CV or CVCV.”*

Communication between visits. The majority of professionals and families shared they actively engaged with each other through one or two-way communication in-between home visits. Across participants four methods of communication were reported – text messaging, phone calls, emails, and Facebook Messenger. Professionals and families shared positive aspects of communication. Families shared they felt supported by their providers and/or service coordinators. One parent said:

They’ve...made it so easy for me... I’ve been able to breathe better, because I’ve been able to talk [to] them about the concerns about my kids, and with no judgment. I’ve even had people...even doctors, judge about my kids. And I’ve never had any problems with the home system.

Another parent offered a similar sentiment: *“She’s really good at contacting us, or we’re really good at contacting her. So, there’s not really a problem. If she needs anything, she calls us and we’re always by our phones.”* EI professionals also provided a rationale for use of different communication methods based on family preferences. One provider shared the following:

They all want texts. I’ve had in the past some phone people that wanted phone calls. I’ve

had in the past some that wanted emails. I still have a couple that want resources mailed to them. And then in the past I did have some that wanted it done by Messenger. Like Facebook Messenger. That's how they wanted it then because they were on cell phone plans that if they ran out of minutes, then they didn't get texts, but as long as they had the Internet they could get messages.

Providers also indicated they communicated with families for a variety of reasons. They often contacted the family to ask “*how it's going.*” Often this included following up on a joint plan such as this example from a provider:

I was at the home visit last week. I said, “I know my coworker is giving me an example of the social story. I will text you guys during the week to tell you what pictures I need.” [T]hen they took pictures with their phone and texted them to me... I have some parents that like to send me videos and pictures a lot, just because we've talked about something.

In addition to following up on plans made, providers were in contact with families to remind them of scheduled home visits, to follow-up on the completion of paperwork, or to communicate about the child's progress towards outcomes. For example, a provider said a parent sent her a picture of her child to demonstrate the progress discussed: “*I had a little guy who's on the autism spectrum and [he] wouldn't wear anything but a red shirt. And so she [the parent] sent me a picture with a green shirt.*”

Participants reported the *Getting Ready* approach increased the frequency of communication with families. In the quote below, one provider reported that families communicate more in-between visits when those visits were less frequent:

If it's an every other week visit, I usually try to set a reminder in my phone or on my calendar to text them exactly a week later just to be like, hey, just wondering how the two

things we talked about are going. If it's not going great, that way it gives me some time to think about what we need to change versus – I kind of have it scripted on a text so I can copy and paste it... Just to kind of check in so that I don't get blindsided when I go into that visit and they're like, well we didn't do anything for the last two weeks because it didn't work. And that way, I can at least get back in there if I need to sooner than later.

Participants shared several challenges with communicating. These commonly included (a) use of personal cell phones, (b) difficulty managing communication with high caseloads, (c) unclear expectations, (d) difficulty with professional boundaries, (e) technology barriers, (f) family preference of communication method not matching the needs of the professional, and (g) communication when the family requires an interpreter. Regarding personal cell phones, most professionals reported communicating with families using this method. There were difficulties with this due to families preferring to communicate with them in the evening after work hours. One provider explained this dilemma and offered a solution:

There [have been] a couple of times where it's [personal cell phone] been abused by families, and we've had to go back and set parameters a little bit. So, the only thing maybe is if it wasn't [my personal phone] I could essentially shut it off... just to have that separation when I do get home to not feel like when a parent texts me at 10:00 that I can't wait until 7:30 the next morning when I'm headed to work. To me, that'd be the only thing I just feel like I could have separation between my work and my personal phone.

One professional noted she has difficulty with communication when her caseload is high, but that she wished communication occurred more frequently:

I wish we could talk more between visits...when it's more time in-between, I wish that I was better at establishing [that] we're going to check-in this many times, or I'm going to

text you. Now, some of that is because I have 31 families right now. I am swamped. So, it's just remembering to get visits scheduled and check-in with families who've fallen...off a little bit, that's about all I can do right now.

Some families appeared unsure of the method or how frequently they should communicate with professionals as evidenced by this quote: *"I don't know if they're supposed to answer their phone all the time or even when it's... just... a little bit after hours but they've always been there to answer my phone calls."*

Two professionals noted that their school district purchased a phone app to communicate with families; however, they indicated it was cumbersome and had associated errors and few providers used it. Also, several professionals shared that families prefer text messages, but in some instances they need to share more information than is feasible in a text. The quote below represents this perspective:

You know, a lot of families will only text, and there's just some things you just can't text [laughs]. I was... "Oh if we could just talk on the phone." [But], if they won't answer the phone, that's not an effective strategy either. Sometimes...they only want text messages, or a visit...I have a mom that will say, "I will never answer the phone, if you call me, I will never answer you." So trying to text about "How do I reapply for SNAP?" Well, it's going to take me 20 minutes to put that in a text message, if you would just answer the phone. But in a text message it goes, because otherwise she won't answer.

Professionals and families were asked what might make communication better for them. Families overwhelmingly shared that communication was good or fine and that improvements were not needed. One family shared that scheduling was often difficult and that the provider was not available during the time of day when support was needed. Professionals reported that they

wished they could connect in a “*more personable*” way and “*not through text message all the time.*” They shared that sometimes families change their number and then the provider cannot communicate with them. Additionally, professionals noted that it might be helpful to have a better way to remind families of the visit because they are required to remember many days/times due to caseloads.

Theme 2: Accountability-- gains and gaps. A second overarching theme that emerged from the rich qualitative data set was that of accountability. This term is defined by Merriam-Webster as “an obligation or willingness to accept responsibility or to account for one's actions.” The *Getting Ready* framework provided home visitors with systematic prompts for checking progress on previous-determined child and family outcomes, selecting an outcome as a target of home visit problem-solving, defining strategies to address an outcome, planning acceptable times in daily routines/activities for families to implement strategies, and specifying an in-between visit communication system should families desire more support. These prompts were intended to strengthen the impact of EI home visits on family competence and confidence in supporting their young children with disabilities by focusing all team members (including family members) on accountability to IFSP outcomes. Data collected for this project provided support for gains in accountability, as well as revealed gaps that still exist in the process.

Gains in accountability. Participants reported observing families increasingly taking ownership of the collaboratively developed strategies. Although some needed a bit of encouragement, most families were willing to try strategies/ideas during the home visits. Planning for between-visit implementation of strategies was consistently conducted during the visits, and this was documented in the home visit action plan and left with the families. An EI provider explained:

There's a little portion at the bottom [of the home visit plan where] we always... write out what they're going to do between visits, and that's something that the family normally decides on. It's not necessarily something I wrote...and they come up with it on their own which I do think helps with buy-in.

The very act of putting “who does what” down on paper reportedly made the plans tangible and concrete. This lent itself to teams reviewing the plans at subsequent visits to ensure that the plans had been accomplished or to make needed adjustments for success of the plan: *“I always start my next visit...by pulling out the last home visit note to check on how it's going.”* Checking was usually done informally through conversation with family members, rather than the use of more formal fidelity checks. One parent explained: *“I kind of tell her, this is what happened for the week, this is what's going on, and everything else. She pretty much just asks me. So, what did I do, and what I think was progress, and what not.”* An EI provider said: *“Yeah, so every time we're going out and doing the Getting Ready strategy, and we're asking about those goals, we're documenting the progress and what the parents are telling us.”*

Gaps in accountability. While many participants reported strengthening in accountability regarding implementation of strategies/ideas on a regular basis, there remain gaps in accountability regarding the monitoring and documentation of progress toward child and family IFSP outcomes. Integral components of a data-driven decision making process include checking on fidelity of family use of planned interventions, monitoring progress through frequent, efficient, and systematic collection of data, documenting and organizing the data, and utilizing the documentation to inform team decision making (Grisham-Brown & Pretti-Frontczak, 2011).

When participants were asked about the collection of data regarding progress, the methods reported ranged from formal to informal to non-existent. One participant described a systematic approach to data collection, depending upon the goal:

Some of the goals, like if it's a talking goal, we'll keep...a list of new words that they're saying or new sounds that they're making. If it's a potty training goal, we might keep a potty chart as a step towards potty training.

At the other end of the spectrum were professionals not reporting any process for documenting progress toward outcomes between IFSP meetings. For example, one EI provider stated:

There's really no place to document specific progress, other than putting it on our notes. Actually right now there's no, I would say, I don't feel that there's any push to show that we're actually making specific progress other [than] six months to six months.

When asked how child/family progress was documented, another EI provider reported relying on progress monitoring by the SC:

I'm not honestly sure. I know that [the SCs] have -- Yeah. Yeah. I just know that when they call, they're always really great at...checking in on all the goals, and then they'll shoot us an email if...something comes up that...the family maybe mentioned to them.

Many of the professionals utilized informal strategies to monitor child and family progress toward achieving IFSP outcomes. This was generally accomplished through having conversations with families about progress or the professionals observing particular child skills during home visits. An EI professional shared:

How do I measure them? I don't know that I measure them. The parents measure them.

We go over them. I mean we check, and she lets me know this is what's the goals, and we need to work on [these] a little bit more, and...then I'll focus on [them] a little bit more.

Another EI provider said:

I have a lot of -- on the [home] visit sheets-- just observation notes, things they're doing, things they're saying. So I feel like that lends kind of to show progress. It's not like a formal progress [monitoring], but ...really, I could go through my notes for six months and say, oh, well at the beginning he was saying dad. Now, he's saying 10 words, or he's saying two word phrases, just observations, I guess.

This EI provider described partnering with one family to collect meaningful and specific data:

I think I really need to get into a habit of having my goal sheets and then just being intentional during some of the visits so that it's not just "Okay, how are you feeling about this?" But like that one family, the word log, I know, I know that he's met his goal of 50 words because mom kept track.

Similarly, another EI provider described supporting a parent data collection system for purposes of targeting a behavioral intervention for the child:

Our plan between now and next time is she was going to take some data so that she really got some good information on how often things were happening and how often they were having to put him in time out. And, we talked a lot about that too because he's got some trauma about their schedules and really making sure that they kind of focus in on like those times of day that maybe are harder. And so... we wrote her data sheet so that she could just tally between morning, afternoon, and evening and then looking at the days where maybe he had to go to grandma's house versus staying at home and seeing if things got harder. So, that was our plan. We'll see how it goes.

Several providers, however, expressed that they were reluctant to ask families to engage in more formal data collection procedures due to concerns about the burden such practices might place on the families.

Interviewees were asked about the frequency of progress monitoring. Families and professionals consistently reported discussion about child and family progress, usually during the opening segments of home visits. The data suggested, moreover, that the usual focus of such discussions was progress or barriers in implementing ideas/strategies from the previous home visit. Thorough progress checks (i.e., addressing the progress thus far on all child and family IFSP outcomes) were infrequent as many professionals said they focused on progress toward the immediate outcome of concern during most visits, and only checked on all outcomes when a six-month review was imminent.

There were a number of concerns regarding the documentation process, specifically. Professionals described relying upon a variety of means to document the information including provider notes, copies of the home visit action plan, or copies of the IFSP. Since IFSPs tend to be copious documents, some teams had devised a one-page summary of child/family outcomes to help EI providers and SCs remember and focus on all of the outcomes, and notes were jotted on these summaries.

Service coordinators, in particular, expressed concerns about the time burden of redundancy in documentation. For example, SCs write information in a triplicate action plan then must write down the information again in the CONNECT system, and if they are documenting the information in more than one language it adds to the time needed to complete this task.

Meanwhile, some families expressed that the process used to measure and document progress was not clear to them. One parent shared these thoughts:

They'll be... "Okay, well this is her goal. This is what, you know, we think, we have observed and this is, you know, whether we...feel that she's met the goal or not."

And...that's where I don't know if that's exactly right. I don't know if it should be them exactly judging whether they feel that she met that goal or if it should be me, as the parent, judging that she's met that goal.

Another parent offered a suggestion:

I feel like we talk about when the goal is met and we know when the goal is met. But maybe like a yearly progress report type of thing would be helpful. Like this was the goal met...show all the goals he has met to see the progress... [It] might make me feel better.

Finally, participants reported that documentation gathered regarding child and family progress toward achieving outcomes was inconsistently utilized to drive decisions about the strategies/ideas selected to meet the outcomes. When asked if she and the families she worked with used collected data in this way, one EI provider shared:

I think informally we do. I don't know that we do that... with a formal process, but I think that, a lot of time, guides what we do next. If something's been working, then we know we need to shift gears to a new goal. If something's not working, or, okay, we're getting some progress this way, but our goal is this, I think, informally, we would...adjust.

Another provider said:

I felt like I use the documentation, I don't think my families necessarily do. But yeah...I definitely look at my logs and I'm like, okay, we've done this a couple times now and it's not really helping, we need to try something else.

A researcher asked a family member if her team used documentation to make decisions about either continuing or changing an idea that she was using to address a need or a concern and the

parent said:

“Yes, we have. An example is his weight gain. There's been so many things we've tried. So, she's flipping through the paper and I've been telling her stuff we've used. So, we are in the process of looking at all of that.”

Theme 3: Implementation challenges. Several key implementation challenges arose from the interviews. First, some providers shared that they struggled to provide EI services with diverse families that did not speak English as their first language. These families required the use of an interpreter to participate in all meetings and visits and challenges were observed related to the combination of having a child with a delay/disability and not speaking English. One provider shared that it may be helpful to receive professional development on how to support families that speak another language. An example of training needs is described below:

...Because if you think about it, there's training here...[if] you have an autistic caseload, you go to the Autism Conference. You have some behavioral issues – you go...get that information. There's really nothing out there for when you have to work with Spanish-speaking families and that's...[a] problem.. On top of having a child with special needs. So, you're adding a lot to [families that] speak Spanish.

Some SCs shared challenges with filling a dual role of the services coordinator and the interpreter. They felt stretched thin between interpreting, facilitating meetings, and completing paperwork. One SC said:

It gets tricky when I'm doing a lot of--mostly everything. So at IFSPs, or RBIs, I'm always a primary interviewer. The interpreter. And a lot of times, because I'm the interpreter, I make--I keep my own stars. I can't do the notes, I think I've tried it, and I was just like, no, it's not working. So it's just where I have... what, three or four roles? It gets--I can do it.

Manually do it. I mean it's just when you have an RBI after RBI, after RBI, it's just very draining.

Second, providers suggested professional development may be helpful to address the needs of parents that have disabilities themselves. Often, these individuals required specialized instruction, or significant support to remember and use strategies in the home with their children.

One EI provider explained:

That was a very low cognitive family. Sometimes trying to do the Getting Ready strategy with families like that is hard. It's hard. It works really well with some families, and some families, it really is... out of their comfort zone to follow that structured, organized [format]. "Here's what we worked on last time. What are you feeling really good about?" You know, they're like, "What am I feeling good about? ... Well, my husband is in jail and my kid can't talk." Sometimes it's hard not to tweak it to fit a family.

A third implementation challenge related to the presence and role of the SCs. There was considerable variability across the PRTs. In some districts, the families reported meeting with the SCs and provided concrete examples of what goals they had addressed together. In other districts, families indicated they rarely engaged with the SC and that most of the interaction was during meetings or over the phone. One parent said: *"She typically only comes during meetings. She has come a couple of times... to give me paperwork for things I needed for them. During those visits when we were going over the IFSP she's usually the one that asks all the questions."* Furthermore, SCs reported they tended to depart from the use of *Getting Ready* when conducting home visits with a provider that was not trained. One SC shared her experiences implementing the *Getting Ready* strategies when conducting joint visits with a provider who was not trained: *"Not, I mean not a whole lot [of use of Getting Ready] ...I still, you know, if there's a specific*

goal that... we haven't touched on maybe...[But] I haven't done...home visit notes or anything with them."

A final implementation challenge noted by SCs was related to the focus of the visits. The focus was often determined by the opening conversation, and SCs were not always sure how to incorporate the *Getting Ready* framework. They reported opening conversations often led to discussion about the child's progress, experiences with the primary service provider (PSP), and/or needed resources/supports. Services coordinators reported most frequently following up on tasks the parent needed to complete in order to access services and supports in the community. Specifically, participants shared information about families making progress in EI towards: (a) scheduling doctor's appointments, (b) reapplications for the Supplemental Nutrition Assistance Program (SNAP), (c) obtaining Supplemental Security Income (SSI), (d) completing health insurance paperwork, or (e) accessing electricity in the home. Visits with families that were "in crisis" required more guidance and support than other families that indicated they were receiving all the services and supports they needed. Often, when a family noted they did not need external supports the SC became unsure of her role in service provision.

Results of the member check. An anonymous survey was distributed to 36 interview participants. Eleven participants (31%) responded. The survey contained a summary of the study's three key themes and four questions probing whether or not the findings matched participants' experiences and whether or not other important experiences were not reported in these findings. There was unanimous agreement across participants with the summaries of Theme 1 (family engagement) and Theme 2 (accountability). With regard to Theme 3 (implementation challenges), one participant reported not having personally experienced such issues, however, the other participants agreed with this finding.

Discussion

Findings from this study revealed a number of ways that the quality of EI home visits in Nebraska pilot site PRTs has been enhanced by the use of the *Getting Ready* framework. Professionals, both EI providers and SCs, received training in a number of evidence-based strategies designed to strengthen parent-child interactions and parent-professional collaboration. Stronger interactions and collaborations were focused on developing interventions that would propel families to meeting prioritized outcomes (as stated in IFSPs) for their families and children. The *Getting Ready* strategies aimed to add structure to home visits and engage families in developing useful home visit action plans that would encourage families to utilize planned interventions between home visits.

Generally speaking, the *Getting Ready* framework resonated with EI providers interviewed for this project to a high degree, and was met with mixed reviews by SCs—mainly due to the nature of many SC home visits. There was evidence that concrete ideas and strategies for achieving desired IFSP outcomes were frequently practiced during home visits and documented in home visit actions plans, and more rarely, multi-step interventions were planned during home visits by EI providers. The ideas/strategies were usually embedded in regular family routines or activities which resulted in functionality for children and families. Also, families and professionals usually identified a method of communication for touching base before the next home visit; most frequently, text messaging and Facebook Messenger were used.

Regarding the frequency of communication, it seems *Getting Ready* may have increased the number of times professionals communicated with families between home visits. While communication may have occurred more often, providers and SCs reported that there were challenges associated with communication—specifically, professionals were challenged by

families communicating via text message at a high frequency and families communicating after designated work hours.

These results add to the limited research that has been conducted examining parent-professional communication in-between home visits. The *Getting Ready* home visit plan is a tool that can support families as they progress towards goals in-between home visits. An additional component that would strengthen the approach may be to give professionals an effective method of communicating with families that clearly separates family-professional boundaries. An example of this may be to use a phone application that is feasible and allows for seamless communication across all team members. Furthermore, challenges were reported with communicating with families that needed an interpreter present. The coordination and time that is required for these families reportedly increased the expectations for professionals employed in districts with large populations of non-English speaking families.

Regarding use of the *Getting Ready* approach by SCs, the reviews were mixed. Some shared they appreciated the framework and that it provided more structure to their visits. Others shared they were not sure about the approach and how it related to them; specifically, when the family was thriving and did not need as much support. Families generally reported they were well supported by their SC and that they focused mostly on accessing formal and informal community resources and/or follow-through with tasks that would support the family or child. A few families discussed the absence of the SC or their impression that this professional's role was to conduct meetings and complete paperwork.

For both EI providers and SCs, the monitoring and documentation of progress toward IFSP outcomes is largely informal and there is a great deal of variability in practices used by the professionals. Roles and responsibilities in the progress monitoring/documentation process may

be ambiguous on some teams. Currently, most professionals rely upon caregiver report and child observations, and write anecdotal notes to document this information. While anecdotal notes are a rich and valued source of information, few professionals tap into methods of progress monitoring data collection that go beyond anecdotal notes. Thus, teams may be missing key data regarding the effectiveness of chosen strategies/ideas that would be critical to a data-driven decision-making process. In addition, the data collection and documentation process used by professionals is routinely unclear to families, thus suggesting that many families are not full partners in this aspect of EI services.

Recommendations for Practice and Further Investigation

The pilot PRTs tapped for this study are making some observable gains in implementing routines-based interventions during home visits by EI providers. Home visit plans typically document family/provider focus on one to two immediate outcomes of concern and a strategy or idea is described in the plan as well as routines where the family plans to try the strategy. In addition, a plan for communication between visits is often present on the home visit plan. There are, however, across the pilot site teams inconsistencies in methods used to gather and document information about child/family progress toward achieving IFSP outcomes. There may also be ways to strengthen communication between visits to prompt the level of engagement of families in implementing home visit plans. And, within this small sample size of SCs, the roles and responsibilities of these providers as well as how those functions are carried out using the *Getting Ready* framework for structuring home visits often seems unclear.

One recommendation that emerges from these findings is that EI teams may want to consider the “content” of home visit sessions. This is not an issue of implementation of the *Getting Ready* framework, rather consideration of the content of planned interventions that fit

within that framework. Often, EI providers and families reported use of strategies and ideas within daily routines, but many struggled to define the planned “intervention” specifically. It would likely be helpful for providers, therefore, to strengthen their knowledge of evidence-based interventions and the steps that are used to implement these interventions. This would likely influence how providers coach families to effectively use the interventions.

A second recommendation for practice that emerges from this study is that the Co-Lead agencies consider initiatives for both strengthening and streamlining the process EI teams use to monitor and document child/family progress toward IFSP outcomes. The literature indicates this is a commonly found concern in the field of EI:

Studies indicate that more needs to be done to provide early interventionists...with the training, tools, and resources they need to engage in effective and consistent child progress monitoring (Thomas & Marvin, 2016, p. 185).

Conceptually, this process would require compatibility with natural environments, including home settings. In addition, data collection would need to occur on a regular basis, and ideally include both formal and informal measures (DEC, 2014; Thomas & Marvin, 2016).

There are a number of evidence-based assessment practices found in the literature that might provide teams methods for efficiently collecting data to guide team decision-making. One is the use of formal tools such as the Assessment, Evaluation & Programming System (AEPS-2; Bricker, Capt, Johnson, Pretti-Frontczak, & Straka, 2002), Individual Growth and Development Indicators (IGDIs; Greenwood, Carta, & Walker, 2004), or Developmental Snapshot (Gilkerson & Richards, 2008).

Secondly, collection of quantitative data regarding obvious, distinct skills or behaviors is well-documented as lending itself to frequent assessment of progress (Dunlap, Lee, Joseph, &

Strain, 2015). This includes data about the occurrence—percentage of time or percentage of opportunities, frequency, duration, or latency of particular behaviors/skills. The development of rating scales with quality indicators also allows families and early childhood professionals to efficiently collect data about a measurable dimension of a skill or behavior, as well as key qualitative features present when the skill/behavior is demonstrated. Rating scales are often conceptualized as 1 – 5 Likert-type measures with anchors created to correspond to the numbers. These “typically take only about 10 seconds or less to complete each day” (Dunlap et al., 2015, p. 6). One of the authors of this report developed such a checklist and trained staff to utilize this process for collecting and documenting information about IFSP outcome progress in Hawai’i Early Intervention. Many of these tools have options of technological support to ease gathering and management of data (Buzhardt, Walker, Greenwood, & Heitzman-Powell, 2012).

DEC Recommended Practices (2014) suggest that professionals partner with family members (A-2) and utilize a variety of methods (A-6) in the important task of gathering meaningful assessment data. Ultimately, this data has the potential to inform EI teams to make solid decisions regarding effective interventions designed to achieve family-prioritized outcomes. Several families in the current study expressed interest in having more transparency, and indeed more involvement, in the process currently used by the pilot site teams. The reliability of parent report as one means of assessment (Gilkerson, Richards, Greenwood, & Montgomery, 2017; Libertus & Landa, 2013) has been established. There are additional tools to consider to strengthen and add accountability to this process.

With regard to streamlining the documentation process, SCs specifically reported encountering redundancy in documentation. Thus, exploring electronic systems to reduce these sorts of demands may be beneficial and make the SC workload more manageable.

Based on the findings of this study, it is apparent that communication between home visits varies in method, frequency, and focus across families and professionals. Individualization of support for families is a critical aspect of providing services; however, several improvements in this area may be helpful in supporting the EI workforce in Nebraska. First, it may be helpful for professionals to assess family preference (e.g., text messaging, phone call) as well as barriers that exist (e.g., phone turned off due to lack of finances) during initial encounters with families. Second, professionals may appreciate guidelines related to recommended methods, frequency, and focus of communication efforts. For example, families receiving services one time per month may benefit from more frequent communication between visits than a family receiving services once per week. Additionally, it may be beneficial for professionals to utilize an online portal or phone application (e.g., *TheraWe Connect*) to communicate and document home visit plans that are shared by families and team members. This type of documentation should be available at no-cost and accessible to families at all times. This may allow for better collaboration and consistency across team members, family use of jointly-determined strategies, and completion of action items between home visits. Methods such as these may improve parent-professional boundaries and decrease the frequency of which families contact the provider after working hours.

Further clarification of the roles and expectations for SCs within the *Getting Ready* framework would benefit teams implementing this model for home visiting. At this time, SCs are being utilized in varied ways across teams. For example, for some teams, face-to-face visits by SCs are infrequent or SCs carry a challenging workload with responsibilities for interpreting and translating for non-English speaking families. A deeper examination of how SCs and providers are working together to serve families and children may be warranted—are they collaborating

through information-sharing or conducting joint visits? How might they partner with each other and/or families to collect data on child/family progress? What role might they play if families do not see the need for SC support? As more teams, including SCs are training in and implementing the *Getting Ready* framework, such on-going examination may lead to adjustments in how SCs develop effective parent-professional partnerships through the *Getting Ready* strategies.

Finally, further investigation of evidence of *Getting Ready* strategies found in home visit descriptions by family and trained professional pilot PRT participants would be of interest. This would potentially be possible through a secondary analysis of the data set collected for this study.

Conclusion

Qualitative data gathered through interviews with a total of 41 participants and 11 home visit action plans yielded a rich description of EI home visiting practices in the pilot PRTs across the state that have participated in the three phases of Nebraska's RDA process. Results include evidence of family engagement in setting the home visit agenda, focusing on a prioritized IFSP outcome during the visit, and "practicing" strategies developed in a collaborative process. This study also explored professional-family communication practices between home visits, and suggestions for strengthening these are provided. Additional recommendations for renewed focus on evidence-based interventions as well as a closely related topic, progress-monitoring and documentation, are addressed.

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Appendix A

Family Team Member Interview Protocol

Project: Understanding Early Intervention Home Visiting Practices in Nebraska

Participant ID#: _____

Time of Interview: _____

Date: _____

Place: _____

Interviewer: _____

Say: Thank you for agreeing to chat with me about your experiences with Early Intervention home visits for your child and family. Before we begin, I'd like to go over the consent form with you. *After obtaining interviewee signature:* OK. Let's get started.

Questions:

Part A: Focus on Early Intervention home visit

1. How would you describe what happens during a typical home visit with your provider(s)?
2. During the home visits, does the service provider(s) help you and your child participate in your family's activities and routines? If so, what activities or routines?

[If so....] Would you be able to tell me about some of the strategies/ideas you have discussed with your service provider(s) to help with those activities/routines?

[If not...] Would you be able to tell me about some of the strategies/ideas you have discussed with your service provider(s) to help your child and family achieve your IFSP outcomes?

3. Would you be able to walk me through one specific strategy you discussed with a service provider to achieve a child or family IFSP outcome?
4. What would make the process of choosing and learning new strategies/ideas better for you and your family?
5. How does the service provider make sure you are comfortable using strategies/ideas after the provider is gone?
6. During home visits, is there anything your provider(s) does to help you remember and use the strategies discussed when the provider(s) is not present?
7. Does your provider develop a home visit plan you will use when he/she is not present?

[If so....] Would you be able to tell me about the components of that plan?

[If so...] Tell me about an example of a home visit plan you developed with the service provider recently.

[If not...] Would you be able to tell me about some of the ways your service provider has used to help you remember and use strategies when he/she is not present?

8. How does the home visit plan usually go for you?
9. Do you ever communicate with your service provider(s) about a strategy between home visits? If so, how do you communicate?
10. What would make the communication system you have in place with your service provider(s) better for you and your family?
11. How does your service provider know that you tried to use the strategy when he/she was not present?
12. How does the service provider support you if you did not have a chance to use the strategy before the next session?
13. What challenges have you had using the strategies you and your service providers develop?
14. What would make the process using the strategies between home visits better for you and your family?
15. How do you and your service provider(s) check to see if your child and family are making progress on IFSP outcomes?
16. How often do you check on progress?
17. How is the progress documented?
18. Do you and your service provider(s) ever use the documentation to make decisions about either continuing or changing a strategy?
19. What would make the process of monitoring or documenting your child's or family's progress on IFSP outcomes better for you?
20. Is there anything else you would like to share about the process you and your team use during or between Early Intervention home visits that we haven't yet talked about?

Part B: Focus on services coordination home visit

Now if I may, I'd like to shift gears a bit and ask you just a few questions about visits with _____ (name of the SC.)

21. How would you describe a typical home visit with _____ (name of the SC)?

22. Does _____ (name of the SC) develop a home visit plan you will use when he/she is not present?

[If so....] Would you be able to tell me about the components of that plan?

[If so...] Tell me about an example of a home visit plan you developed with _____ (name of the SC) recently.

[If not...] Would you be able to tell me what you do with your home visit plan after _____ (name of the SC) has gone?

23. Do you ever communicate with _____ (name of the SC) about a need, concern, or idea between home visits? If so, how do you communicate?
24. What would make the communication system you have in place with _____ (name of the SC) better for you and your family?
25. How do you and _____ (name of the SC) check to see if your child and family are making progress on IFSP outcomes?
26. How often do you check on progress?
27. How is the progress documented?
28. Do you and _____ (name of the SC) ever use the documentation to make decisions about either continuing or changing an idea you were using to address a need or concern?

Thank you for your time!

EI Service Provider Team Member Interview Protocol

Project: Understanding Early Intervention Home Visiting Practices in Nebraska

Participant ID#: _____

Role on EI team: _____

Time of Interview: _____

Date: _____

Place: _____

Interviewer: _____

Say: Thank you for agreeing to chat with me about your experiences with Early Intervention home visits in your community. Before we begin, I'd like to go over the consent form with you.

After obtaining interviewee signature: OK. Let's get started.

Questions:

1. What changes have you seen in your home visiting practices since your PRT began using the *Getting Ready* framework?
2. How would you describe what happens during a typical home visit with a family?

[If routines/activities are not mentioned in #2] During home visits, do you help family members and their children participate in family activities and routines? If so, what activities or routines?

3. Would you be able to share some of the strategies/ideas you have discussed with family members to help with those activities/routines?

[If routines/activities are not mentioned in #2] Would you be able to tell me about some of the strategies/ideas you have discussed with the family members to help the child and family achieve their IFSP outcomes?

4. Would you be able to walk me through a specific example of a strategy you discussed with a family member that included use within activities/routines to achieve child or family IFSP outcomes?
5. What would make the process of choosing and coaching new strategies/ideas better for you?
6. During home visits, is there anything you do to help the family member remember and use the strategies you discussed when you are not present?
7. Do you develop home visit plans with the family? If so, what components are included in the plan?

8. **[If #7 is yes]:** Tell me about an example of a home visit plan you developed with a family recently.
9. How do you make sure the family member is comfortable using [strategy/ideas] [home visit plan] after you are gone?
10. Do you ever communicate with families about a [strategy/ideas] [home visit plan] between home visits? If so, how do you communicate?
11. What would make the communication system you have in place with your families better for you?
12. How do you know if the family member follows the steps of the [strategy/ideas] [home visit plan] in the way you discussed?
13. How do you know if the [strategy/ideas] [home visit plan] worked or not for the child and family?
14. How do you respond if the parent shares that he/she has not completed the steps of the [strategy/ideas] [home visit plan]? Or that it was not effective?
15. How would you describe family implementation of planned strategies between home visits in general across your caseload of families?
16. Describe how you measure child and family progress on IFSP outcomes?
17. How often do you measure progress?
18. How is the progress documented?
19. Do you and the families ever use the documentation to make decisions about either continuing or changing a strategy?
20. What would make the process of monitoring or documenting child or family progress on IFSP outcomes better for you?
21. Have you noticed any changes in the number of home visits you typically provide to families since receiving training in *Getting Ready*?
22. Is there anything else you would like to share about the process you use during or between Early Intervention home visits that we haven't yet talked about?

Thank you for your time!

Services Coordinator Team Member Interview Protocol

Project: Understanding Early Intervention Home Visiting Practices in Nebraska

Participant ID#: _____

Time of Interview: _____

Date: _____

Place: _____

Interviewer: _____

Say: Thank you for agreeing to chat with me about your experiences with Early Intervention home visits in your community. Before we begin, I'd like to go over the consent form with you.

After obtaining interviewee signature: OK. Let's get started.

Questions:

1. What changes have you seen in your home visiting practices since your PRT began using the *Getting Ready* framework?
2. How would you describe what happens during a typical home visit with a family?
3. Would you be able to share some of the ideas you have discussed with family members to help the child and family achieve their IFSP outcomes?
4. Would you be able to walk me through a specific example of an idea you discussed with a family member to achieve child or family IFSP outcomes?
5. What would make the process of choosing and coaching new ideas better for you?
6. Do you develop home visit plans with the family? If so, what components are included in the plan?
7. **[If #6 is yes]:** Tell me about an example of a home visit plan you developed with a family recently.
8. How do you make sure the family member is comfortable using ideas in the home visit plan] after you are gone?
9. Do you ever communicate with families about a the home visit plan] between home visits? If so, how do you communicate?
10. What would make the communication system you have in place with your families better for you?
11. How do you know if the family member follows the steps of the home visit plan in the way you discussed?
12. How do you know if the ideas in the home visit plan worked or not for the child and family?
13. How do you respond if the parent shares that he/she has not completed the steps of the home visit plan? Or that it was not effective?
14. How would you describe family implementation of the home visit plans between home visits in general across your caseload of families?

15. Describe how you measure child and family progress on IFSP outcomes?
16. How often do you measure progress?
17. How is the progress documented?
18. Do you and the families ever use the documentation to make decisions about either continuing or changing an idea you had discussed to address a need or concern?
19. What would make the process of monitoring or documenting child or family progress on IFSP outcomes better for you?
20. Have you noticed any changes in the number of home visits you typically provide to families since receiving training in *Getting Ready*?
21. Is there anything else you would like to share about the process you use during or between Early Intervention home visits that we haven't yet talked about?

Thank you for your time!