Nebraska Phase III Year 4 Report

Indicator C11: State Systemic Improvement Plan – Nebraska – Phase III

Monitoring Priority: General Supervision

The State's SPP/APR includes a State Systemic Improvement Plan (SSIP) that meets the requirements set forth for this indicator.

Baseline and Targets

Baseline Data – C3B Summary Statement 1 - Acquisition and Use of Knowledge and Skills:

FFY	2013
Data	40.2

Performance Data – C3B Summary Statement 1 – Acquisition and Use of Knowledge and Skills:

FFY	2014	2015	2016	2017	2018
Data	50.4	46.1	45.2	39.41	33.6

FFY 2014 – FFY 2018 Targets- C3B Summary Statement 1 – Acquisition and use of Knowledge and Skills:

FFY	2014	2015	2016	2017	2018	2019
Target	40.2	40.5	41	41.5	42.5	42.5

Section A: Summary of Phase III Year 4

This section provides a summary of Nebraska's: SSIP baseline and targets for Indicator C11, the SiMR and Theory of Action, three coherent improvement strategies, implementation progress to date, and brief overview of evaluation activities demonstrating a positive impact on federal child outcome data.

Nebraska has one SiMR and is using a unified set of 3 coherent strategies to improve child outcomes.

<u>Nebraska's Part C SIMR</u>:

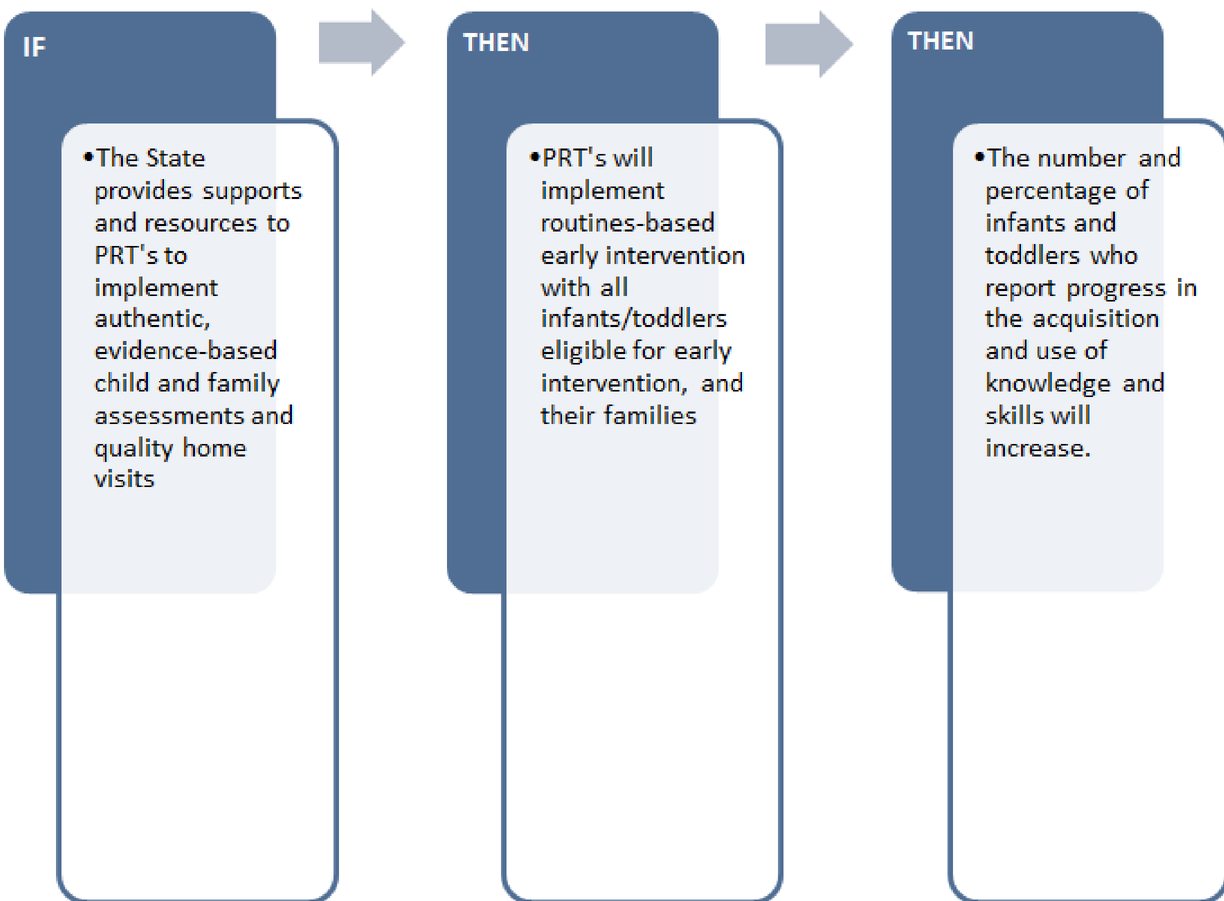
Increase the number and percentage of infants and toddlers who demonstrate progress in the acquisition and use of knowledge and skills (including early language/communication) – C3B, Summary Statement 1. Baseline, targets, and performance data for C3B are outlined above. In addition, Nebraska identified Indicator C4B: Effectively Communicate Child's Needs as a benchmark. Benchmark baseline and performance to date are illustrated in Table A1 below.

Table A1: Benchmark - Indicator C4B – *Families effectively communicate their children's needs:*

Year	Target	Baseline	Performance
2013-14		80.9	
2014-15	81.00		83.8
2015-16	81.50		84.8
2016-17	82.00		84.6
2017-18	82.30		86.4
2018-19	82.60		88.0
2019-20	82.60		

The state's Theory of Action is illustrated in Figure A1 below.

Figure A1

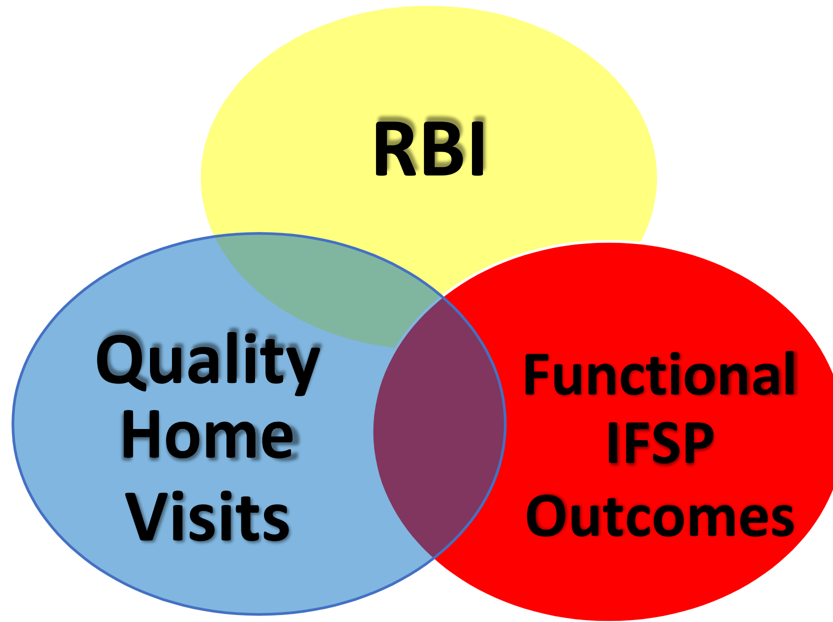


Nebraska's SSIP includes three coherent improvement strategies:

a. The Routines-Based Interview (RBI);
b. Functional child and family IFSP outcomes; and
c. Routines-based home visits.

The improvement strategies, as a unified set, are referred to as a "routines-based early intervention" (RBEI) approach. Nebraska expects to see a positive effect on the SiMR when EI teams (1) fully implement an evidence-based child and family assessment (RBI); (2) use the priorities identified during the RBI to develop functional child and family IFSP outcomes based on everyday routines; and (3) implement routines-based home visits focused on meeting the child and family IFSP outcomes. Figure A2 below illustrates the interconnectedness of the three strategies.

Figure A2: Three Coherent Improvement Strategies Venn Diagram



In Nebraska, the Planning Region Team (PRT) is responsible for the general oversight of local implementation of the RDA strategies. Beginning in 2015, each of the state's 29 Planning Region Teams (PRTs) were required to submit a Targeted Improvement Plan (TIP). The TIP was to address five key areas: data analysis, the region's focus for improvement, an infrastructure analysis, the design of a multi-year implementation plan, and an ongoing evaluation plan. All 29 PRTs have adopted a multi-year plan to implement the RBEI approach within their region.

Nebraska is utilizing a cohort approach to scale-up the three coherent improvement strategies through the state's Planning Region Team system. Cohort 1, comprised of PRTs 1, 22 and 27, began RBI and functional IFSP outcome training in January 2015. Cohort 2, comprised of PRTs 4, 18, 19, and 21, began RBI and functional IFSP outcome training a year later (January 2016). Cohort 1 received training on strategy 3- routines-based home visits in June 2017. PRT 1, however, declined to participate and PRT 7 replaced PRT 1 in Cohort 1 for this strategy. In addition, four of the non-cohort regions of the state were ready for home visit training earlier than other non-cohort regions. They received training along with Cohort 1 in June 2017. In June 2018, Cohort 2 received training on strategy 3. In June 2019, the Co-Leads began offering routines-based home visit training to the remaining non-cohort regions in the state, beginning with PRTs 3, 6 and 10.

SSIP Training Implementation Progress to Date

Table A2 below illustrates the SSIP training implemented to date and projected implementation timeline for each PRT.

Table A2: PRT implementation to date and projected implementation timelines

PRT	Strategy 1: RBI Training	Strategy 2: Functional IFSP Outcome Training	Strategy 3: Routines-Based Home Visit Training
Cohort 1			
1	2015	2015	TBD
22	2015	2015	2017
27	2015	2015	2017
Cohort 2			
4	2016	2017	2018
18	2016	2017	2018
19	2016	2017	2018
21	2016	2017	2018
Non-Cohort Regions			
2	2016	2018	2020
3	2016	2018	2019
5	2016	2018	TBD
6	2016	2018	2019
7	2014	2016	2017
8	2017	2018	TBD
9	2016	2018	TBD
10	2016	2018	2019
11	2016	2018	TBD
12	2016	2018	TBD
13/14	2016	2018	TBD
15	2016	2018	2020
16	2015	2017	2017
17	2017	2018	2020
20	2015	2017	2017
23	2015	2017	2017
24	2017	2019	TBD
26	2015	2017	2017
28	2017	2019	2020
29	2015	2018	TBD

Principle Training Activities Implemented this Year

During 2019-20 the principle training activities were:

Cohort 1: At full RBI and functional outcome implementation, PRTs 1, 22 and 27completed their fourth annual RBI fidelity checks for providers and services coordinators (SCs) *actively involved* in child/family assessment. In addition, this cohort received feedback regarding training needs identified during the fourth annual IFSP outcome analysis to drive improvement. Finally, the Cohort 1 regions who received routines-based home visit training in June 2017 and completed the home visit approval process in 2017-18, submitted their first annual home visit fidelity checks in spring 2019.

Cohort 2: At full implementation with the RBI, providers and SCs in PRTs 4, 18, 19 and 21 completed their third annual RBI fidelity checks for providers and services coordinators in fall 2018. In addition, they received feedback from their third annual IFSP outcome analysis to drive improvement. This cohort received routines-based home visit training in June 2018 and went through the home visit approval process in 2018-19. They will complete their first annual home visit fidelity checks in spring 2020.

Non-Cohort Regions: The non-cohort regions of the state began implementing their Targeted Improvement Plans (TIPs) in 2016. Active implementation of the TIPs continued throughout 2019 with a primary focus on RBI training and functional IFSP outcome training. All non-cohort regions were at full RBI implementation by the end of 2019. Seventeen of 22 non-cohort regions have had IFSP outcome training. This is up from four regions in 2018. Similar to the data collection in cohort regions, the Co-Leads are recommending the ongoing collection and analysis of IFSP outcomes in the non-cohort regions utilizing the IFSP Outcome Quality Checklist (Appendix L). Additionally, four of the non-cohort regions attended home visit training in June 2017. Internal coaches from these regions completed home visit approval in 2018 and began the process of training the providers and services coordinators in their regions during 2019 with technical assistance from the state level RBEI TA providers. In June 2019, three more non-cohort regions attended home visit training. Providers and services coordinators from these regions are currently completing the home visit approval process with state level coaches. Additionally, the internal coaches from these regions are currently completing the home visit approval process and will train any new providers and services coordinators within their regions beginning in 2020 with technical assistance from the state level RBEI TA providers.

Infrastructure Improvement Strategies

No changes were made to the state infrastructure during the past year. One change was made to the Part C SSIP leadership team: a third RBEI state coordinator was added. The Part C SSIP Leadership team now consists of Amy Bunnell (Birth to 5 Supervisor/NDE Part C Co-Coordinator), Julie Docter (DHHS Part C Co-Coordinator), Cole Johnson (Part C Data Manager/PRT Coordinator), and Sue Bainter, Cindy Hankey and Janice Lee as RBEI State Coordinators. This team meets weekly regarding the on-going implementation and evaluation of the Part C SSIP.

Summary of Evidence-Based Practices and Evaluation Activities Implemented to Date

Strategy 1: Routines-Based Interview (RBI)

All seven PRTs in Cohorts 1 and 2 are at full RBI implementation. Full RBI implementation is defined as "all providers and SCs involved in the child/family assessment process are approved in the RBI". RBI approval is documented when providers/SCs achieve a score of 85% or better on the RBI Implementation Checklist (Appendix C).

For evaluation purposes, initial RBI implementation checklists for providers/SCs in Cohorts 1 & 2

are collected by the Co-Leads. In addition, RBI fidelity checks are required annually and the Co-Leads document completion of the fidelity check for each of the cohort providers/SCs. To date, all providers and SCs in Cohort 1 and Cohort 2 involved in the child/family assessment process are RBI approved and have demonstrated on-going fidelity to the RBI.

Strategy 2: Functional IFSP Outcomes

Baseline data for IFSP outcomes was collected and analyzed prior to RBI training in each of the cohort PRTs. Baseline data consists of an analysis of IFSPs developed the year prior to RBI training using the IFSP Outcome Quality Checklist. Once regions reach full RBI implementation, they receive additional functional IFSP outcome training. Post additional training, annual IFSP outcome reviews are conducted in the cohort regions. Similar to baseline data collection, annual IFSP outcome reviews consist of an analysis of IFSPs developed during the year using the IFSP Outcome Quality Checklist.

In fall 2019, the state conducted the fourth annual IFSP outcome review for Cohort 1 and third annual IFSP outcome review for Cohort 2. Section C highlights the comparison of baseline to the annual analysis of IFSP outcome results for Cohorts 1 and 2.

Strategy 3: Routines-Based Home Visits

Training for Nebraska's third coherent improvement strategy—routines-based home visits utilizing the Getting Ready approach—began in June 2017 with Cohort 1. Providers and services coordinators from these regions engaged in the home visit approval process in 2018 and completed their first home visit annual fidelity check in the spring of 2019. Cohort 2 regions received home visit training in June 2018 and engaged in the home visit approval process during 2019. Their first home visit annual fidelity check will be due in 2020.

Highlights of Changes

Strategy 1- RBI
Three state-sponsored RBI boot camps were held this past year to support long-term, statewide sustainability of RBI. It is expected that some combination of state and locally sponsored RBI boot camps will be offered each year. Because most of the providers and services coordinators in the state have been trained, the number of personnel from each region needing training is expected to be relatively small. It makes sense to support the training of these small numbers through collaborative state-sponsored boot camps. Some local boot camps are likely to continue however due to geographical isolation (travel costs) and targeted training needs.

Strategy 2- Functional IFSP Outcomes
As a part of the on-going support of functional IFSP outcomes, the state annually completes an analysis of IFSPs (from the cohort regions) and provides feedback to the cohort teams.
These teams report that the feedback is very helpful but does not occur early enough in the year or with enough frequency to build capacity across the regions. In response to this feedback, the state prioritized IFSP outcome analysis this past year and cohort regions received their outcome analysis results and targeted training recommendations by November 2019. In addition, beginning in 2018, the state has encouraged cohort regions (and non-cohort regions) to build an "internal review" team to support systematic development of functional child and family outcomes. To help build the capacity of an internal review team, regions can request a repeat of the initial IFSP outcome training for their staff or a newly developed (2018-19) "IFSP Outcome Scoring Reliability Training". This past year, eight regions requested IFSP outcome training.

Strategy 3- Routines-Based Home Visits (Getting Ready)
Home visit training was provided to Cohort 1 and to four non-cohort regions in June 2017 and to Cohort 2 in June 2018. In June 2019, it was provided to 3 other non-cohort regions (PRTs 3, 6 and 10). For the

cohort regions, state coaches support the home visit approval process for the region's internal coaches AND for each provider and services coordinator in the region during the year following the initial training. To facilitate the training process for new staff in both cohort and non-cohort regions, the state has developed on-line training modules. The modules "mimic" the face-to-face training provided to participants at the annual home visit training. Initial feedback about the modules from the internal coaches has been very positive.

As mentioned above, regions are identifying internal coaches whose responsibilities include training of new staff and completing fidelity checks in the cohort and non-cohort regions. Originally, only EI providers were invited to be internal coaches. This was because the training for EI providers included content related to facilitation of parent-child interaction, which is not included in the Getting Ready approach home visit training content for SCs. However, based upon feedback from the field, the state invited SCs from the cohort as well as the non-cohort regions to attend the internal coach training in June 2019 to enable them to train/complete fidelity checks for other SCs in their regions.

Because the home visit (HV) training and practices are new to the state, the first annual fidelity checks for the cohort regions will proceed differently than it does for the RBI fidelity checks. As has been noted, annual RBI fidelity checks are completed peer to peer across the planning regions, so anyone who is RBI approved can carry out a fidelity check on anyone else. For HV training however, state level coaches will complete the first fidelity check on the internal coaches for cohort regions. Once an internal coach has achieved fidelity, she/he will complete fidelity checks for the remainder of the region. This was the approach taken with Cohort 1 in the spring of 2019 and it worked well.

Section B: Progress in Implementing the SSIP

This section illustrates the extent to which Nebraska has carried out planned training activities for Cohorts 1 and 2, the milestones met, and whether timelines have been followed. This section concludes with a summary of stakeholder involvement.

Table B1: Planned Training Activities for Cohorts 1 & 2.

COHORT 1 Strategy 1: RBI	
Date	**Training Activity**
July 2014	2-day RBI Boot Camp for Cohort 1 coaches
January-February 2015	2-day RBI Boot Camps in each of Cohort 1 regions
March-July 2015	RBI Approval Process
August 2015 - Full RBI Implementation	
Strategy 2: Functional IFSP Outcomes	
April 2014	Collect & Analyze baseline IFSP Outcome data
November 2015	Functional IFSP Outcome Trainings in each of Cohort 1 regions
October 2016	Begin Annual IFSP Outcome Review
December 2016 Full Functional IFSP Outcome Implementation	
Strategy 3: Routines-Based Home Visit Training	
June 2017	1-Day Routines-Based Home Visit Training providers/services coordinators
June 2017	1-Day Routines-Based Home Visit Internal Coach training
June 2018 Full Routines-Based Home Visit Implementation	

COHORT 2 Strategy 1: RBI	
Date	**Training Activity**
July 2015	2-day RBI Boot Camp for Cohort 2 coaches
January-February 2016	2-day RBI Boot Camps in each of Cohort 2 regions
March-November 2016	RBI Approval Process
December 2016 - Full RBI Implementation	
Strategy 2: Functional IFSP Outcomes	
April 2015	Collect & Analyze baseline IFSP Outcome data
November 2016-March 2017	Functional IFSP Outcome Trainings in each of Cohort 2 regions
October 2017	Begin Annual IFSP Outcome Review
December 2017 Full Functional IFSP Outcome Implementation	
Strategy 3: Routines-Based Home Visit Training	
June 2018	1-Day Routines-Based Home Visit Training providers/services coordinators
June 2018	1-Day Routines-Based Home Visit Internal Coach training
June 2019 Full Routines-Based Home Visit Implementation	

Nebraska has met all projected SSIP timelines. Cohort 1 (PRTs 1, 22 and 27) and Cohort 2 (PRTs 4, 18, 19 and 21) reached full RBI implementation in 2015 and 2016 respectively.

The state completed annual IFSP outcome reviews in 2016, 2017, 2018 and 2019 for Cohorts 1 and 2 and provided feedback to their leadership teams. In addition to state feedback, these regions are also building internal IFSP outcome review processes for the purpose of providing continuous feedback and support to providers and services coordinators writing child and family IFSP outcomes.

PRT 1 declined to participate in the state's third improvement strategy of routines-based home visits. In their place, PRT 7 joined the Cohort 1 group. As indicated in Table B1 above, both Cohort 1 regions (PRTs 7, 22 and 27) and Cohort 2 regions (PRTs 4, 18, 19, and 21) are now at full implementation of the state's home visit strategy (Getting Ready).

<u>Stakeholder Involvement and Supports for Principle Training Activities</u>

Nebraska established a Results Driven Accountability (RDA) stakeholder committee in January 2014 to assist in the planning and implementation of the SSIP. In the fall 2018 the Stakeholders made several recommendations regarding implementation of the state's improvement strategies. Activities implemented in response to the stakeholder recommendations are below:

1. Recommendation: Repeat the quantitative/qualitative study previously conducted by the University of Nebraska Medical Center with Cohort 1 PRTs to determine:

    a. the value the quality home visit strategy (Getting Ready) has added to the overall results of SSIP implementation, and

    b. whether or not the quality of home visits has improved.

    Activity: The quantitative/qualitative study conducted by the University of Nebraska Medical Center with Cohort 1 was repeated. Please see results in Section C.

2. Recommendation: Continue the evaluation by the University of Nebraska-Omaha (see 2018 study by Dr. Miriam Kuhn: *Improving Early Intervention Services in Nebraska Through a Results-Driven Accountability Process*) to specifically focus on potential qualitative changes that resulted from the addition of the routines-based home visit practices.

    Activity: The evaluation conducted by the University of Nebraska-Omaha was continued. Please see results in Section C.

3. Recommendation: Continue providing guidance to non-cohort regions to follow same implementation steps/procedures as cohort regions which include:

    a. establishment of PRT leadership teams,

    b. sequential implementation of the three improvement strategies and related training activities,

    c. adherence to fidelity practices/requirements for each strategy, and

    d. establishment of and adherence to local data collection/reporting processes.

    Activity: Guidance to non-cohort regions as described above was provided. See training timeline at the end of this section and updated training descriptions in Appendix AA.

In the fall 2019 the Stakeholders provided the following recommendations and input:

1. Recommendation: Continue implementation of the three improvement strategies statewide. Stakeholders who are members of Cohort regions echoed a research finding that the three RDA strategies selected by Nebraska build on each other. They indicated that home visits are more effectively guided by an IFSP written with functional outcomes based upon a family's concerns and priorities identified during an RBI. In addition, functional outcomes aid the discussion and measurability of a child's skill development between visits. Finally, the Getting Ready Approach to home visits increases parental input during home visits.

2. Recommendation: The stakeholders recommended that the state leadership team continue to work with Teaching Strategies GOLD in partnership with ECTA and DaSy centers to review potential issues related to the downward trend of the child outcome data. Stakeholders recommended efforts be made to determine the root cause of the unexpected changes to the child outcome data and develop solutions to improve the validity of data for reporting child outcomes in the future.

3. Input: The stakeholders recommended that the state leadership team continue collaboration with Higher Education to ensure that college preparatory coursework aligns to Nebraska's Part C improvement strategies.

Additionally, the Stakeholders were given an opportunity to provide input on OSEP's proposed changes to the State 2020 Determinations Process. Their responses are outlined below:

1. In response to the question, "Should the SSIP be used as a supplemental data point that could improve but not lower a State's determination?", the stakeholder recommendation was no, the work that it would take to develop a rubric to evaluate the SSIP as a supplemental data point might not be worth the effort. The effectiveness of Nebraska's strategies is revealed through other forms of evidence.

2. In response to the question, "The two factors being considered for representativeness of family outcome data are race/ethnicity and family income. Are these the right factors to include?" The stakeholders indicated that Nebraska does not charge for early intervention services so asking family income is irrelevant in our state. The stakeholders also expressed concern that asking family income in the family survey could lower the return rate from both lower and higher income families and families might pick and choose which questions to answer if they thought their answers could be identified based on income level selected. Selection of questions/responses could result in incomplete responses, and therefore, an incomplete picture of the early intervention program in the state. Finally, Nebraska is already reporting ethnicity.

3. In response to the question, "What other factors could be considered?", the stakeholders asked that the current political climate, particularly regarding immigrant and minority families, be kept in mind when considering the addition of factors concerning representativeness.

Tables B2-B5 below illustrate activities implemented in response to stakeholder recommendations, as well as additional activities necessary to support Nebraska's principle training actions.

- Table B2 outlines activities implemented to support the work of the state's RBEI TA providers with non-cohort regions.
- Table B3 identifies activities primarily designed to support statewide implementation of the improvement strategies within the PRTs.
- Table B4 illustrates activities to support the state leadership team.
- Table B5 provides an updated training timeline for implementation of the state's three improvement strategies.

Table B2: Activities to Support Work of RBEI TA Providers – 2019-2020

Needs	Activities	Output
Training & Support for 5 RBEI TA Trainers	• Conducted Biannual full-day training and quarterly calls. • Updated standardized training resources and repository. • Provided individualized technical assistance from the state leadership team.	RBEI TA providers have supports necessary to scale up RBI/functional IFSP outcomes/home visit training in non-cohort regions.

Table B3: Activities to support all (cohort and non-cohort) PRTs

Needs	Activities	Output
Develop strong PRT Leadership Teams	Support PRT efforts to develop leadership teams by: • conducting biannual regional conference calls to share successes/barriers with leadership teams; • holding a specific session at EDN conference on roles and responsibilities of leadership teams • following up on information about roles & responsibilities of leadership teams on biannual conference calls; • meeting individually with regions as needed to spur development of leadership teams; • utilizing templates for tracking regional training progress; and • having state level infrastructure necessary to respond to regional inquiries/needswithin48hours.	PRTs in the state have knowledgeable and capable leadership teams to support the implementation of evidence-based practices.
Provide additional training necessary to support principle training activities	In support of Strategy 1: • Provided RBI Scoring Reliability Workshop. • Individually tailored RBI Refresher Workshops to support regions not fully implementing or having difficulty maintaining momentum implementing change in EI practices. • Provided training to support the use of child and family assessment data to enhance child outcomes entry and exit data. In Support of Strategy 2: • Individually tailored Cohort functional IFSP Outcome training based on each region's annual IFSP outcome analysis. In Support of Strategy 3: • Implemented on-line training modules in the Getting Ready Approach. Developed and implemented internal coach training in the Getting Ready Approach for services coordinators.	Improved full implementation and fidelity of strategy 1 (RBI); strategy2(Functional IFSP outcomes), and strategy 3 (Routines-based home visits).

Needs	Activities	Output
Updated training descriptions and routinely incorporate timeline and training descriptions into contacts with PRTs	• Updated training descriptions to inform PRTs of training necessary for the implementation of the state's three improvement strategies. • Routinely incorporate the training descriptions and timeline into contacts with PRTs. (Training timeline - Figure B5 below. Updated training descriptions located in Appendix AA).	On-going statewide scale up of improvement strategies.
Fiscal Support	• Maintained fiscal support to PRTs for implementation and sustainability of evidence-based practices statewide.	Continuous statewide scale-up of evidence-based improvement strategies.
Collaborate with University of Nebraska-Lincoln (UNL) to expand early childhood professional development opportunities in pre-service coursework	• Met routinely with UNL staff to share EI workforce needs within the state and incorporate appropriate RBI, functional IFSP outcomes and routines-based home visits concepts into required curriculum.	EI competencies reflect state workforce expectations.
Partner with University of Nebraska-Lincoln (UNL) to support comprehensive Personnel Development for professionals in the field	• Stipends for EI coursework offered through UNL to providers from OT, PT, SLP, TVI, TOD, psychology, and services coordination lacking coursework in child development, home visiting and working with families.	Increased number of professionals trained in NE with ECSE endorsement and increased number of providers from related services with specific training in child development, home visiting and working with families.

Table B4: Activities to support State Leadership Team 2018-2019

Needs	Activities	Output
Expand/modify state infrastructure as needed	Expanded state leadership to include third RBEI state coordinator, Janice Lee. Expanded purveyor group to include Dr. Lisa Knoche and Dr. Johanna Higgins, University of Nebraska-Lincoln; Dr. Miriam Kuhn, University of Nebraska- Omaha; Dr. Kerry Miller and Dr. Barb Jackson, University of Nebraska Medical Center; Dr. Haidee Bernstein, SRI International; and Vera Stroup-Rentier, Westat. Continued meetings with purveyors to develop ongoing evaluation activities.	Purveyor group includes experts to assist in evaluating all aspects of RDA, i.e. evidence-based improvement strategies, training, implementation fidelity and results.
Inform stakeholders of RDA Activities and SSIP Progress	Quarterly updates to ECICC/SEAC on implementation and impact of SSIP. Update special education directors statewide on monthly Special Education Conference Calls. Frequent update of "RDA" section on the EDN website. Presentations at Annual EDN Conference Updated and disseminated SSIP infographic to stakeholders. (Appendix Z)	Progress toward SSIP, resources and updates are available to the field as quickly as possible.

Figure B5: PRT Recommended Training Timeline

Part C PRT Recommended Training Timeline- Updated Fall 2018

	First...	Next...	Then.....	After RBI boot camp (BC)...	Once RBI is fully implemented across the region...	Analyze IFSP Outcomes...	When RBI is fully implemented & IFSP outcomes are of high quality...
Team Self-Assessment	—						
Rule 52/ 480 NAC 3		—					
Identify RBI coaches; RBI Boot Camp			—				
RBI Scoring Reliability				—			
RBI Refresher				—			
IFSP Outcome TA					—		
RBI Informing GOLD					—		
IFSP Outcome Scoring Reliability						—	
Routines-Based Home Visit Training							—

Bainter& Hankey, 2016; Updated 2018

Prepared by Jessie Cook, UNL

Section C: Data on Implementation and Outcomes

Measuring the Effectiveness of the Improvement Strategies

Table C1 below illustrates the evaluation measures in place for the three improvement strategies with a brief description of the data sources for each measure, baseline data collected, data collection timeline and procedures, and the measures used to assess progress. These evaluation measures demonstrate the implementation of the three key components discussed in our Theory of Action.

Table C1: Cohort Evaluation Measures for Three Improvement Strategies

Improvement strategy	Data Sources	Baseline Data	Data collection timeline and procedures	Measures used to assess progress
RBI	Initial RBI Implementation Checklists, completed by approved RBI coaches, documenting 85% accuracy or better for each EI provider/SC in Cohort regions collected by Co-Leads. Documentation of annual fidelity for each EI provider/SC in Cohort regions involved in child/family assessment - collected by Co-Leads.	At initial stage of RDA implementation, no EI providers/SCs in cohort regions were trained to state required approval level.	Initial RBI implementation checklists are submitted to Co-Leads upon approval of each provider/SC. Once per year, following initial approval, cohorts collect RBI implementation checklists to demonstrate provider/SC fidelity. Annual fidelity checks began in Cohort 1 in fall of 2016 and in fall of 2017 for Cohort 2. Co-leads contact leadership teams from cohort regions annually requesting documentation of annual fidelity checks for each provider/SC.	RBI Implementation Checklists documenting 85% accuracy or better used annually; completed by RBI approved providers or coaches.

Table C1: Cohort Evaluation Measures for Three Improvement Strategies (continued)

Improvement Strategy	Data Sources	Baseline Data	Data Collection Timeline and Procedures	Measures used to Assess Progress
Functional IFSP Outcomes	Analysis of 10-20% of IFSPs from cohort regions using IFSP Outcome Quality Checklist.	20% of IFSPs written prior to RBI training were collected from Cohort 1 in fall of 2014, and 20% of IFSPs written prior to RBI training were collected from Cohort 2 in fallof2015. The IFSP Quality Outcome Checklist was used for analysis of baseline data.	For Cohort 1- Annual Functional IFSP Outcome review began Fall, 2016 and continues to date. For Cohort 2, Annual Functional IFSP Outcome review began Fall 2017 and continues to date.	Annual analysis of 10-20% of IFSPs, depending on size of region from Cohorts 1 and 2 using IFSP Quality Outcome Checklist.
Quality Home Visits	Home visit implementation checklists completed by approved home visit coaches.	No one in cohort regions trained to approval level prior to Routines-Based home visit training.	Data collection began for Cohort 1 approval post home visit training June2017 and continues to date. Data collection for Cohort 2 approval began post home visit training in June 2018 and continues to date.	Home Visit Implementation Checklist documenting state-determined 80% approval level used annually; completed by Home Visit approved providers or coaches.

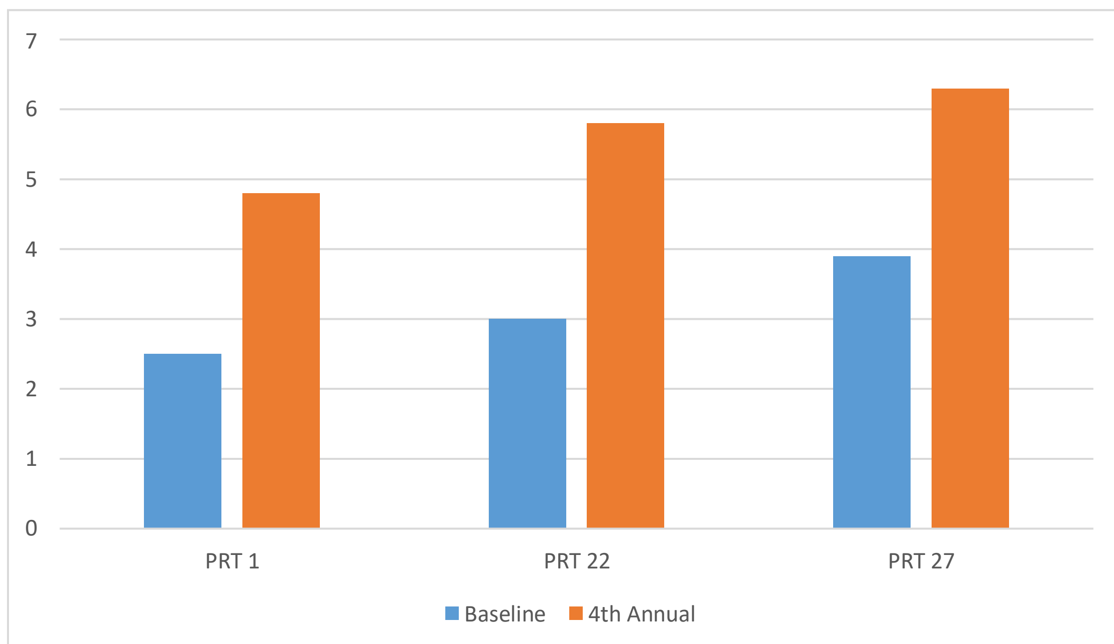
Strategy #1: RBI

As illustrated in Table C1, the fourth annual fidelity checks for Cohort 1 and third annual fidelity checks for Cohort 2 were completed in the fall of 2019. The fidelity checks were completed by approved RBI providers/SCs in the region using the RBI implementation checklist. RBI Implementation checklists documenting fidelity are tracked by the PRT with results provided to the Co-Leads.

Strategy #2: Functional IFSP Outcomes

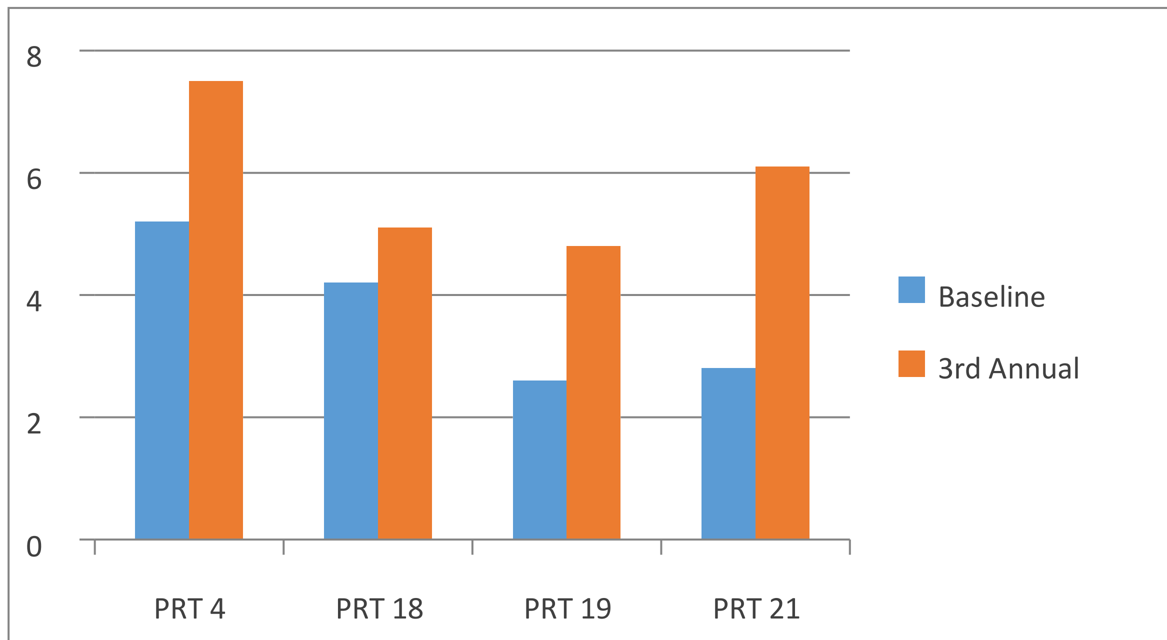
The annual IFSP outcome review began in 2016 for Cohort 1 and in 2017 for Cohort 2. Using the IFSP Quality Outcome Checklist (Appendix L) as the quality indicator, the Co-Leads are looking for an increase and ultimately stabilization in mean number of outcomes on IFSPs from baseline and an increase in quality scores for both child and family outcomes from baseline. Results of the 2019 analysis of mean number of outcomes on IFSPs compared to baseline data are provided for Cohort 1 in Graph C1 below and for Cohort 2 in Graph C2 below.

Graph C1: Cohort 1 Mean # of Outcomes on IFSPs Baseline to 4th Annual Review



As indicated in Graph C1 all regions in Cohort 1 demonstrated significant improvement in mean number of IFSP outcomes present on IFSPs from baseline.

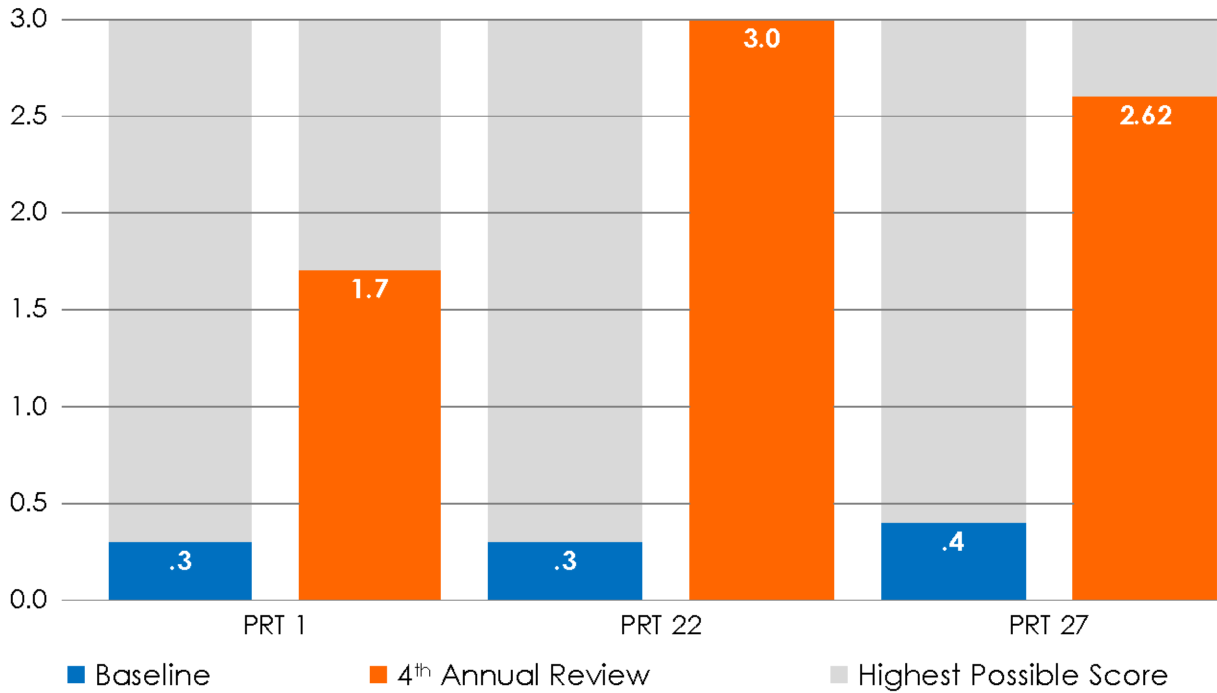
Graph C2: Cohort 2 Mean # of Outcomes on IFSPs Baseline to 3rd Annual Review



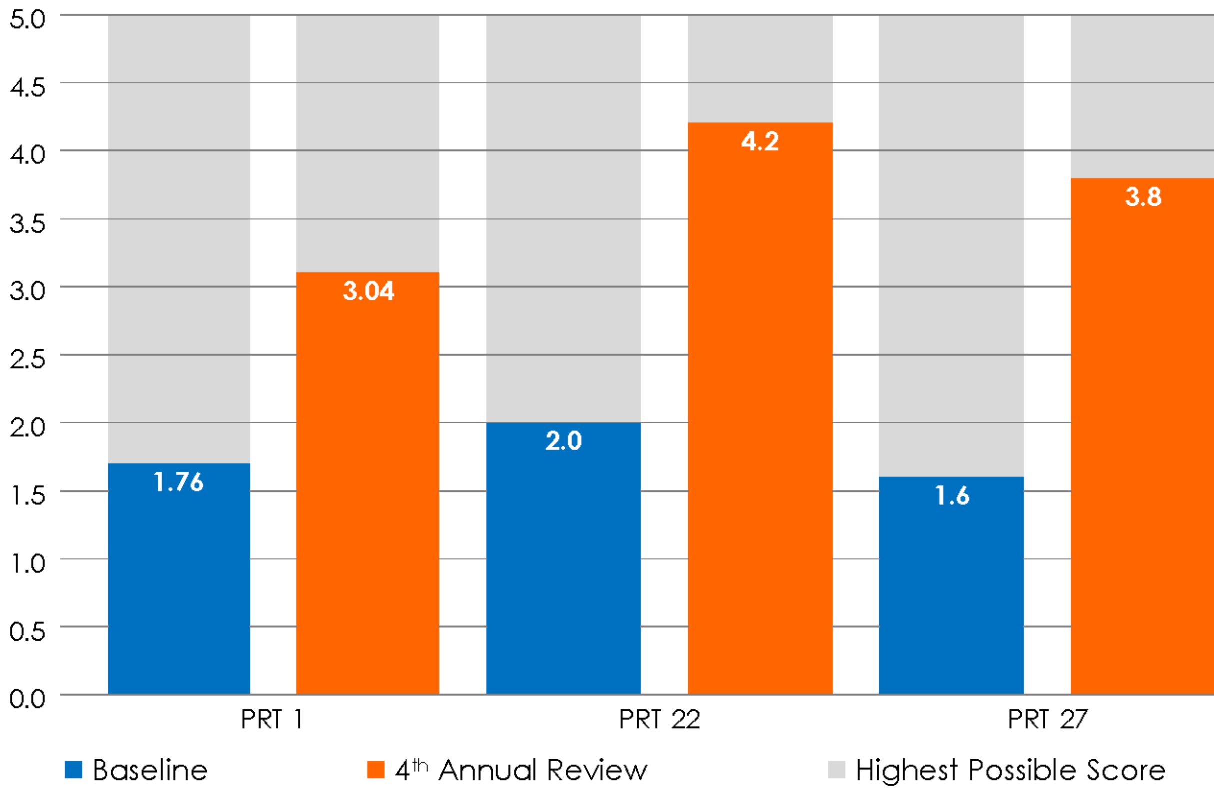
As indicated in Graph C2 all regions in Cohort 2 demonstrated significant improvement in mean number of IFSP outcomes present on IFSPs from baseline.

Graphs C3-C6 below reflect the results of IFSP outcome quality analysis for Cohorts 1 and 2. The annual IFSP outcome quality analysis review began in 2016 for Cohort 1; and in 2017 for Cohort 2. The child outcomes have a maximum possibility of 5 points and the family outcomes have a maximum possibility of 3 points. As the graphs indicate, results of the 2019 analyses show all cohort regions significantly improved in the quality of both child and family outcomes from baseline. Results of the data analyses have been provided to the cohort leadership teams. Feedback included discussion of any IFSP outcome quality issues and possible training needs within the region.

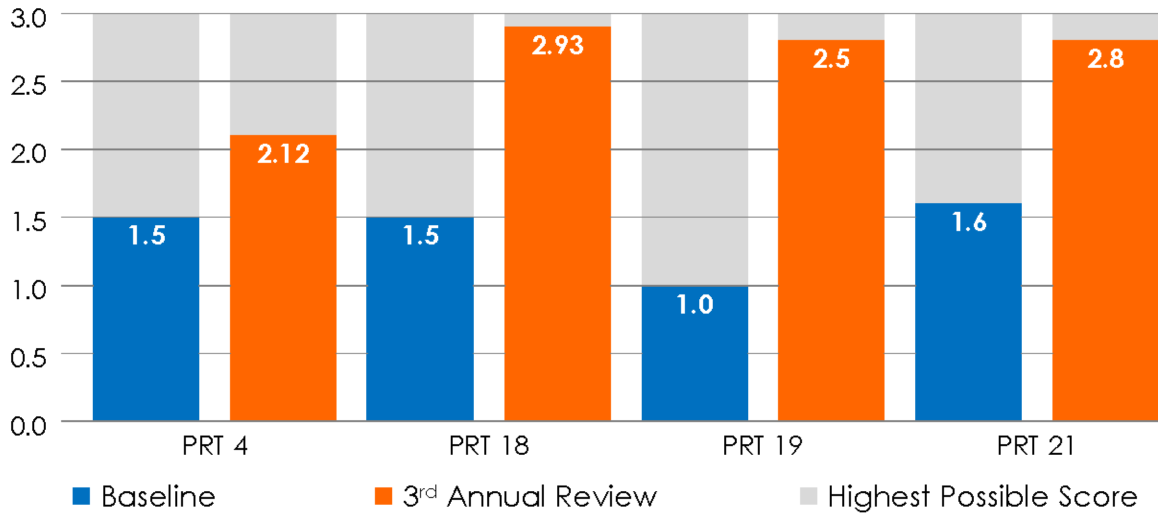
Graph C3: Cohort 1 Quality Mean Scores for Family Outcomes



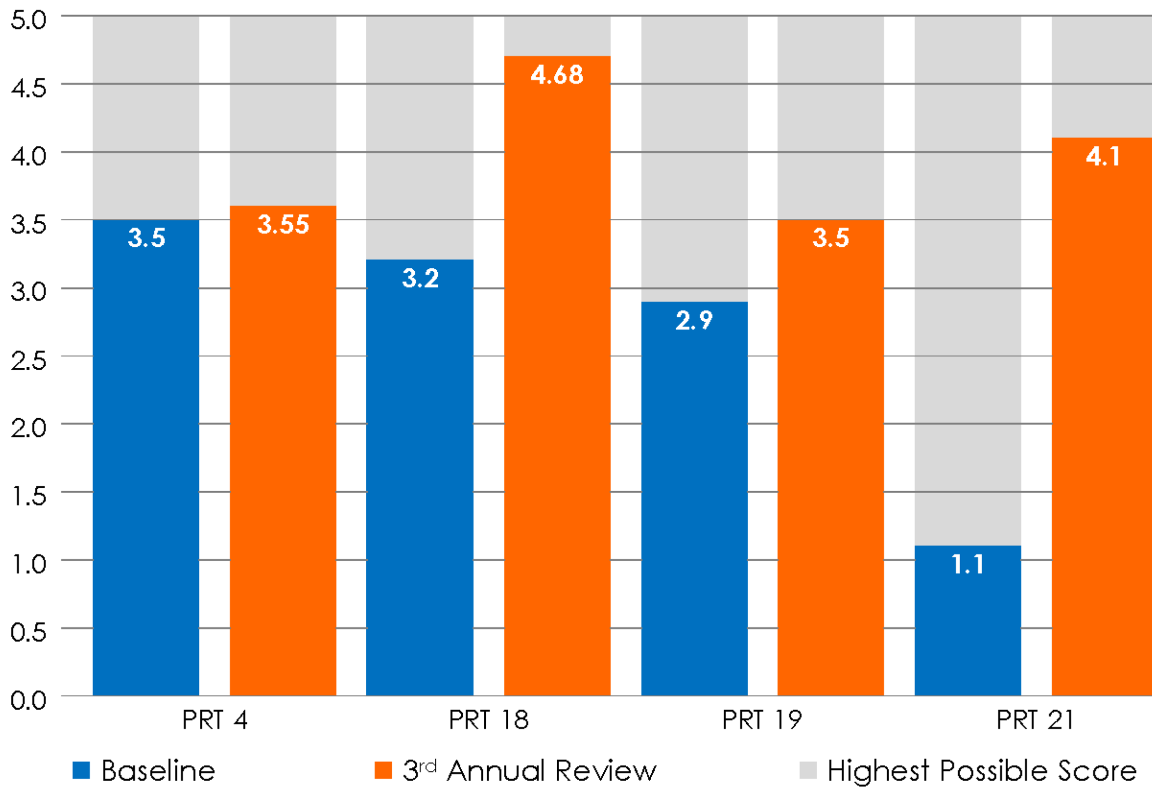
Graph C4: Cohort 1 Quality Mean Scores for Child Outcomes



Graph C5: Cohort 2 Quality Mean Scores for Family Outcomes



Graph C6: Cohort 2 Quality Mean Scores for Child Outcomes



Measuring Impact and Effectiveness of Improvement Strategies #1 and #2

In addition to the evaluation measures implemented above for strategies 1 and 2, the Co-Leads contracted with Dr. Miriam Kuhn from the University of Nebraska at Omaha to conduct a research study investigating the impact of the RBI and functional IFSP outcome strategies on various aspects of EI services and family/PRT member perceptions of the EI process utilized in their regions.

Phase 1 of the study was reported in the SSIP submitted in 2018. Phase 2 of the study was reported in the SSIP report 2019. An investigation of strategy 3, the impact of the Getting Ready approach on quality home visits, was investigated this year. See results of the current study in the section entitled Measuring Impact and Effectiveness of Improvement Strategy #3 below.

Strategy #3: Routines-Based Home Visits

Table C2: Cohort 1 Initial Approval and Fidelity Check Data 2019-2020

	# Approved	1st Annual Fidelity Check	2nd Annual Fidelity Check
PRT 7	17	2019	2020
PRT 22	3	2019	2020
PRT 27	6	2019	2020

As illustrated in Table C2, routines-based home visit initial implementation checklists were collected for Cohort 1 EI providers/SCs in 2018 and their first annual fidelity checks were collected in the spring/summer of 2019. All EI providers/SCs providing EI services in the Cohort 1 regions passed their fidelity checks in 2019. Second annual fidelity checks will occur in the spring of 2020.

Table C3: Cohort 2 Initial Approval and Fidelity Check Data 2019-2020

	# Approved	1st Annual Fidelity Check
PRT 4	8	2020
PRT 18	25	2020
PRT 19	23	2020
PRT 21	17	2020

As illustrated in Table C3, Cohort 2 EI providers/SCs engaged in the initial approval process following their home visit training in June 2018. Results of the first annual fidelity check data for Cohort 2 will be available in the summer of 2020.

Measuring Impact and Effectiveness of Improvement Strategy #3

In addition to the evaluation measures implemented above for strategy 3, the Co-Leads contracted with Dr. Miriam Kuhn from the University of Nebraska Omaha and Dr. Johanna Higgins from the University of Nebraska Lincoln in 2019 to conduct a qualitative study to better understand family, services coordinator (SC) and early intervention (EI) provider experiences with routines-based home visits utilizing the Getting Ready approach.

The study, "Evaluation of Quality Home Visitation in Nebraska," focused on two research questions:

1. How do family members and EI service providers describe the influences of the *Getting Ready* approach 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 parents' 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) parent-provider communication between visits, and (f) parent-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* approach on (a) establishment of the home visit agenda in partnership with the family, (b) development of a home visit plan to support parents' access to desired services and resources, (c) implementation of the home visit plan between visits, (d) parent-provider communication between visits, and (e) parent-professional collaborations to monitor child and family progress on IFSP outcomes?

Findings from this study revealed that the quality of EI home visits in Nebraska cohort PRTs has been enhanced by use of the *Getting Ready* approach. Generally, the *Getting Ready* approach resonated with EI providers interviewed for this project to a high degree and was met with mixed reviews by SCs. Specifically, the findings for each research question were as follows:

Research Question #1-
1 a. and e.: There were widespread reports of collaboration between EI service providers and families in generating home visit agendas (specifically in the selection of IFSP outcome(s) to be the focus of the home visit) and planning for communication between home visits. The *Getting Ready* framework prompted providers to set the home visit agenda around one or more specific IFSP outcomes and to identify possible routines for use as teaching/learning opportunities.

The framework also prompted planning for communication. Four methods of communication identified by EI providers, services coordinators (SCs), and families were text messaging, phone calls, emails, and Facebook messenger. Purposes of between-visit communication included following up on plans made during the home visit, providing reminders of upcoming visits, following up on completed paperwork, and discussing the child's progress toward IFSP outcomes. Participants reported that the *Getting Ready* approach increased the frequency of communication with families.

Several challenges with communication between visits were also reported. These included (a) use of personal cell phone, (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 required an interpreter.

1 b. and c.: EI providers and families consistently reported collaboration in the **selection** and **practice** of strategies related to IFSP child outcomes during home visits. Documentation of family intentions to use the strategies in specific routines was reported across participants and seen in home visit documents. Participants thought this led to improved family engagement, buy-in, and use of strategies between visits.

1 d. and f.: However, few participants reported checking on family use of and fidelity to strategies documented in the home visit actions plans in any formal way. Typically, child and family progress on IFSP outcomes was measured informally, through conversation with families and observations of children during home visits. This information was typically documented in home visit plans and/or provider notes and was inconsistently used to guide collaborative decision-making about strategies. A thorough investigation of child/family progress across all IFSP outcomes was most often reportedly conducted at the time of six-month reviews.

While anecdotal notes are a rich and valued source of information, few professionals tapped into methods of progress monitoring data collection that went 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 appeared to be routinely unclear to families, suggesting that many families are not full partners in this aspect of EI services.

Research Questions #2-
2. a. Services coordinators shared that the focus of the home visit was often determined by the opening conversation. Visits with families "in crisis" required more guidance and support than families who indicated they were receiving all services and supports needed. Thus, for some families, the visit agenda was frequently developed in reaction to "a crisis" while other families had difficulty identifying agenda items for their visit.

2. b. The presence and role of the SC was identified as a challenge in the implementation of the GR approach. In some PRTs, families reported meeting with the SC on a regular basis and provided concrete examples of the outcomes addressed together. In other regions, families indicated they rarely met with the SC; with most interactions occurring during IFSP meetings or over the phone. This resulted in fewer home visit plans specific to services coordination for this study as compared to home visit plans specific to EI providers. When asked about their comfort level in using the GR approach, some SCs reported being comfortable utilizing the *Getting Ready* framework to carry out their home visits, while others expressed uncertainty about the utility of the *Getting Ready* strategies when applied to services coordination.

2. c. Due to the limited number of home visit plans specific to services coordination available in this study, clear trends in how services coordination home visit plans are being implemented by families between visits were not established.

2. d. (See information about communication findings for all professionals and families under Research Question #1a. and e. above.)

2. e. Services coordinators reportedly played a key role in gathering information on child and family progress on IFSP outcomes, particularly in preparation for six-month IFSP reviews. Progress determination on IFSP outcomes was largely informal and variable across professionals; gathered primarily through conversation with families either in a home visit or by phone. EI providers and services coordinators also reported sharingsuch information with each other to complete this task.

An executive summary and complete report of this study can be found in Appendix DD. A summary of next steps can be found in Section F.

Nebraska's SSIP implementation and evaluation highlighted at National Conferences:

Dr. Miriam Kuhn, Dr. Johanna Higgins, and Julie Docter, Nebraska Part C Co-Coordinator, presented a poster session of the preliminary findings from Drs. Kuhn and Higgins' study at the October 2019 Division of Early Childhood conference in Dallas, TX.

Progress toward the SiMR and Modifications to the SSIP as Necessary

The Co-Leads continue to monitor Federal Child and Family Outcomes data and implement strategies to improve the collection of this data. It is expected that full implementation of the three coherent improvement strategies will result in improved child and family outcome data for Cohorts 1 and 2.

Target – Indicator C3B – Summary Statement 1 – Acquisition and Use of Knowledge and Skills:

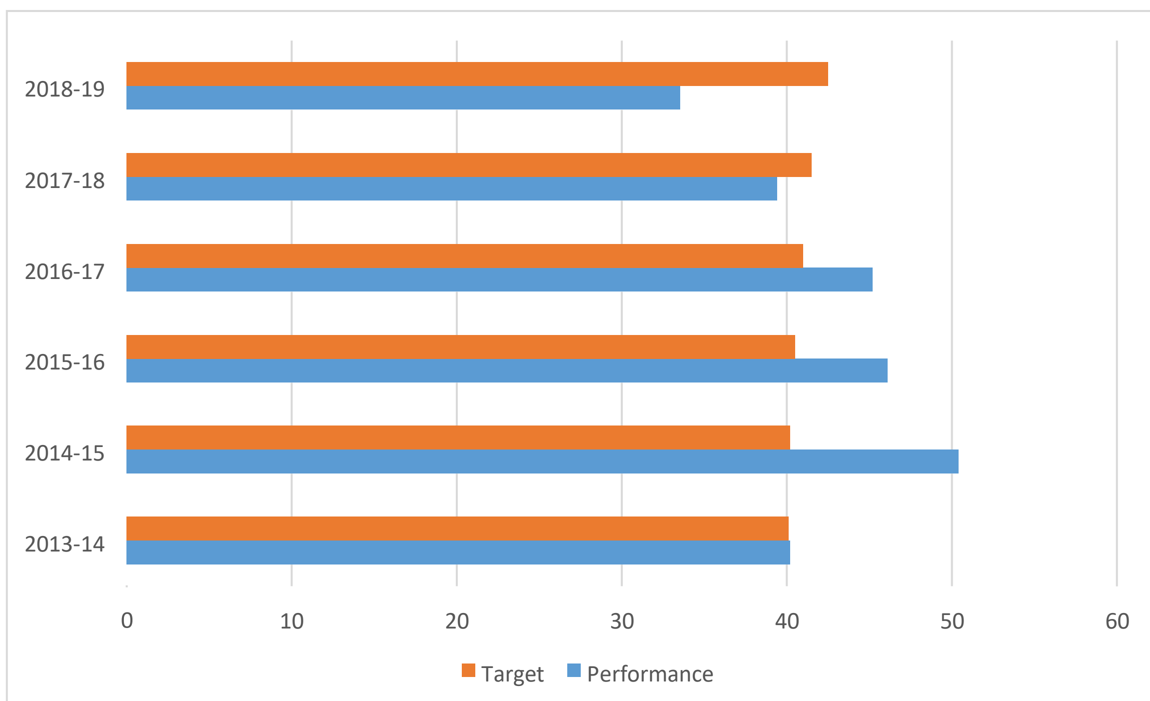
Nebraska's SiMR is focused on improving the results for Indicator C3B Summary Statement 1- to increase the number and percentage of infants and toddlers who demonstrate progress in the acquisition and use of knowledge and skills (including early language/communication). In addition, Nebraska identified Indicator 4B: Effectively Communicate Child's Needs as a benchmark. Comparing the baseline, targets, and performance for these indicators serves as the primary measure of effectiveness for the SiMR.

Graph C7 below illustrates the results for Indicator C3B SS1 compared to state targets. Please note that Nebraska reset their targets for Indicator C3B for their 2013-14 data. Therefore, for that year, the target is the same as the performance. The FFY 2017 and 2018 C3B Summary Statement 1 data demonstrated a decline which was unexpected as in the previous two years the scores have been stable. In reviewing current state infrastructure practices, there had not been any major shifts or changes. The Results Driven Accountability (RDA) strategy implementation has demonstrated high quality home visitation practices. Several states using the TS GOLD online calculations for OSEP reporting have been meeting regularly as all states using the Teaching Strategies GOLD online system for generating OSEP reports have seen slippage in Summary Statements that are inconsistent with any changes in state infrastructure or improvement activities. In August 2017, Teaching Strategies converted their online platform to accommodate the changes made to the tool to include items up to third grade. Collectively the state representatives proposed that the following factors related to this platform change may be contributing to this slippage of data including:

- Changes to indicators and dimensions as a result of expanding the TS GOLD to third grade;
- Teacher/practitioner confusion due to changes to the front-end look of the online platform; and
- Fewer data points on which data can be entered for each child.

Nebraska is working with other states using Teaching Strategies GOLD and DaSy, ECTA, and SRI centers to conduct ongoing in-depth analysis with Teaching Strategies staff to determine the root cause of the unexpected changes to these summary statements and develop solutions to improve the validity of data for reporting outcomes in the future.

Graph C7: Annual Results for Indicator C3B Summary Statement 1 Compared to State Targets

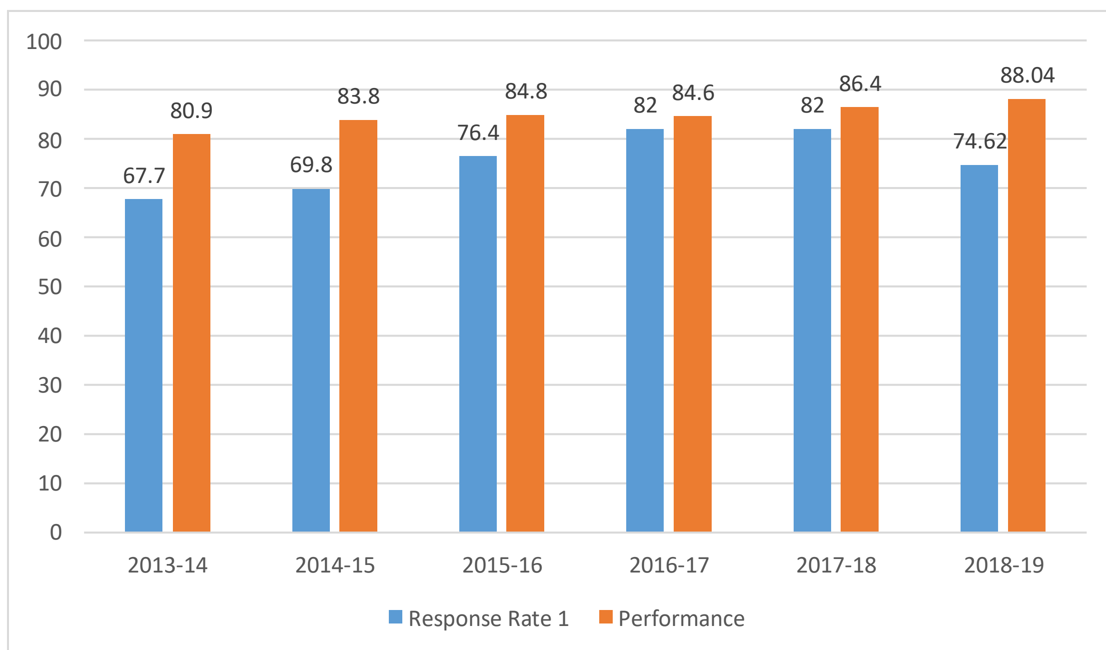


Benchmark – Indicator C4B– Effectively Communicate Child's Needs

Nebraska also chose to use Indicator C4B as a benchmark for the SiMR. The Co-leads believe that taken together, the three improvement strategies of the SSIP will increase families' perceptions of their ability to effectively communicate their children's needs.

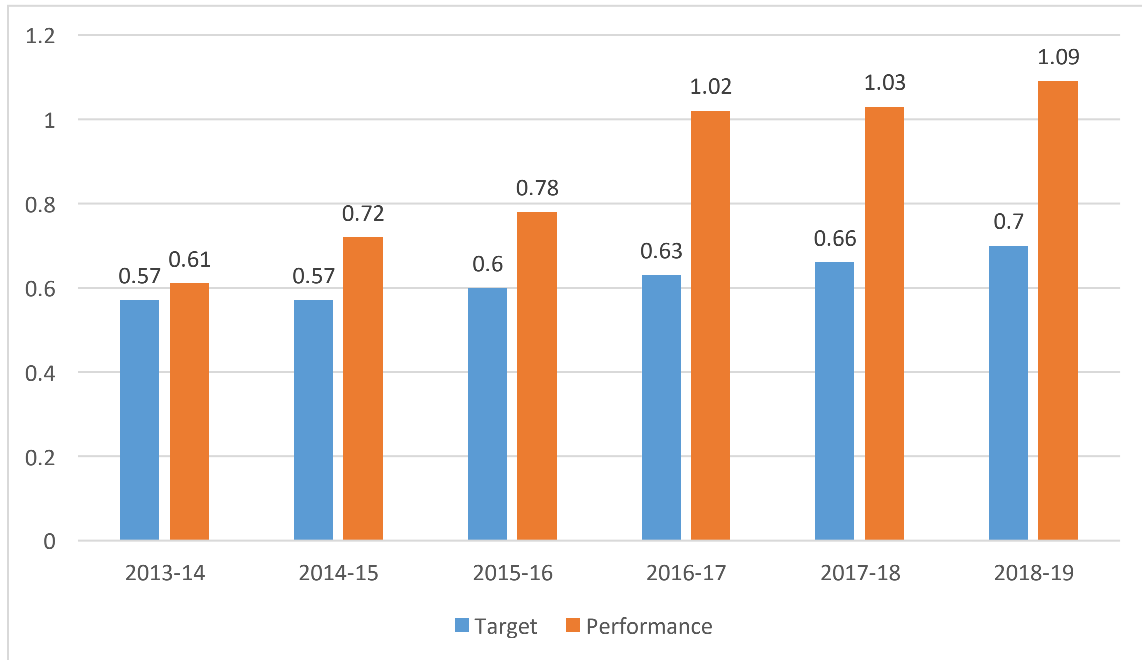
As Graph C8 illustrates, the percent of families reporting that they are effectively able to communicate their children's needs continues to trend upwards. The increase also exceeds the target set each year. Finally, Nebraska has a very high response rate to the Family Survey. Nebraska continues to use a personalized introductory letter to families before delivering the survey, a follow-up postcard to families, and personal contacts by services coordinators to remind families to return the survey. A total of 2222 surveys were delivered to families with children in Part C in 2018-2019; 1658 surveys were completed and returned for a state return rate of 74.62%.

Graph C8: Growth in Performance with Return Rates for Indicator C4B

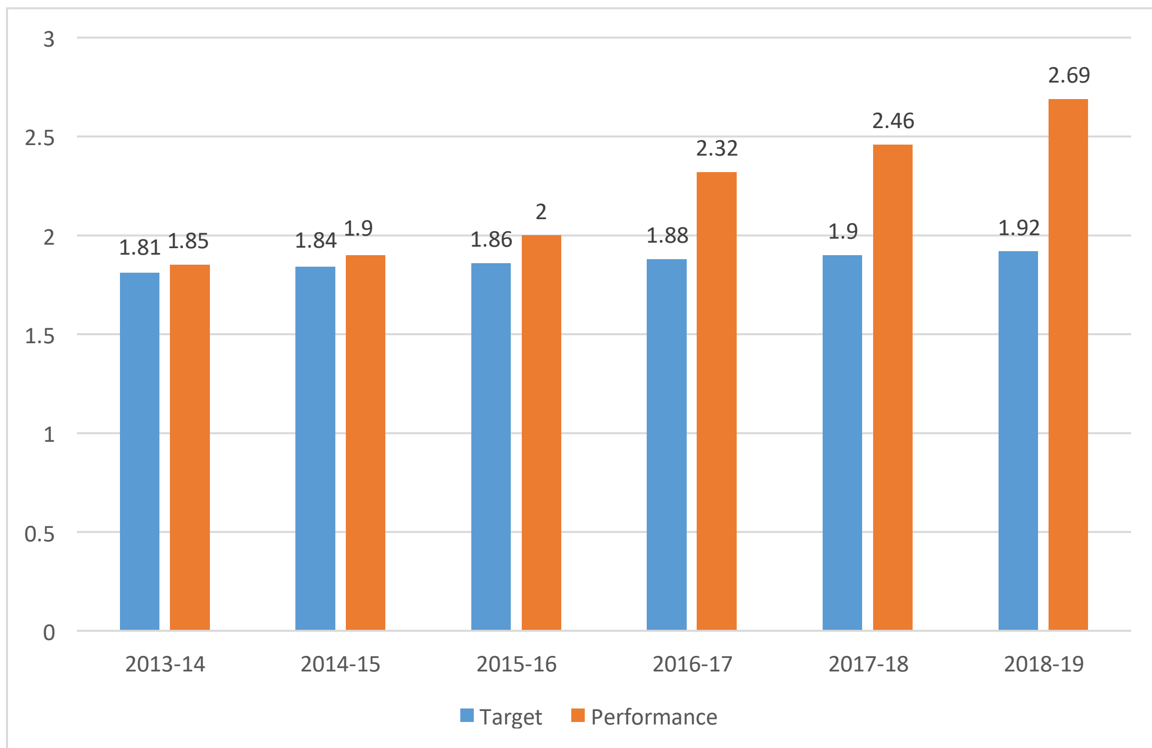


To fully understand the impact of the SiMR statewide, the Co-Leads reviewed additional indicators. Indicator 5: the percent of infants and toddlers ages birth to one with IFSPs compared to national data and Indicator 6: the percent of infants and toddlers ages birth to three with IFSPs compared to national data. We believe that this data provides examples of distal impact. As shown in the graphs below, over the last six years, the state has exceeded its targets. Additionally, the state has increased the percent that it exceeded the target each year. The Co-Leads believe this increase is attributable to additional state-wide training activities implemented in 2014 which focus on procedural implementation of early intervention regulations. This training is provided on an ongoing basis to each PRT and targets implementation of correct evaluation and identification procedures, specifically providing extensive technical assistance in the use of informed clinical opinion.

Graph C9: Six-year trend data for Indicator 5



Graph C10: Six-year trend data for Indicator 6



Stakeholder Involvement in the SSIP Evaluation

As noted in Section B, the RDA Stakeholder Committee meets annually, and the Nebraska ECICC meets four times per year to assist in the continuous evolvement of the SSIP and help provide for ambitious and meaningful change statewide. In the fall of 2019, Dr. Kuhn and Dr. Higgins presented preliminary findings from their study, "Evaluation of Quality EI Home Visitation in Nebraska" to the RDA Stakeholder Committee. The study focused on quantitative descriptions of differences among parent, services coordinator, and EI service provider experiences regarding quality of early intervention home visits. Dr. Kuhn and Dr. Higgins facilitated discussion about the findings and the RDA Stakeholder Committee provided feedback, stating that the findings give a snapshot from the cohort regions about how the three coherent improvement strategies are progressing and building on each other. A more detailed description of this study was provided earlier in this section and a complete report can be found in Appendix DD.

Before a specific home visit training approach was selected as the third improvement strategy, the Co-Leads contracted with Dr. Kerry Miller from the University of Nebraska Medical Center (UNMC) to review the quality of home visits as a baseline measure. As a result of Dr. Miller's study in 2016, the Getting Ready Approach was selected. In 2019, with the Cohort 1 regions at full implementation of this approach, the Stakeholders recommended the Co-Leads conduct another quantitative/qualitative study by Dr. Miller within these regions to determine:

- added value of the routines-based home visit strategy (Getting Ready) to the overall results of SSIP implementation, and
- improvement in quality of EI home visits since implementation of the routines-based home visit strategy

The title of the 2019 study was "Measuring the Influence of Improvement Strategy #3 on the Quality of Home Visit Practices and Parent Self-Efficacy". In preparation for the study, the Co-Leads actively recruited participants from two groups: those who had received the Getting Ready training and those who were not yet trained in this strategy. Participation in this study was voluntary. Recruitment yielded seven participants who had received training and no participants from the non-trained group. Therefore, it was not feasible for Dr. Miller to answer the comparative evaluation question. Dr. Miller was able, however, to assess the home visit video recordings from the seven recruits who agreed to participate in the study using the Home Visit Rating Scales- Adapted and Extended. In general, the results of the study revealed improvement in the mean ratings for the home visit practices scales as well as the family engagement scales. The providers, fully implementing all three strategies, built strong relationships with their families and displayed high-quality home visit practices. The providers demonstrated strength in the targeted improvement areas identified as needs during the 2016 home visit practices evaluation. They established active engagement with both the parent and child during the visit, promoted positive parent-child interactions during the home visit, and collaborated with parents to support their child's development outside of the home visit. A detailed comparison of the mean scores for the Home Visit Practices and Family Engagement domains achieved by the providers in the 2016 and the 2019 evaluation studies are provided in Table C4 below.

Table C4: Comparison of Mean Scores for the Home Visit Practices and Family Engagement Domains in the 2016 and 2019 Evaluation Studies

	2016 ***n*=31**	**2019** ***n=7***	**Mean Difference**
	Varying levels of strategy implementation	**Implementation of all three strategies**	
Home Visit Practices	**4.47**	**6.04**	**+1.57**
Relationship with Family	5.97	6.43	+0.46
Responsiveness	4.23	6.43	+2.20
Facilitation of Parent-Child Interactions	3.41	5.57	+2.16
Non-Intrusiveness	4.26	5.71	+1.45
Family Engagement	**4.96**	**6.71**	**+1.75**
Parent Engagement	5.55	6.86	+1.31
Child Engagement	4.71	6.71	+2.00
Parent-Child Interaction	4.61	6.57	+1.96

A complete summary of this study can be found in Appendix CC.

In addition to the home visit study above, the Co-Leads also contracted with Dr. Kerry Miller to evaluate the influence of the three improvement strategies on parent's perceptions of self-efficacy, as recommended by the stakeholders. To answer the question of whether perceptions of self-efficacy vary among the groups identified above, Dr. Miller cross walked the state's NCSEAM family survey items related to self-efficacy with The Early Intervention Parenting Self-Efficacy Scale (EIPSIS; Guimond, et al., 2008). Twenty-two self-efficacy impact items were identified. Results indicated no significant differences between the three groups on the impact items. All Nebraska family survey data collected in 2019 related to parent self-efficacy revealed high scores on parent self-efficacy. These high scores suggest that regardless of level of strategy implementation, parents had high levels of perceived abilities to produce positive change in their child and promote their child's development. The complete report of this study can be found in Appendix CC.

Stakeholder Recommendation to Continue Collaboration with Higher Education

In 2019 the Co-Leads entered into a partnership with the University of Nebraska- Lincoln (UNL) for Comprehensive Personnel Development. The partnership arose out of a need to increase the number of professionals with early intervention coursework specific to child development, home visiting, and working with families. Participants in the project had a choice of completing 1 to 3 EI courses: SPED 861 Infants with Disabilities and Home Visiting, SPED 863 Medically Fragile Infants, and SPED 860 Issues in Early Childhood Special Education. A total of 25 professionals participated in this project. Please see the full report titled "NE EDN Professional Upgrade Partnership with UNL" located in Appendix BB for a more detailed analysis of the first two course offerings. Participation in the third course (SPED 860) will be reported in UNL's final report to the Co-Leads coming later this year.

Section D: Data Quality Issues

Nebraska has several measures in place to ensure implementation fidelity of the three coherent improvement strategies. The state is confident with the quality and quantity of the implementation data collected for Cohorts 1 and 2 to date. The Co-Leads have also instituted measures to ensure quality of impact data.

This section describes the processes in place to safeguard the quality of implementation and impact data, thereby minimizing data concerns and limitations.

Strategy #1: Routines-Based Interview

Quality Training and Approval Requirements

1. Each RBI training is conducted by a trained facilitator. Facilitators follow a training script to ensure each training is standardized.
2. Each region of the state receives support from state approved RBI coaches. In addition, PRTs identify internal coaches who are required to go through RBI Scoring Reliability Training. All coaches participate in required fidelity processes and all providers/services coordinators receive coaching.
3. Strict adherence to RBI Approval Requirements (Appendix H).
4. Use of RBI Implementation checklist for initial approval and required annual fidelity checks. See Appendix I for fidelity requirements.
5. RBI training is a standardized process with provision of evidence-based "practice with feedback."
6. Rules for scoring the RBI Implementation Checklist (Appendix J). Training is available for coaches on scoring reliability when using the checklist.
7. When determining RBI approval, coaches complete the Implementation Checklist and provide feedback using the same protocol. Guidelines for providing feedback have been developed (Appendix K).

Strategy #2: Functional IFSP Outcomes

Quality Training and Approval Requirements

1. Initial training for functional IFSP outcomes is a part of the RBI training described above. All quality protections as applied to the RBI training exist for initial Functional IFSP outcome training as well.
2. Additional in-depth IFSP Outcome training is provided after regions are at full RBI implementation. The in-depth training is provided by the regional Technical Assistance provider with the assistance of a trained state facilitator as needed. The facilitator follows a training script.
3. At both the initial and in-depth training sessions, IFSP outcomes from providers in the region are analyzed using the IFSP Outcome Quality Checklist (Appendix L), and feedback is provided.
4. Rules for scoring the IFSP Outcome Quality Checklist have been developed (Appendix M) and are utilized for scoring and feedback.
5. In 2018, the state introduced a new training, available to all regions of the state: "IFSP Outcome Scoring Reliability Training". The purpose of this training is to assist regions in developing their own internal process for systematically monitoring IFSP outcomes region-wide using the IFSP Outcome Quality Checklist. Some regions have developed an internal monitoring process. This is being actively encouraged statewide. An internal review team allows for ongoing feedback to providers and services coordinators in the region regarding the use of quality indicators when writing IFSP outcomes.
6. Annual analysis of randomly selected IFSPs by the Co-Leads is conducted in the cohort PRTs.
7. IFSP outcome "scorers" have achieved 85% or greater inter-rater reliability with RBEI state coordinators and each other.

Strategy #3: Routines-Based Home Visits (Getting Ready Approach)

Quality Training and Approval Requirements

1. Each Getting Ready training is conducted by a trained facilitator. Facilitators follow a training script to ensure each training is standardized.
2. Regional coaches participate in a coaching training with Getting Ready content integrated and are approved by state level approved coaches.
3. All participants have access to a virtual introduction to the approval process.
4. Coaching is provided to each participant to become approved. All coaches are approved and participate in required fidelity processes (Appendix Y).
5. Strict adherence to the Home Visit Implementation Checklist (one for EI providers and one for services coordinators) is used to determine initial approval and annual fidelity. (Appendices S and T respectively).
6. Rules for scoring the Home Visit Implementation Checklist have been developed and are available to coaches (Appendix X).
7. All participants participate in virtual coaching sessions (Appendix R), facilitated by an approved coach, using the same coaching agenda as a guide.
8. Because of the dynamic nature of ongoing home visits, all participants are required to be reliable on two home visits, using the home visit checklist, to be considered "Getting Ready approved."

Data Quality for Federal Child and Family Outcomes (C3b/SS1 and C4b) Data

C3b, SS1 – Child Outcomes: Teaching Strategies (TS) GOLD is a scientifically-based authentic, observational assessment system designed for children from birth through kindergarten. In Nebraska, it is used for children from birth to kindergarten to evaluate their development and learning across the three functional outcomes. At a child's entry and exit, teachers/providers gather and document observations in the GOLD online system, which form the basis of their scoring across four areas of development (social-emotional, physical, language, and cognitive) and two areas of content learning (literacy and mathematics). Objectives and dimensions that comprise each of the functional outcomes are based on a crosswalk recommended by the national Early Childhood Outcomes (ECO) Center. Criteria for defining "comparable to same-aged peers" was determined through Item Response Theory (IRT) analyses by Teaching Strategies, based on a national sample. The algorithms result in a 7-point rating system that parallels the ECO Child Outcome Summary (COS) ratings. These ratings by age are programmed into the GOLD online system which generates a rating based on TS GOLD scores. Research studies examining the reliability and validity of TS GOLD may be found at http://teachingstrategies.com/assessment/research. Since FFY 2013, the Co-Leads have been concerned with the OSEP Part C results as they continue to be significantly different from previous Nebraska data, as well as national data. The Nebraska Part C Co-Leads have established an ongoing partnership with the DaSY Center and TS GOLD to determine ongoing strategies to address identified problems. Based upon this, in FFY 2013 Nebraska Part C established new cut scores that formed the bases of the OSEP ratings. The original cut scores, prior to FFY 2013, were based on a small sample. In FFY 2013 a larger representative sample was available from which to complete the analyses. TS GOLD decided to rerun the analyses. Data from this one year's worth of data formed the bases of the FFY 2014 Nebraska targets. These targets were based on a single year of data (FFY 2013). Since that time, it has become apparent that the data used in FFY 2013 for Summary Statement 2 was an anomaly (higher than any subsequent year) across all three outcome areas. Dr. Barb Jackson of UNMC-MMI serves as our consultant and performs the analyses on the child outcome data.

The FFY 2017 and 2018 C3B Summary Statement 1 data demonstrated a decline which was unexpected as in the previous two years the scores have been stable. In reviewing current state infrastructure practices, there had not been any major shifts or changes. Inter-rater reliability and completion of TS GOLD training modules are still required of providers. Statewide training was provided as in previous years and was

expanded to include a comprehensive administrator training. The Results Drive Accountability (RDA) strategy implementation has demonstrated high quality home visitation practices. Several states that are using the TS GOLD online calculations for OSEP reporting have been meeting regularly as all states using the TS GOLD online system for generating OSEP reports have seen slippage in Summary Statements that are inconsistent with any changes in state infrastructure or improvement activities. In August 2017, Teaching Strategies converted their online platform to accommodate the changes made to the tool to include items up to third grade. Collectively the state representatives proposed that the following factors related to this platform change may be contributing to this slippage of data including:

- Changes to indicators and dimensions as a result of expanding the TS GOLD to third grade;
- Teacher/practitioner confusion due to changes to the front-end look of the online platform; and
- Fewer data points on which data can be entered for each child.

Nebraska is working with other states using TS GOLD and DaSy, ECTA, and SRI centers to conduct ongoing in-depth analysis with Teaching Strategies staff to determine the root cause of the unexpected changes to these summary statements and develop solutions to improve the validity of data for reporting outcomes in the future. The data analysis has just been completed and a meeting to review the data and determine action steps will occur this spring. If satisfactory solutions are not generated, the state is strongly considering examining potential alternatives for its statewide assessment.

In 2018 and 2019, additional trainings were developed by Nebraska Department of Education Staff and Consultants in order to enhance EI providers' reliability in scoring TS GOLD items from the information gathered at an initial RBI (for TS GOLD entry scores), as well as ensure ongoing data validity and reliability of children's assessment data by EI providers within the TS Gold system. These trainings are supplemental to Nebraska's RDA strategies in order to enhance validity and reliability of Part C Child Outcome data collection/reporting. Additionally, RBIs completed following the initial IFSP, together with gathering routines-based documentation from ongoing home visits, should provide the necessary data to inform TS GOLD exit data. These new trainings provide practice and strategies for the exit scoring as well.

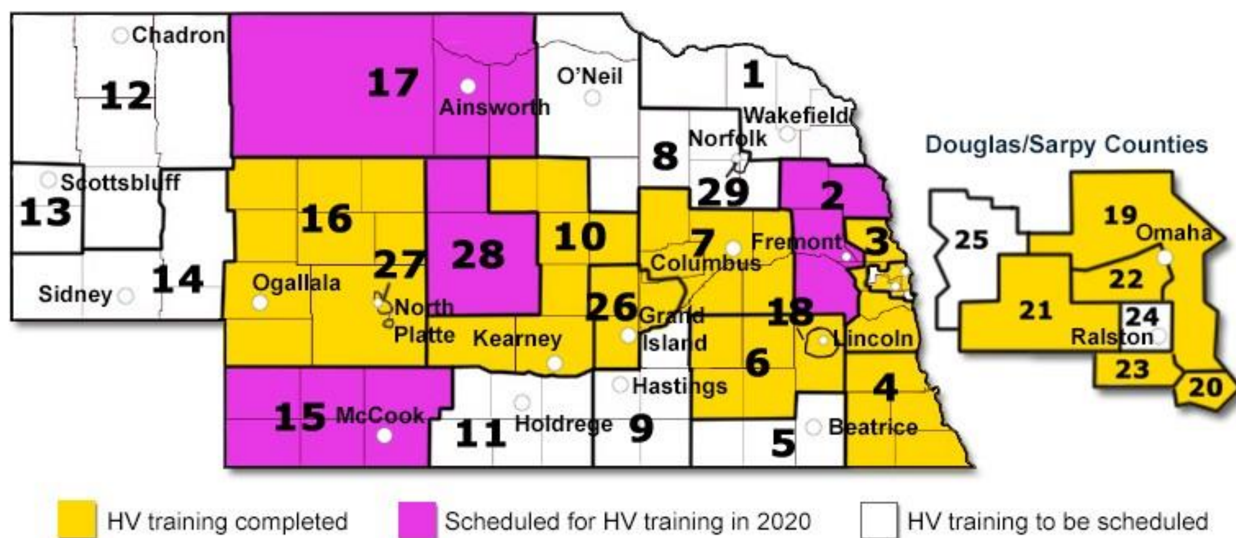
C4b - Family Survey: The Family Survey adheres to all NCSEAM standards. Dr. Batya Elbaum serves as our consultant and performs the Rasch analyses on all survey data. Our survey response rate has consistently been among the highest in the country due to services coordinators hand delivering the survey to each EI family and the provision of the survey in multiple languages in addition to the use of translation services for families in need of this service. Our response rate this year (75%) was slightly lower than recent years, attributable to the natural disasters Nebraska experienced during the late winter and early spring months, just at the time when the surveys were due. Eighty-three of Nebraska's 93 counties received Major Disaster Declarations. Nevertheless, we are confident that our responses represent our state. All data is double- keyed at Westat using a process that identifies all keystrokes different between the first and second keying. The individual keying the data reconciles all data. We are confident our data is accurate and represents the perceptions of our families.

Section E: Progress Toward Achieving Intended Improvements

This section addresses the state's progress toward achieving intended improvements, including infrastructure changes that support SSIP initiatives, evidence that practices are being carried out with fidelity, and measurable improvements in the SiMR relative to the targets.

Nebraska's training sequence begins with the RBI, followed by Functional IFSP Outcome training; culminating in Routines-Based Quality home visit training. To be considered "ready" for training in a new strategy, a region must be at or near full implementation of the preceding improvement strategy (see training timeline Section C).

Table E1: PRT Implementation Status of 3rd Strategy, Routines-based Home Visits



As illustrated in Table E1 above, fourteen (in yellow) of Nebraska's 29 planning region teams are engaged in the implementation of all three of the state's improvement strategies. Four regions (in purple) will receive home visit training in June 2020. The remaining PRTs are in the process of training and implementing strategies #1 and #2.

Training and approval for two of the three improvement strategies- the RBI and Routines-Based Home Visits- use coaching and feedback as integral aspects of the approval process. These training practices require professionals to submit videotapes of themselves implementing the strategies/practices for approval. TORSH Talent continues to be the online platform selected by the state for coaching, observation, feedback and data management. The platform allows users to upload, retrieve, and share video and documents in a secure, cloud-based online repository. The Co-Leads have increased funding for TORSH Talent to enable all Cohort and non-cohort regions to utilize the online platform.

The benefits of peer-to-peer coaching have been clearly documented in professional literature. In Nebraska, not only has peer coaching led to more frequent and transparent communication across teams and regions, it has also led to the development of leadership teams comprised of both supervisors and internal coaches, the latter of which allows leadership teams to get feedback from the field. Building coach capacity has required the state and PRTs to identify EI providers and services coordinators who are leaders, while making available training materials and TA to develop their skills and reliability.

Table E3 below illustrates infrastructure development at the local PRT level from Phase 1 to Phase 3 in terms of leadership team development, coach capacity, and full RBI implementation as of 2019.

Table E3: Impact of SSIP on Local Level PRT Infrastructure

Phase I	Phase III (Year 4)
PRTs with Leadership Teams - 6	PRTs with Leadership Teams- 29
PRTs with RBI Coaches - 16	PRTs with RBI Coaches - 27
PRTs with HV coaches - 0	PRTs with HV coaches - 14
PRTs at Full RBEI Implementation of all three strategies - 0	PRTs at Full RBEI Implementation of all three strategies - 8

Section F: Anticipated Plans for Next Year

This section describes planned evaluation activities, additional activities to be implemented next year, anticipated barriers, and need for additional supports.

Planned Evaluation Activities

Planned evaluation activities for Cohorts 1 and 2 will be implemented as described in Section C. Table F1 below gives a brief illustration of the planned evaluation activities for the improvement strategies during the next year and beyond.

Table F1: Evaluation Plan for Implementation of Improvement Strategies

Strategy	Cohort 1	Cohort 2
RBI	5th Annual RBI fidelity checks	4th Annual RBI fidelity checks
Functional Outcomes	5th Annual Functional IFSP Outcome Review	4th Annual Functional IFSP Outcome Review
Routines-Based Home Visits	2nd Annual Home Visit fidelity checks	1st Annual Home Visit fidelity checks

Nebraska will continue to work closely with the RDA Stakeholder Committee, the Early Childhood Interagency Coordinating Council (ECICC) and the Special Education Advisory Council (SEAC) during 2020-2021 as they assist in the continuous evolvement of the SSIP.

Additional Activities to be Implemented

In 2019 the Co-Leads contracted with Dr. Miriam Kuhn and Dr. Johanna Higgins to complete an evaluation of Quality Home Visitation in Nebraska. The evaluation focused on 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 action plans to support parents' use of strategies with their children,
   (d) use of and fidelity to the strategy steps outlined by the action plans in family routines/activities with their children between visits,
   (e) parent-provider communication between visits, and
   (f) parent-professional collaborations to monitor child and family progress on IFSP outcomes?

2. How do family members and *service coordinators* 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 parents' access to desired services and resources,
   (c) implementation of the home visit plan between visits,

(d) parent-provider communication between visits, and
(e) parent-professional collaborations to monitor child and family progress on IFSP outcomes?

Findings related to these research questions were provided in Section C. An executive summary and full report of the findings and recommendations from this study can be found in Appendix DD. In terms of further training and/or investigation, the following recommendations were made and will be implemented:

- Incorporate guidance regarding recommended methods, frequency, and focus of communication efforts in between home visits into training, technical assistance materials, and coaching activities.
- Incorporate guidance about services coordinators' roles within the Getting Ready framework in training and technical assistance activities.
- Collaborate with University of Nebraska to learn strategies that are successful in working with diverse families such as those who do not speak English as a first language or have disabilities themselves.

Additional activities the Co-leads plan to implement within the next year include the following:

Teaching Strategies Gold Activities

- Develop and implement action steps with Teaching Strategies Gold to improve the validity of the child outcome data and the Teaching Strategies Gold tool.

Getting Ready (GR) Approach in Community-Based Settings

- Collaborate with the University of Nebraska Lincoln (UNL) to develop a plan to implement the GR approach to promote parent partnership and ultimately improve child outcomes within community- based early childhood settings.

Revision of Annual Part C Family Survey

- Explore the addition of questions to the Annual Part C family survey in order to better assess overall satisfaction with (1) EI services, (2) progress toward child and family outcomes and (3) frequency of service provision.

Partner with University of Nebraska-Lincoln for Comprehensive Personnel Development

- The Co-Leads will continue their partnership with the University of Nebraska for Comprehensive Personnel Development. Areas of focus will include aligning existing coursework to early childhood evidence-based practices utilized within Nebraska as well as developing solutions to address early intervention provider shortage.

Anticipated Barriers

To date, the Co-Leads have implemented robust evaluation measures and methodologies in the cohort regions. These processes have been manageable for the cohort regions because the state is managing them and is contracting with national TA centers to assist in the data collection and analysis.

In addition to compliance monitoring activities, the state leadership team continues to address implementation and evaluation barriers for the non-cohort regions via the provision of additional TA, training opportunities, and extra resources and funding. It is the intent of the Co-Leads to ensure statewide fidelity of the three coherent improvement strategies. However, these activities are taxing on state staff time and funding resources available for implementation and sustainability of the coherent improvement strategies and

data collection/reporting mechanisms for the entire state.

Additional Supports Needed

The state will continue to utilize OSEP-funded TA Centers, DaSy and ECTA, in the implementation of the SSIP requirements. Also, the state will continue our collaborative work with Westat and the University of Nebraska higher education system to assist us in training, evaluation activities, and data.

Nebraska Phase III - Year 4 Report
Appendices

Appendix C: RBI Implementation Checklist

RBI Implementation Checklist

Interviewer__________________________________Date____________________

Observer______________________Items Correct:_______Scored:______%: _______

SCORING. + OBSERVED AS DESCRIBED. +/- PARTIALLY OBSERVED. – NOT OBSERVED OR OBSERVED TO BE INCORRECT

Goal: 85% items scored as + needed for Nebraska approval

Did the interviewer:	+	+/-	-	Comments
Beginning				
1. Greet the family and review the purpose for the meeting (i.e., to get to know the family and to determine how best to provide support to their child and family)?				
2. Ask the parents their main concerns for their child and family?				
Routines				
3. Stay focused on routines rather than developmental domains?				
4. Ask open-ended questions initially to gain an understanding of the routine and functioning (followed by closed-ended questions if necessary)?				
5. Find out what people in the family other than the child are doing in each routine?				
6. Ask follow-up questions related to engagement?				
7. Ask follow-up questions related to independence?				
8. Ask follow-up questions related to social relationships?				
9. Ask follow-up questions to gain an understanding of functioning?				
10. Ask developmentally appropriate follow-up questions?				
11. Avoid unnecessary questions, such as the specific time something occurs?				
12. Attempt to get the parent's perspective on behaviors (why he/she thinks the child does what he/she does)?				
13. Put a star next to notes where the family has indicated a desire for change in routine, has said something they would like for their child or family to be able to do, or raised a red flag for the interviewer?				
14. If there are no problems (stars) in the routine, ask the family what they would like to see next?				
15. Ask for a rating at the end of the parent's description of *each* routine?				
16. Ask "*What happens next" (*or something similar) to transition between routines?				
17. Use "time of day" instead of "routine"?				

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Style				
18. Use good affect (e.g. facial expressions, tone of voice, responsiveness)?				
19. Have a good flow (conversational, not a lot of time spent writing)?				
20. Maintain focus throughout the session?				
21. Use affirming behaviors (nodding, positive comments or gestures)?				
22. Use active listening techniques (rephrasing, clarifying, summarizing)?				
23. Avoid giving advice?				
24. Act in a nonjudgmental way?				
25. Return easily to the interview after an interruption?				
26. Allow the family to state their own opinions, concerns, etc. (not leading the family towards what the interviewer thinks is important)?				
Family Issues				
27. Ask the family if they have enough time for themselves or with another person (if this information was not shared previously)?				
28. Ask the family "When you lie awake at night worrying, what is it you worry about"?				
29. Ask the family "If you could change anything about your life, what would it be"?				
Recap/Outcome/Goal Selection				
30. Ask the person taking notes to summarize the starred concerns during the recap?				
31. Complete the recap in 5 minutes or less?				
32. Ask the family, after the note-taker has summarized the concerns, if anything should be added?				
33. Make it clear to the family that the concerns (i.e., starred items) were not outcomes/goals?				
34. Following the recap, ask the family what they would like to work on (i.e. a list of outcomes) and record their responses *on a clean sheet of paper*?				
35. Ask the family to prioritize the outcomes in order of importance?				
36. Say what will happen next with this information (e.g., outcomes/goals written in behavioral, measurable terms; services decided upon)?				

Appendix H: Nebraska RBI Approval Requirements

Requirements for Nebraska RBI Approval

During the Boot Camp

______Lead an RBI as the Primary interviewer—receive feedback from feedback giver and coach
______Assist with an RBI as the Secondary interviewer
______Observe an RBI as the Feedback Giver- use the implementation checklist and provide feedback
______Complete functional goal writing homework assignment and receive feedback from your coach
______Participate in workshop discussions and RBI debriefings

After the Boot Camp

Practice RBI's with families. When ready, or no later than__________________, send your coach a:
______Signed consent to videotape
______Copy of the Ecomap
_____Videotaped RBI with YOU as the primary interviewer. The tape must include the ecomap. The interview itself should be AT LEAST 1 hour in length, excluding the eco-map. You may have a secondary interviewer assist you.
_____Copy of the family's priorities from the interview
_____A participation-based outcome developed for each of the family's priorities (must include at least one family outcome). Aim for 6-10 total outcomes.

NOTE: The child and family outcomes submitted must come from the family priorities expressed during your taped RBI. Use the "7 Steps to Writing Functional Outcomes", the templates and the examples provided in your Boot Camp binder as a guide.

Following receipt of the videotape and the accompanying materials, the coach will...
______complete an RBI implementation Checklist and provide you with a copy
______provide verbal feedback via a phone call or F2F meeting
______provide written feedback on the Ecomap and RBI
______provide written feedback on the outcomes using the Quality Outcomes Checklist as a guide.
______send you these results by ________________

NOTE: You must have a score of 85% or better on the RBI Implementation Checklist for RBI approval.

Many participants need the feedback they receive on their first video submission in order to reach 85% accuracy on a second submission. If a score of 85% is not reached on the first video, follow the feedback you received in your practice and resubmit the required documents listed above by______________.
Your coach will complete an implementation checklist and provide feedback by__________________.

*Participants and coaches are asked to adhere to the submission timelines as directed in the boot camp agreement. An extension may be granted if absolutely necessary but MUST be made in conjunction with the assigned coach. Please copy all emails between coaches and participants to the Boot Camp facilitator and participant supervisor/PRT designee.

Revised May 2016

Tips for getting approved:

- Folks consistently get higher scores on an implementation checklist when they interview a family they DON'T know and when they give themselves LOTS of practice!
- You can practice the RBI with any family or even with one another! Remember that much of what you are practicing is the "script"-- how to introduce the RBI, the sequence of questions, remembering to rate the routines, how to ask the worry/change questions, when to take out a clean sheet of paper etc. You can do this with anyone.
- You CAN also submit a videotape of an RBI you have done with <u>any</u> family (not each other). The family does NOT have to be an "initial" referral or even a family receiving EI services. People who have gone through the approval process, say it is helpful if the person being interviewed has a child between the ages of Birth-5. They also say it is easier to ask in-depth questions and elicit priorities if the family has a child with a disability but this is not necessary.
- There are a few other things to consider when selecting a family to interview….some families are more difficult to interview than others. For example, it is difficult to demonstrate your skill at asking in-depth EISR questions when interviewing a family with a very young infant. There simply aren't as many questions to ask. Interviewing a family who is non-English speaking also adds a layer of difficulty. Completing an interview with an interpreter is a skill you will need to learn but you may not wish to add this "stressor" when submitting a videotaped interview.
- Maximal learning comes from getting good feedback. Asking someone to give you feedback every time you do an interview is a GREAT idea. We are recommending that teams have the secondary interviewer routinely complete an implementation checklist after each interview (when you've left the family's home). This helps you to debrief and prepare for the next interview opportunity.
- Poorly written outcomes will <u>not</u> prevent you from becoming RBI approved. However, your coach will provide you with feedback on your outcomes and may request that you re-submit if necessary.
- **We recommend you use a secondary interviewer. However, please note that your secondary interviewer will be scored as part of your overall RBI implementation checklist and this is factored into YOUR overall score. So, make sure they feel ready for their job!**
- If you are going to have difficulty with the due dates, please contact your coach.
- Remember, the ultimate goal is for ALL team members to become RBI approved. Interviewing is a "skill"; it develops over time with practice and feedback.

Revised May 2016

Appendix I: Nebraska RBI Fidelity Process

NEBRASKA DEPARTMENT OF EDUCATION

Nebraska's RBI Fidelity Process

Trainer Description	Training	Fidelity Check
Certified Trainers	Certified at the Siskin Institute in Chattanooga, TN.	Every 2 Years NDE facilitates process
Approved PRT Trainer/Coach	Approved at an RBI Boot Camp; designated as a PRT RBI Coach; attended an RBI Scoring Reliability Training	Annual Observation by an approved RBI interviewer. Achieves 85% or better on RBI Implementation Checklist.
Approved Interviewers	Approved at an RBI Boot Camp or approved through an Individual Mentoring Process following the Nebraska 7 steps for RBI Training found at: http://edn.ne.gov/cms/sites/default/files/pdf/Nebraska-Rec-Training-Practices.pdf	Annual Observation by an approved RBI interviewer. Achieves 85% or better on RBI Implementation Checklist.

Initial and annual RBI implementation checklists for providers and services coordinators should be kept on record by the PRT Leadership Team. Status of RBI training in the PRT will be a part of the annual PRT grant application/TIP evaluation process.

Sue Bainter & Cindy Hankey, October 2016

Appendix J: RBI Implementation Checklist Rules

RBI Implementation Checklist – <u>Rules for Scoring Reliability</u>

Interviewer_________________________________**Date**____________________
Observer_____________________**Items Correct:**_______**Scored:**______**%:** ______

SCORING: + OBSERVED AS DESCRIBED. +/- EMERGING OR PARTIALLY OBSERVED. – NOT OBSERVED OR OBSERVED TO BE INCORRECT

Did the interviewer:	+	+/-	-	Comments
Beginning				
1. Greet the family and review the purpose for the meeting (i.e., to get to know the family and to determine how best to provide support to their child and family)?				Must include the content from the script but does not need to be word for word.
2. Ask the parents their main concerns for their child and family?				Should be short and sweet, not encouraging elaboration; MUST include "family" reference, if not, score +/- or -
Routines				
3. Stay focused on routines rather than developmental domains?				Most of the time; asks about development as described within the context of routines (should NOT sound like a checklist).
4. Ask open-ended questions **initially** to gain an understanding of the routine and functioning (followed by closed-ended questions **if necessary**)?				During MOST of the routines; can also use "tell me about" and "paint me a picture" as alternative. Most of the time for #4 means MORE open-ended questions than close ended with the focus being on "initially"
5. Find out what people in the family other than the child are doing in each routine?				During most of the routines.
6. Ask follow-up questions related to engagement?				During MOST of the routines, also consider, do you have a picture of the child in most routines. Cannot simply ask using the word "engagement". Questions in EISR may also count as #9 and 10 (see below).
7. Ask follow-up questions related to independence?				Same as above. Cannot simply ask using the word "independence".
8. Ask follow-up questions related to social relationships?				Same as above. Cannot simply ask using the word "social relationships".
9. Ask follow-up questions to gain an understanding of functioning?				During MOST routines and using: How does that work for you, where does he sit, how does that look – think: how does a family "function". ? Particularly for questions about behavior, fighting, fits, attention, etc.
10. Ask developmentally appropriate follow-up questions?				During most routines. Consider child's age and developmental level.
11. Avoid unnecessary questions, such as the specific time something occurs?				If this happens 1 or 2 times, would not count against participant; should not be frequent. Should not interfere with the structure of the questions within routines.
12. Attempt to get the parent's perspective on behaviors (why he/she thinks the child does what he/she does)?				Should ask at least once, more if behaviors are discussed.
13. Put a star next to notes where the family has indicated a desire for change in routine, has said something they would like for their child or family to be able to do, or raised a red flag for the interviewer?				Should get most of them, be sure to include the concern raised in question 2; worry and change questions, ecomap, and time to self..
14. If there are no problems (stars) in the routine, ask the family what they would like to see next?				Would NOT be used when concerns were already described; should be asked BEFORE the rating; if the interviewer misses a few chances to use, or if they ask <u>after</u> the rating a few times, do not score as - **as long as they correct it later** (try to use the word "next" and

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(Updated by NE January 2018)

				not “different” or “changed” as this is meant to capture next steps).
15. Ask for a rating at the end of the parent’s description of *each* routine?				Most of the time; if “routines” are not clear, look for interviewer identifying and rating at natural breaks within a period of time.
16. Ask “*What happens next” (*or something similar) to transition between routines?				Most of the time; if they miss a few, it’s okay.
17. Use “time of day” instead of “routine”?				Most of the time, if they use the word routine a few times (2-3) it’s okay to give a +; if parent uses the word and interviewer then uses it back to them, it’s okay;
Style				Do not score until at least half way through the interview. Style items may begin as awkward but as long as interviewer corrects self and improves as interview proceeds can score +.
18. Use good affect (e.g. facial expressions, tone of voice, responsiveness)?				Appropriate most of the interview; does not use non-professional references.
19. Have a good flow (conversational, not a lot of time spent writing)?				Most of the interview; some writing is okay but would be scored as +/- or – if the parent having to wait while interviewer writes a lot of the time.
20. Maintain focus throughout the session?				Most of the time stays focused on the structure of the interview.
21. Use affirming behaviors (nodding, positive comments or gestures)?				Appropriate to the situation; if affirming behaviors too fast or interrupts parent, score +/- or -. e.g. not at times that take the interview off track.
22. Use active listening techniques (rephrasing, clarifying, summarizing)?				Acknowledges, repeats/rephrases as needed to check for understanding, “I heard you say…”, “is this what you mean”, “so you said you get him dressed and then….”
23. Avoid giving advice?				Should not see suggestions at all; should try to redirect (“that will come later”), if parent persists with a topic can give information.
24. Act in a nonjudgmental way?				Most of the interview, regardless of differences in parent’s perspective from the interviewer’s.
25. Return easily to the interview after an interruption?				Most of the interview;, comes back to the RBI without following side conversations or encouraging attention to things other than the interview’ can respond to child or parent but comes back quickly.
26. Allow the family to state their own opinions, concerns, etc. (not leading the family towards what the interviewer thinks is important)?				Most of the interview, does not lead/suggest to families to things that should come next or in making assumptions without asking parent for perspective. At times, clarifying questions appear leading (see #22).
Family Issues				
27. Ask the family if they have enough time for themselves or with another person (if this information was not shared previously)?				Must find out from parent at any time during the interview; if both parents are present, asking both is preferable, if only asks one parent, make a note but still give +.
28. Ask the family “When you lie awake at night worrying, what is it you worry about”?				Must use as written in script; asking both parents if both present is preferable, if only asks one parent, make note but still give +.
29. Ask the family “If you could change anything about your life, what would it be”?				Must use as written in script; asking both parents if both present is preferable, if only asks one parent, make note but still give +.
Recap/Outcome/Goal Selection				
30. Ask the person taking notes to summarize the starred concerns during the recap?				Let the parent know – use the script – now we are going to review the concerns or things you talked about. Did they ask or not, + or -.
31. Complete the recap in 5 minutes or less?				Summarize only, no elaboration or asking the parent additional questions. Show or give access to parent the notes.
32. Ask the family, after the note-taker has summarized the concerns, if anything should be added?				Should anything be added?

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(Updated by NE January 2018)

33. Make it clear to the family that the concerns (i.e., starred items) were not outcomes/goals?				Use script to describe as concerns or priorities, should NOT say, “your goals” or “from your list/notes”.
34. Following the recap, ask the family what they would like to work on (i.e. a list of outcomes) and record their responses *on a clean sheet of paper*?				Must start using CLEAN sheet of paper – “what would you like to work on” or something similar. Shares the notes or reviews recap if needed, but the point is for the parent to list ANYTHING. This is NOT a list the interviewer has made, nor is it the list of starred items.
35. Ask the family to prioritize the outcomes in order of importance?				Asks family to prioritize, or gives family the pencil to do themselves. Prefer this to be a conversation but can let parent review themselves and rank.
36. Say what will happen next with this information (e.g., outcomes/goals written in behavioral, measurable terms; services decided upon)?				Next step – does not have to be long, can be IFSP, share with the team, etc. should fit the situation – training might be to share with team; real situation would be IFSP, etc.

Appendix K: Guidelines for RBI Video Review & Feedback

Feedback Guidelines When Reviewing RBI Videotapes

Feedback is provided in 3 formats- (1) using implementation checklists, (2) verbally via a phone call or F2F meeting, and (3) in writing.

- First set up *phone call/F2F meeting* to provide verbal feedback; follow up with checklists and written feedback after the phone call.
- *Verbal feedback* should mimic the SOAP format described in detail below and including – *Subjective* observations of overall strengths, *Objective* data including the score and approval status, a description of the *Assessment* including positive observations and 2-3 main things to work on, and finally the *Plan* for next steps. Give the participant the opportunity to ask questions, make comments and give feedback.
- *Written feedback* should be 1-3 typed pages in length. Typically 3 pages are for participants who did not get approved because more in-depth information is usually needed. EVERYONE, regardless of approval, should get specifics as to strengths and areas of growth for the ecomap, the RBI and functional outcomes. Include the RBI Implementation checklist (scanned copy) in your feedback.
- Use SOAP format for both the phone call and the written feedback, which includes:
    1) "Subjective" or general and overall strengths (E.g. Your interview had a great flow, the parent was opening up so well at the end, you did great at remembering to ask what everyone else is doing, a sure sign this was a good RBI was when Abby started to reflect herself and see why some things don't go as well when they are away from home, …)
    2) "Objective", which states the data: i.e. percentage from the checklist, specific items you want to highlight that the participant needs to focus on, and the pass/no pass decision, e.g. "I'm so glad you used the protocol; that helped you structure the interview but unfortunately, I cannot pass you because I did not hear enough questions about engagement, social relationships and independence; and you forgot to have the parent rate their routines until the very end. More information will follow."
    3) "Assessment": the bulk of the feedback is in this section and typically is chunked into headings or sections such as "open-ended questions", "recap", "stars", etc. Start with positive observations, particularly if the participant DID demonstrate one or two examples that can be developed, e.g. "if you explore all routines like you did play time, you will be able to gather more specifics for the recap". If it is difficult to find good examples, provide a narrative of what the participant should use so that they have something to compare to. Include the chunks of "areas for growth", however be strategic in which items you elaborate upon. It is

not necessary to include an example and feedback about every single item. The participant will have the checklist and can come back for clarification if they have questions about an item not covered.

4) "Plan" for next steps: choose wisely, what 2-3 important things (or less) does the participant need to focus their practice on so that they can pass, or if they DID pass, what else can they work on (every RBI can be improved upon); you do not need to list everything. What resources might you suggest? Be encouraging. E.g. "Work on the timing of when to ask what the parent would like to see next, remember it comes BEFORE the rating". Or, "be sure to use the protocol for items 27-29 so that you get the correct wording." Or "continue to work on the EISR questions – there are some sample clips on the EDN website that you can watch. I think you will find that interviewing parents of children you don't already know will help you to be more thorough as well." And, "this was a much better interview! Congratulations on passing! Continue to work on the recap."

- Ecomap: does not influence approval, but use the Ecomap checklist for providing feedback and include at least 1 positive and if needed, include 1 next step, in your verbal and written feedback. Include a scanned copy of the ecomap checklist.

- Outcomes: Participants should have developed an outcome for each of the family's priorities. Use the Quality Outcome checklist to guide your feedback but it is NOT necessary to actually score the checklist. Make suggestions as needed in your verbal and written feedback if they missed key information from the RBI itself that you noticed while watching it. Try to highlight any outcomes that meet the criteria or mostly meet the criteria as a way to compare to others that might need work. Make sure you refer the participant to the samples in the notebook or the outcome templates if they did not provide any well written outcomes. Even though the outcomes themselves do not influence approval, ask them to resubmit poorly written outcomes, even if they passed the RBI. It is not necessary to re-write all of them when asking for resubmissions. Instead, choose a few representative samples (both child and family if needed) that would allow the participant to practice adequately. *Participants do not have to use the EXACT wording provided in the templates. Their outcomes DO need to include the information listed in each of the items on the checklist.*

Things to keep in mind:

- Regarding the RBI time length - Participants are reminded both verbally and in the written approval requirements that RBIs less than an hour in length (excluding the ecomap) will not be approved. This requirement is based on experience with many RBIs

and the level of detail that tends to be missing when it does not last at least an hour. However, the coach should STILL accept the submission and provide feedback to the participant. When explaining this to a participant, highlight the data about short interviews rather than simply stating the time limit, the latter of which, on its own, can be frustrating for the participant.

- Protocol- Participants are encouraged to read the bolded sections of the protocol. However, they don't have to read verbatim as long as their orations include the pertinent information in each section.
- Checklists – score the checklists using the (+), (-), and (+/-) columns. Remember that a (+/-) is considered an "emerging skill" but is scored a (-) when computing the RBI percentage. Jot down notes and/or helpful examples on both checklists that the participant can use when resubmitting.
- Outcomes – Remember that the participant's list of outcomes needs to include at least one family outcome and one child outcome.

Appendix L: IFSP Quality Outcome Checklist

IFSP Outcome Quality Checklist Outcome #:__________

Child NSSRS: _________________ Connect #:___________IFSP Date: _________ PRT #:______Rater: _____________ Date Completed: _________

Child Outcomes – Does the Outcome:	**Yes (+)**	**No (-)**	**Comments**
1. Emphasize child participation in a **routine(s)**? (Child will participate in *outside time* by*….NOT* child will participate in *running; or* child will participate in *breakfast and snack time* by*….NOT during eating and drinking times).*			
2. Include **an observable indicator** of what the child will do that is necessary, clearly connected, and/or useful in participating in the **<u>above routine(s)?</u> (Routine(s) must be identified in #1 to score a +).** (Child will *hold spoon for 4 bites* during *….NOT grasps spoon;* or child will *use word or sign to let family know* during*….NOT* child will *not scream;* or child will *play with a car by rolling it on the floor* at playtime*...NOT* child will *sit up and hold bottle* at*….)*			
3. Include a reasonable time frame for completion, with criteria that are clearly linked to the outcome? (Child will hold spoon for 4 bites at lunch *each day for 2 weeks… NOT 3 of 4 trials;* or child will use 2 words together at playtime *on the weekends for 2 weeks…. NOT 1 day across 3 observed days/sessions)*			
4. Describe priorities in words the family would use (i.e. jargon-free)?			
5. Link to the family priorities as listed on page 2 of the IFSP?			
Family Outcomes – Does the Outcome:	**Yes (+)**	**No (-)**	**Comments**
1. State specifically what the family will do (i.e. the family is the actor) based on a family priority as listed on page 2 of the IFSP, i.e. reflecting a family need or interest? (Sally will *get information about child care or respite…. NOT have knowledge of medical, financial, and developmental services;* or Russ will *feel satisfied or comfortable that he knows how to play with Ronnie…. NOT* family will *play appropriately with their child)*			
2. Include an indicator of when or how the family will know the goal is met? (find child care *by June 15 or by the end of the month)*			
3. Written in words the family would use? (I.e. jargon-free…. NOT *family will utilize resources in their community*. **(If it is difficult to determine whether the outcome is written in the "family's words", score as a "yes").**			

Please check one:________Child Outcome_______Family Outcome **Raw Score for this outcome** (# correct items/total # of items) __________

Instructions for completion: Rate each IFSP outcome using a separate page. Begin by categorizing the outcome as either a **family** outcome in which the parent's name is specified as the focus; or as a **child** outcome in which the child's name designates the focus. Using the appropriate section, rate the outcome on each of the criteria listed. A (+) indicates the criterion is present, a (–) indicates it is missing. Use the comments section for feedback or next steps. Record the raw score for this item in the space provided. When all outcomes on the IFSP have been scored, complete a summary sheet.
<u>(Adapted with permission from RA McWilliam Goal Functionality Scale III 2009)</u>

Sue Bainter and Cindy Hankey, February 2015; Nebraska RDA project

Appendix R: Getting Ready (GR) Coaching Agenda

Getting Ready Coaching Agenda

The purpose of this template is to provide a guide for conducting an individual coaching session, using the Home Visit implementation checklist data.

Opening – Individual Session
Set the agenda/Review joint plan: Establish rapport. Purpose of coaching session: establish the context to support individual professional development. *After initial session – reminder of previous "joint plan" – what did you focus on, what do you need help with, etc.* Agree to an agenda for this coaching conversation.
Main Agenda
Observation/Reflection/Feedback: Coach asks coachee to reflect by comparing/contrasting the coachee's perception of home visit to their intentions/checklist/focus that were agreed upon in joint plan from previous coaching session – what went well, what didn't, does it match what you intended and if not, why? Share coach's feedback and show 1-2 clips of exemplars and/or preferred focus, if applicable. Support coachee reflection on feedback. Coach explores/encourages ideas for next steps: • Which Getting Ready strategies have you tried? • Which Getting Ready strategies would you use differently next time? • What steps of the GUIDE process do you want to focus on? Share informative feedback from checklist if coachee does not reference specific items/behaviors.
Closing
Setting the joint plan: Coach provides recap from main agenda, including strengths identified. Coach reviews potential actions from the main agenda and facilitates coachee's reflection and planning for next steps: • What do you want to do? • What supports are needed for implementation? • By when, how or with whom will you share this information? Coach and coachee finalize next steps (joint) plan.

Appendix S: Getting Ready Provider Implementation Checklist

Provider Implementation Checklist - Ongoing

Provider__________________________________Date____________________
Observer ______________________
Items Correct:______Scored:______%:_______/ Getting Ready Strategies Observed:_Yes_No
Getting Ready Reliable:_Yes_No
Checklist is to be completed for an ongoing visit that includes a parent-child interaction.
+ OBSERVED AS DESCRIBED. – NOT OBSERVED OR OBSERVED TO BE INCORRECT

Goal: At least 80% of items 1-10 (8/10) scored as + needed for reliability*			
	+	-	Comments
Did the provider:			
OPENING			
1. Establish/Re-establish the Partnership			
2. Discuss Child/Family Strengths & Concerns/ Observations/Information Since Last Visit			
3. Co-Establish Purpose for Visit			
MAIN AGENDA			
4. Review child's progress since the last visit specific to selected IFSP outcome.			
5. Co-determine the IFSP Outcome(s) to be Addressed			
6. Support Parent/Child Interaction and Practice (Let's Try It!)			
7. Develop Home Visit Plan			
CLOSING			
8. Reflect and Review			
9. Discuss/Review Possible Ideas for Next Visit			
10. Review and Finalize Home Visit Plan			
Provider must show evidence of at least 5 separate Getting Ready Strategies:			
• Communicate openly and clearly			
• Encourage parent-child interaction			
• Affirm parent competencies			
• Make mutual/joint decisions			
• Focus parents' attention on child strengths			
• Share developmental information and resources			
• Use observations and data			
• Model and/or suggest			

****Must achieve reliability on two checklists (preferably with same family) to obtain approval in the Getting Ready approach.***

Appendix T: Getting Ready Services Coordinator Implementation Checklist

Services Coordinator Implementation Checklist

Services Coordinator________________________________**Date**_____________
Observer _____________________
Items Correct:_____**Scored:**_____**%:**______**/ Getting Ready Strategies Observed:** **Yes No**
Approach for Services Coordination Reliable: Yes No
Getting Ready Approach Approved: Yes No
+ OBSERVED AS DESCRIBED. – NOT OBSERVED OR OBSERVED TO BE INCORRECT N/A NOT APPLICABLE

Goal: At least 80% of items 1-10* scored as + needed for reliability in the Approach for Services Coordination *** Items 5-6 scored if the topic is introduced. If not introduced, mark n/a.*				
	+	-	n/a	Comments
Did the services coordinator:				
OPENING				
1. Establish/Re-establish the Partnership				
2. Discuss Child/Family Strengths & Concerns/ Observations/Information Since Last Visit				
3. Co-Establish Purpose/Design for Visit				
MAIN AGENDA				
4. Review Progress toward Current IFSP Goals; if immediate priorities or concerns exist, then visit includes specific plan to review progress toward IFSP goals later in current month.				
5. **If** Family Rights are Reviewed, Probes for Family Understanding of EI Process**				
6. **If** Transition Plan is Reviewed, One or More Steps of the Plan are Discussed**				
7. Develop Home Visit Plan				
CLOSING				
8. Reflect and Review				
9. Review and Finalize Home Visit Plan.				
10. Provide Copy of Home Visit Plan to Family or Let Family Know It Will be Mailed				

Services Coordinator must show evidence of at least 4 separate Getting Ready Strategies for approval in Getting Ready approach:				
• Communicate openly and clearly				
• Affirm parent competencies				
• Make mutual/joint decisions				
• Focus parents' attention on child strengths				
• Share developmental information and resources				
• Use observations and data				
• Model and/or suggest				

Depending on number of total possible items, 6 out of 8, 7 out of 9, or 8 out of 10 items scored as + are needed for reliability. Must achieve reliability on two checklists (preferably with same family) to obtain approval in the Approach for Services Coordination and Getting Ready approach.

Rev April 2018

Appendix X: Getting Ready Scoring Criteria for Early Intervention Provider Guide

Getting Ready Scoring Criteria for Service Coordinator Guide

Scoring Criteria for the GUIDE: EI Providers

The purpose of this tool is to provide additional scoring clarification for the Getting Ready Approach Implementation Checklist. It follows the GUIDE for Providers and was developed for use by coaches to help determine reliability on the checklist. It is not intended to replace the GUIDE and in fact does not contain enough information for implementation in a home visit.

Provider Implementation Checklist - Ongoing	
Goal: At least 80% of items 1-10 (8/10) scored as + needed for reliability*	
	+ SCORING CLARIFICATION
Did the provider:	
OPENING	
1. Establish/Re-establish the Partnership	*Can be simple, "Hi", or "How are you?" or "How's it going?"*
2. Discuss Child/Family Strengths & Concerns/ Observations/Information Since Last Visit	*This information may be shared by the family spontaneously in conversation or in response to questions from the provider.* Child/Family Strengths & Concerns *The information should touch on all 3 solid bullets on the GUIDE:* • *new strengths and/or interests [not necessarily from IFSP]* • *questions/reference to family developments, not just child [e.g. siblings, new baby, social outings, grandmother, etc.]* • *new concerns/questions and what has been tried* Observations/Info since Last Visit *The information should touch on the solid bullet on the GUIDE:* • *family observations of learning opportunities which may or may not be from last HV plan*

1

3. Co-Establish Purpose for Visit	*Ideas for the visit agenda must include input from both provider and family. Sources of information may include:* • *Previous joint plan.* • *Concern/observation surfaced during opening.* *Input might be simple agreement when asked such as, "okay" but there is some agreement between both – to elicit more input from parent, provider may offer a question such as "what do you want to get out of our visit today?"* *Roles (who will do what during the Main Agenda) are determined together appropriate to agreed agenda OR may be implied.* • *If it is clear during Main Agenda that the parent naturally takes interaction role with child, while the provider is near to observe or help, you can assume that roles have been determined at previous visits and are embedded in the way the parent and provider interact.*
MAIN AGENDA	
4. Review child's progress since the last visit specific to selected IFSP outcome.	Strategy, Routine, Skill Selection/Revision *Review child's progress specific to previously selected IFSP outcome. • *What is parent seeing re: progress* • *What learning opportunities/strategies worked or did not work.* **NOTE: Parent may have shared this information spontaneously during the <u>Opening</u> conversation. If so, the provider may or may not summarize what s/he heard.*
5. Co-determine the IFSP Outcome(s) to be Addressed	Co determine IFSP outcome A OR B (*two open bullets on the GUIDE are options for considering*). • *Must include contributions from both provider and parent even if simple agreement such as, "okay"; includes specifics from IFSP outcome – child will, routine, measurement as appropriate, family will, etc.* Review what we know child can do re: selected IFSP outcome. • *Must happen for A or B. (If A is chosen this will probably already be known after reviewing progress earlier in visit.)* • *Information can come from multiple sources including recent observations of parent or provider.* • *Record selected outcome – you may not see provider writing.*

6. Support Parent/Child Interaction and Practice (Let's Try It!)	• *Must include all three solid bullets on the GUIDE* • *Should include five hollow bullets from the GUIDE as appropriate to situation.* • *Hollow bullet 1 on the GUIDE under "Determine Practice Opportunity" is meant to define context that is as similar as possible to how the child's skill or behavior is seen during a routine and/or activity of a typical day, i.e. location, materials, roles – this is not to be contrived for the visit.* • *If the Let's Try It occurs spontaneously, five hollow bullets from the GUIDE under "Determine Practice Opportunity" can be confirmed after practice.* • *NOTE: *Bullet 3 on the GUIDE under "Discuss Practice Opportunity" may occur during or after the practice. Some reflection/debrief conversation is required, though all italicized questions may not be used.*
7. Develop Home Visit Plan	• *A mutual decision about what the child will be doing by the next visit should be intentional and is required.* • *How the **child** will be supported to reach the short-term goal through daily **routines** and using specific **strategies** must be discussed, or confirmed/restated if it was discussed earlier in the visit.* • *Roles may be implied and not specifically discussed.* • *Some reference to communication between visits should be addressed, though it may be brief if visits are frequent or provider and parent have a previously determined agreement about this.* • *Checking in about progress on other IFSP outcomes is optional.*
CLOSING	
8. Reflect and Review	• *BOTH parent and provider must intentionally respond to the question "What are you feeling good about right now?" The focus of the response to this question may be anything from how the visit went and how the child is doing to a much broader family situation.* • *Even if brief, the provider should ask about any other questions or concerns the parent may have. This is not intended to open up a lengthy conversation, but may inform a topic to note on Home Visit Plan for future discussion.*

<table>
<tr><td>9. Discuss/Review Possible Ideas for Next Visit</td><td>Might come from information gathered throughout the visit.
Can come from provider and/or parent.
Provider should at least ask parent what to consider for next visit if it doesn’t come from another source.</td></tr>
<tr><td>10. Review and Finalize Home Visit Plan</td><td>Quick recap, highlights, based on the Home Visit Plan. The HV Plan is NOT reviewed in full detail.
This is intended to confirm that parent and provider are on the same page at the end of the visit.</td></tr>
<tr><td colspan="2">Provider must show evidence of at least 5 separate Getting Ready Strategies:</td></tr>
<tr><td>Communicate openly and clearly</td><td rowspan="8">Getting Ready Strategies are to be used intentionally throughout the GUIDE to create the parent-provider partnership. As a coach, it is important to identify the strategies as they support collaborative interactions throughout the home visit.</td></tr>
<tr><td>Encourage parent-child interaction</td></tr>
<tr><td>Affirm parent competencies</td></tr>
<tr><td>Make mutual/joint decisions</td></tr>
<tr><td>Focus parents’ attention on child strengths</td></tr>
<tr><td>Share developmental information and resources</td></tr>
<tr><td>Use observations and data</td></tr>
<tr><td>Model and/or suggest</td></tr>
</table>

After scoring a video, review the scores to ensure that any components marked as missing, were not seen/heard at a different point in the visit than indicated on the checklist. [For example, some of the “review the child’s progress since last visit specific to previously selected IFSP outcome” may occur in the *Opening* rather than in the *Main Agenda*. Or “plan for the next visit” may occur during the *Main Agenda* and be only briefly touched on during the *Closing.]*

The intentionality and mutuality of each item is primary, the exact order may be different to match the parent’s focus.

Scoring Criteria for the GUIDE: Services Coordinators (SC)

The purpose of this tool is to provide additional scoring clarification for the Getting Ready Approach Implementation Checklist. It follows the GUIDE for SC's and was developed for use by coaches to help determine reliability on the checklist. It is not intended to replace the GUIDE and in fact does not contain enough information for implementation in a home visit.

<table>
<tr><td colspan="2">Goal: At least 80% of items 1-10* scored as + needed for reliability in the Approach for Services Coordination ** Items 5-6 scored if the topic is introduced. If not introduced, mark n/a.</td></tr>
<tr><td></td><td>+ SCORING CLARIFICATION</td></tr>
<tr><td colspan="2">Did the services coordinator:</td></tr>
<tr><td colspan="2">OPENING</td></tr>
<tr><td>1. Establish/Re-establish the Partnership</td><td>Can be simple, "Hi", or "How are you?" or "How's it going?"</td></tr>
<tr><td>2. Discuss Child/Family Strengths & Concerns/ Observations/Information Since Last Visit</td><td>Discuss Child/Family Strengths and Concerns
This information may be shared by the family spontaneously in conversation or in response to questions from the SC.
The information should touch on both solid bullets on the GUIDE:
strengths and/or new interests [not necessarily from IFSP]
concerns/how they have been addressed
Discuss Child/Family Developments Since Last Contact
This information also may be shared by the family spontaneously in conversation or in response to questions from the SC.
The information should touch on both solid bullets on the GUIDE:
new family developments [since last contact]
review of steps which were to be taken based on previous Home Visit Plan</td></tr>
</table>

3. Co-Establish Purpose/Design for Visit	*Ideas for the visit agenda must include input from both SC and family. Sources of information may include:* • *Plan made at last contact.* • *Concern/observation surfaced during opening.* *Input might be simple agreement when asked such as, "okay" but there is some agreement between both – to elicit more input from parent, provider may offer a question such as "what do you want to get out of our visit today?"* • *If applicable, identify any immediate concerns of parent.*
MAIN AGENDA	
4. Review Progress toward Current IFSP Goals; if immediate priorities or concerns exist, then visit includes specific plan to review progress toward IFSP goals later in current month.	Review Progress toward Child/Family IFSP Goals • *The review should always include questions and/or discussion about solid bullets 1-3 on the GUIDE.* ○ *Use the hollow sub-bullets under each black bullet on the GUIDE as reference points to determine if the SC has covered, even if briefly, the IFSP goals. The goals do not need to be read verbatim, however, it should be clear from the discussion what the goal status is.* ○ *In particular, the SC needs to find out if services are occurring as written on the IFSP, and if the family understands the strategies and supports.* **NOTE: Parent may have shared some progress spontaneously during the <u>Opening</u> conversation. If so, the SC may or may not summarize what s/he heard.* ○ *Solid bullet 4 on the GUIDE: The review will include AD Waiver information and family rights discussion **only when appropriate** as indicated.*
5. **If** Family Rights are Reviewed, Probes for Family Understanding of EI Process**	Review Family Rights and Procedural Safeguards **only as appropriate** • *Use the four hollow sub-bullets on the GUIDE as examples of how reviewing family rights can be accomplished. These sub-bullets might also help the coach to identify missed opportunities*

6. **If** Transition Plan is Reviewed, One or More Steps of the Plan are Discussed**	Review Transition Plan **only as appropriate** to the child's age. • *If the Transition Plan is addressed, SC should use all hollow bullets on the GUIDE to guide discussion.*
7. Develop Home Visit Plan	Develop Home Visit Plan – all three solid bullets on the GUIDE are required. • *Decisions about what will be done and by whom should be mutual and intentional.* • *Some reference to communication between visits should be addressed.* • *A plan for the next visit should be mutually determined with input from both the parent and the SC.* • *A copy of the home visit plan should be provided or reference made to mailing from the office should be heard. This may occur in the closing.*
CLOSING	
8. Reflect and Review	[If addressing immediate family priorities/concerns took up all allotted time for visit, SC must make specific plans for a follow-up contact to review progress toward Child/Family IFSP goals to fulfill monthly SC requirement.] Reflect on Visit • *BOTH parent and SC must intentionally respond to the question "What are you feeling good about right now?" The focus of the response to this question may be anything from how the visit went and how the child is doing to a much broader family situation.* • *Even if brief, the SC should ask about any other questions or concerns the parent may have. This is not intended to open up a lengthy conversation, but may inform a topic to note on Home Visit Plan for future discussion.*
9. Review and Finalize Home Visit Plan.	*A quick recap that highlights key components, particularly action items, on the plan. The HV Plan is NOT reviewed in full detail. This is intended to confirm that parent and SC are on the same page at the end of the visit.*
10. Provide Copy of Home Visit Plan to Family or Let Family Know It Will be Mailed	

Services Coordinator must show evidence of at least 4 separate Getting Ready Strategies for approval in Getting Ready approach:	
• Communicate openly and clearly	*Getting Ready* Strategies are to be used intentionally throughout the GUIDE to create the parent-provider partnership. As a coach, it is important to identify the strategies as they support collaborative interactions throughout the home visit.
• Affirm parent competencies	
• Make mutual/joint decisions	
• Focus parents' attention on child strengths	
• Share developmental information and resources	
• Use observations and data	
• Model and/or suggest	

Depending on number of total possible items, 6 out of 8, 7 out of 9, or 8 out of 10 items scored as + are needed for reliability. Must achieve reliability on two checklists (preferably with same family) to obtain approval in the Approach for Services Coordination and Getting Ready approach.

After scoring a video, review the scores to ensure that any components marked as missing, were not seen/heard at a different point in the visit than indicated on the checklist. [For example, some of the "review progress toward IFSP goals" may occur in the *Opening* rather than in the *Main Agenda*. Or the "copy of the HV plan provided" may occur in the closing.]

The intentionality and mutuality of each item is primary, the exact order may be different to match the parent's focus.

Appendix Y: Getting Ready Home Visit Fidelity Process

Getting Ready (GR) Home Visit (HV) Fidelity Check Process

RDA Pilot Regions

September 2018

	Video Submission Due Date	Final Approval Due Date
PRT Internal GR coaches	Internal coach submits video to assigned state GR coach between **January 1-March 1** NDE facilitates process and records fidelity dates. PRT maintains fidelity implementation checklists.	State GR coach completes fidelity check and notifies internal coach of approval status by **April 1**
EI providers and services coordinators	Annual video submission reviewed by an approved internal coach between **April 1-July 1** PRT facilitates process & maintains fidelity implementation checklists. NDE records fidelity dates.	Internal coach completes fidelity checks and notifies PRT leadership team of approval status by **August 1**

*****_A GR HV implementation checklist must be completed during fidelity checks. Internal coaches/providers/services coordinators must achieve 80% or better on one implementation checklist to maintain fidelity._

**PRT grant funds can be used to contract with state level GR coaches to complete or assist in the completion of fidelity checks for providers and services coordinators.*

Sue Bainter & Cindy Hankey, 2018

Appendix Z: SSIP Infographic 2019

NEBRASKA

IDEA Part C SSIP

What is the SSIP?

The State Systemic Improvement Plan (SSIP) is a multi-year plan that describes how the state will improve outcomes for children served under IDEA. It is Indicator 11 of the state's State Performance Plan (SPP) and part of the Results-Driven Accountability framework (RDA).

What is the SIMR?

The State Identified Measurable Result (SIMR) for Nebraska IDEA Part C is:

Increase the number of Infants and toddlers who demonstrate progress in the acquisition and use of knowledge and skills (including early language/ communication)
Indicator 3B Summary Statement 1

Our Progress

- **Established a State Leadership Team and 3 Local Planning Region Team (PRT) Leadership Teams (Cohort 1) in 2014**
- **Established 4 additional PRT Leadership Teams (Cohort 2) in 2015**
- **All 22 non-cohort PRTs committed to implement the RBI and functional child/family-focused IFSP Outcomes**
- **All PRTs in the state have Leadership Teams**
- **Established Regional Technical Assistant Providers to assist PRTs**
- **Established cadre of RBI Coaches to assist with regional professional development activities**
- **Scaled-up the RBI statewide; all regions actively training and implementing**
- **Increased number of child and family outcomes on the IFSP across 7 Cohort regions**
- **All 7 Cohort Regions have received home visit training and are fully implementing the Getting Ready Approach**
- **6 non-cohort PRTs actively training and implementing the Getting Ready Approach.**
- **5 additional non-cohort PRTs scheduled to receive home visit training in June 2020**
- **Included stakeholders and partner agencies in ongoing work**
- **Development and continuous refinement of evaluation plans**

SSIP Phases

Phase I
2014 - 2015
- **Data analysis**
- **Infrastructure analysis**
- **Selection of coherent improvement strategies**
- **Theory of Action**

Phase II
2015 - 2016
- **Infrastructure development**
- **Support of PRTs' implementation of evidence-based practices**

Phase III
2017 - 2020
- **Evaluation of progress in implementing the SSIP**

Appendix AA: RBI Training Descriptions 2019

PART C PROFESSIONAL DEVELOPMENT OPPORTUNITIES

Nebraska's State Systemic Improvement Plan (SSIP) requires each PRT in the state to ensure that early intervention providers and services coordinators in their region receive professional development (PD) and technical assistance (TA) focusing on evidence-based practices in early intervention. The Nebraska Part C Co-Leads are currently offering the following PD and TA opportunities to Planning Region Teams upon request.

Team Self-Assessment: This is a 4-hour workshop intended for all EI teams in the PRT. EI teams include the following personnel: ECSE, SLP, OT, PT, Services Coordinator and administrators. The purpose of the workshop is to give teams time together to reflect on the way they "typically provide services" and how they would "ideally like to provide services". The regional TA provider facilitates the discussion and shares evidence-based practices that are most impacted by using the RBI. Individual team action plans are developed at the end of the workshop and are shared with the PRT chair/leadership team. This training is a pre-requisite to all other training opportunities. PRT grant funds may be used to support this activity.

*The results of this self-assessment provide the PRT with a region-wide EI team perspective on how EI services are delivered prior to RDA training opportunities. Some regions have re-done the self-assessment after training on the three RDA improvement strategies: RBI, functional outcomes and routines-based home visit training to help evaluate the impact of the professional development activities on EI service delivery.

Rule 52/480 NAC 3 Training: This is a 3-hour workshop provided by the Nebraska Co-Leads. The purpose of the workshop is to review the requirements for the implementation of the Individuals with Disabilities Act, Part C – Early Intervention Program for Infants and Toddlers with Disabilities (IDEA-2004) and the Nebraska Department of Education and Health and Human Services Administrative Codes 92 NAC 52 and 480 NAC 3 in order to assure that the rules and regulations are understood and followed. The training includes practical case scenario discussions and Q/A sessions. This training is funded by NDE/DHHS.

Routines-Based Interview (RBI) Boot Camp: This is a 2-day training; facilitated by the regional TA provider. The purpose of the boot camp is to provide up to 21 participants opportunities to practice the skill of Routines-Based interviewing with actual families, while receiving feedback and coaching from an approved RBI provider/services coordinator. In order to become "RBI Approved", participants must attain 85% or better on the RBI Implementation Checklist completed by an RBI approved provider or services coordinator. RBI Approval is required for all EI providers and services coordinators engaged in child and family assessment activities. The training also includes practice writing routines based, functional and measureable child and family IFSP outcomes from the interviews the participant conducts. The TA provider provides on-going assistance to the PRT before, during and after the boot camp. PRT funds may be used to fund "on-site" TA support (e.g. facilitation at a boot camp, F2F meetings etc.) "Off-site" TA supports (i.e. CC's, emails, webinars etc.) are funded by NDE/DHHS.

Bainter & Hankey, 2016. Updated October 2019.

RBI Scoring Reliability: This is a 4-hour workshop, provided by a state trainer, designed to increase reliability of scoring the RBI checklist and is a required training for a PRT's internal RBI coaches. RBI coaches are the services coordinators and/or EI providers who have been designated by a PRT's leadership team to assist with coordination of RBI training and annual fidelity checks, as well as provide coaching and mentoring to any services coordinator or EI provider in the PRT who needs to be approved. Workshop activities include hands-on practice completing the RBI implementation checklist using clips of real interviews aimed at improving scoring reliability of the RBI across PRT coaches. This training is funded by NDE/DHHS.

IFSP Outcome TA: This is a 2-hour technical assistance activity provided by the regional TA provider via distance format (Zoom). This training has also been done in a 4-hour on-site format. All services coordinators and EI providers in a PRT who have participated in an RBI Boot Camp received initial training and practice in writing functional child and family IFSP outcomes. The IFSP Outcome TA is a follow up to the Boot Camp IFSP outcome training. Because the quality of IFSPs are directly influenced by the RBI, this training is best provided AFTER most or all of the EI services coordinators and providers are approved and the PRT is fully implementing the RBI as their child and family assessment. Prior to the Zoom call or on-site training, EI teams identify 6 to 12 child and family outcomes which are scored by the EI team, as well as the facilitators, using the Quality Outcome Checklist. A comparison of the scores and feedback on the outcomes are provided on the Zoom call. This training is funded by NDE/DHHS.

***IFSP Outcome Scoring Reliability Training:** This is a 3-hour on-site training facilitated by the regional TA provider. This training is designed to help PRTs develop an internal process for systematically monitoring IFSP outcomes using the IFSP Outcome Quality Checklist to provide feedback to providers and services coordinators in the region about their use of quality indicators for IFSP outcome writing. Workshop activities will include improving scoring reliability among internal IFSP review coaches using the IFSP Outcome Quality Checklist, and ultimately assisting with the design an internal IFSP outcome review process for the region. This training is funded by NDE/DHHS.

RBI Refresher Training: This is a 4-hour on-site training provided by the regional TA provider. The purpose of this activity is to assist PRT's who are working toward the collection of annual RBI fidelity checks for their approved providers and services coordinators. On-going fidelity checks ensure that approved providers and services coordinators continue to implement the RBI to fidelity. Training activities include overview of selected RBI components, Q/A, practice using the RBI implementation checklist using clips, and practice providing feedback to teammates. PRT grant funds may be used to support this activity.

***Using RBI and On-Going Assessment to Inform GOLD Scoring**: This is a 4-hour training provided on-site by a state trainer. The purpose of the training is to help participants learn about linking data gathered during routine-based early intervention to inform GOLD entry and exit criteria. Training activities will include practice scoring GOLD using RBI notes, RBI video clips, IFSP outcomes, home visit video clips and the SHORE. The training is intended for any EC professional who is responsible for entering GOLD data. This training is funded by NDE/DHHS.

Bainter & Hankey, 2016. Updated October 2019.

***Routines-Based Home Visit Training:** Using IFSP outcomes derived from the RBI and parent-child interactions within RBI-identified routines, this training will focus on the use of the Getting Ready (GR) Approach to home visiting. The GR Approach targets development of parent-professional partnerships to: 1) strengthen relationships between families and professionals, and 2) build parent competencies to support their child's development. This is a 1-day training facilitated by state trainers. To become GR approved, participants must attend the training, receive coaching/feedback on the use of the GR Approach post training in videotaped home visits, and attain 80% or better on the home visit implementation checklist during 2 home visits. Internal home visit coaches identified by the PRT will achieve GR Approach approval and participate in GR coaching training. This training is intended for all EI providers and services coordinators in the region, AFTER the RBI and functional outcomes strategies are well established across the region. The regional TA provider will help the PRT determine readiness for this training. This training is cost shared between NDE/DHHS and the PRT.

To find out more about any of these training opportunities, contact your RBEI TA provider: http://edn.ne.gov/cms/sites/default/files/pdf/RBEI_TA_Providers_Map.pdf

*New training as of August 2018

Bainter & Hankey, 2016. Updated October 2019.

Appendix BB: Nebraska Early Development Network Professional Upgrade Partnership with UNL Report October 2019

FINAL REPORT

Nebraska Early Development Network
Professional Upgrade Partnership with the
University of Nebraska-Lincoln

October 17, 2019

Submitted by:
Johanna P. Higgins, PhD
Project Director

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This project was made possible through a grant from Nebraska Department of Education #H181A1700

Nebraska Early Development Network and University Nebraska-Lincoln Professional Upgrade Partnership (EDN-NU-PUP)

Rationale and plan

The need for qualified services coordinators and practitioners in early intervention programs is greater than ever, given the increased identification of young children with special needs under age 3 years and the advances in medical and intervention technologies. Earlier identification of autism is more common due to national attention on the exploding numbers of children receiving this diagnosis and the publicized case studies of successful interventions. Chronic respiratory and cardiac problems can challenge families personally and financially if their children were born prematurely and spent extended time in a Neonatal Intensive Care Unit. Hearing losses identified now through newborn hearing screenings have led to earlier amplification and the advancement of improved cochlear implants for more young children. Non-specific developmental delays have always been associated with populations of children living in poverty, foster care and/or familial abuse /neglect. Is estimated that 47% of infants and toddlers entering foster homes each year have developmental delays or are at high risk for neurodevelopmental problems (Rosenberg, et al., 2006). National data on CAPTA referrals suggest that 39% of the children under age 3 referred to early intervention have at least five risk factors associated with poor developmental outcomes and school success (Stahmer, 2005). In Nebraska in 2017, 2,063 children under age 3 were identified with a developmental delay or specific disability (Early Development Network, 2017).

Services coordinators and practitioners (Early Childhood Educators, Teachers of the Deaf, Vision Specialists, Speech-language Pathologists, Physical and Occupational Therapists, Psychologists) in early intervention programs for children under age three years with disabilities need to be aware of these trends and advances. Some of these professionals working today in Nebraska's Early Development Network (N-EDN) had little to no college preparation for the service/support roles they play with families and these very young children. Furthermore, family systems theory, typical/atypical infant/toddler development, medical advances and family-focused, evidence-based interventions are not commonly addressed in many of the preparation programs in human services, but instead provide a more generalist and life-span perspective. Focused and ongoing professional development is essential to assure families that Nebraska's EDN services coordinators and practitioners are providing high quality, evidence-based supports/services that reflect the most recent trends in our field. But professional development activities are time-consuming and expensive. More specifically, they are challenging to orchestrate at a state level, given the geography and time zones such as we have in Nebraska. Concentrated training with adequate technical assistance/follow-up are taxing state budgets and personnel because of the range of skills and knowledge each professional brings to the job at the time of hiring.

Additionally, the range of experience represented on Individualized Family Service (IFSP) Teams, from novice to 20+ year veteran, makes planning professional development events tricky. The use of distance technologies and university-based coursework offered Nebraska an opportunity to upgrade their EDN professionals with easy access to a breadth of foundational information and skilled instructors who can facilitate skill development to a desired entry-level competence. Distance education technologies and pedagogies have become common-place at the University of Nebraska-Lincoln with the faculty in Department of Special Education and Communication Disorders, providing a leadership role. Furthermore, faculty expertise in the field of early intervention makes UNL a logical player in Nebraska's efforts to upgrade its EDN personnel. UNL offers the only graduate-level coursework in early intervention in the state.

This project aimed to support professional development by offering tuition waivers for approximately 25 EDN services coordinators and practitioners to complete one or two courses between January and August 2019 for courses at UNL delivered via distance education

technologies. All participants were employed with a Nebraska Educational Service Unit, School District, or contracting agency and have assignments with the Nebraska EDN and families and children with IFSPs. Tuition waivers were provided for selected participants to enroll in SPED 861 Infants with Disabilities and Home Visiting (Spring 2019) and SPED 863 Medically Fragile Infants (Summer 2019). These participants were recruited on a) years of employment in EDN, and b) reported lack of college coursework in work with infants with disabilities and medical issues in young children with disabilities. No degree or new endorsements were awarded to the participants, although they could use the credits toward a UNL degree/credential if they choose to continue their studies at their own expense. This university-based professional development program is intended to enhance Nebraska EDN's abilities to meet the needs of families and young children with developmental delays and disabilities and enhance the collaboration between services coordinators, practitioners, and families on IFSP teams.

Process and recruitment

The flyer seeking applicants was emailed to EDN services coordinators and providers on 9/19/18. Appendix A contains a copy of the advertisement. Due to the high number of applicants (84), the application portal was closed on 10/18/18. Applicants needed to meet the following criteria to be accepted: (a) be interested in all three course offerings, (b) be missing coursework in one or more areas (i.e., child development, home visiting, working with infants and families) and (c) have already obtained a bachelor's degree in any field. Incomplete applications were omitted.

Forty-four students met acceptance criteria; therefore, applications were reviewed through a second round. Participants that reported: (a) no coursework in working with children birth to three and (b) missing coursework in more than one area mentioned previously) were identified. Several students were only interested in taking one of the two courses. After this review, 27 students were contacted to determine if they were interested in taking one or two courses (depending on interest). Applicants that were not accepted were sent an email from the project coordinator. This email provided a link to a survey which asked if they were interested in being contacted when future course waiver opportunities were offered. The total number of funded applications are described in Table 1 below.

Each applicant received a letter via email from the project director, indicating acceptance or rejection into the project (see Appendix B). Participants were invited to respond by completing an acceptance form signed by the participant and supervisor. By signing this acceptance letter, the participant agreed to pay a $50 application fee, purchase textbooks associated with the course and work towards a letter grade of at least a B-. Each participant was informed that a letter grade of lower than a B- may lead to removal from future course offerings.

Funded applicants

Twenty-five students across both courses completed coursework. Twenty participants completed SPED 861 Infants with Disabilities and Home Visiting, and nineteen participants completed SPED 863 Medically Fragile Infants. Eleven professionals in the special instruction role, two occupational therapists, six service coordinators, and six speech-language pathologists completed the coursework.

See Table 1 for a description of the role of each participant in early intervention, location, PRT, and the course or courses she completed. The role "special instruction" refers to the teacher serving children and families in early intervention. The title for the role of special instruction varied across participants (e.g., early childhood special education teacher, early childhood coach, early intervention provider).

Six of the students that completed SPED 861 did not take SPED 863 due to a lack of interest or that have already completed the course in the past. The breakdown of participants in SPED 861 included six service coordinators, nine special instruction providers, one occupational therapist, and four speech-language pathologists. Five additional students started and then withdrew from the course (two participants serving the role of special instruction and three services coordinators). See Table 2 for a description of SPED 861 participants.

Five of the students that completed SPED 863 did not participate in SPED 861; therefore, they were new to the project in the summer of 2019. The breakdown of participants in SPED 863 included five services coordinators, seven special instruction providers, two occupational therapists, and five speech-language pathologists. No students withdrew from SPED 863. See Table 3 for a description of SPED 863 participants.

Table 1.
EDN-NU-PUP Participant descriptions

#	EARLY INTERVENTION ROLE	LOCATION	PRT #	COURSE COMPLETED
1	Special Instruction	South Sioux City	1	861
2	Special Instruction	Bennington	3	861, 863
3	Special Instruction	Axtell	3	861, 863
4	Special Instruction	Columbus	7	861, 863
5	Special Instruction	Columbus	7	861
6	Special Instruction	Cozad	10	861
7	Special Instruction	Omaha	19	861
8	Special Instruction	Omaha	19	861, 863
9	Special Instruction	Grand Island	26	863
10	Special Instruction	Grand Island	26	863
11	Special Instruction	North Platte	27	861, 863
12	Occupational Therapist	Scottsbluff	13	863
13	Occupational Therapist	Bellevue	20	861, 863
14	Services Coordinator	Omaha	3	861
15	Services Coordinator	Geneva	6	861, 863
16	Services Coordinator	Kearney	10	861, 863
17	Services Coordinator	Kearney	20	861, 863
18	Services Coordinator	Ralston	24	861, 863
19	Services Coordinator	Elkhorn	25	861, 863
20	Speech Language Pathologist	Elmwood-Murdock	3	863
21	Speech Language Pathologist	Gretna	3	861, 863
22	Speech Language Pathologist	Millard	3	861
23	Speech Language Pathologist	Columbus	7	861, 863
24	Speech Language Pathologist	Cozad	10	861, 863
25	Speech Language Pathologist	Grand Island	26	863

Table 2.
SPED 861 Infants with disabilities and home visiting participant descriptions

EARLY INTERVENTION ROLE	TOTAL (n = 20)	LOCATION	PRT #
Services Coordinator	6	Omaha, Ralston, Kearney, Elkhorn, Geneva, Bellevue	3, 6, 10, 20, 24, 25
Special Instruction	9	Cozad, Columbus, South Sioux City, Omaha, Bennington, North Platte, Axtell	1, 3, 7, 10, 19, 27
Occupational Therapist	1	Bellevue	20
Speech Language Pathologist	4	Millard, Gretna, Columbus, Cozad	3, 7, 10

Table 3.
SPED 863 Medically fragile infants participant descriptions

EARLY INTERVENTION ROLE	TOTAL (n = 19)	LOCATION	PRT #
Services Coordinator	5	Bellevue, Elkhorn, Geneva Kearney, Ralston	6, 10, 20, 24, 25
Special Instruction	7	Axtell, Bennington, Columbus, Grand Island, North Platte, Omaha (2)	1, 3, 7, 19, 26, 27
Occupational Therapist	2	Scottsbluff, Bellevue	13, 20
Speech Language Pathologist	5	Grand Island (2), Elmwood-Murdock, Columbus, Gretna, Cozad	3, 7, 10, 26

Results

Across both courses, 25 students completed coursework. All students received a grade of B or higher. Participants who completed their courses were awarded a letter of congratulations and a Certificate of Completion (see Appendix C). In addition, the EDN supervisors of each participant were informed by email of the EDN employees' recent professional development activities at the University of Nebraska-Lincoln.

Budget

The completed project did not exceed the proposed budget of $81,334.00. The project ended with a balance of $6,249.79. Each course costs $1,267.00 in the spring and summer

sessions. This included $1080.00 for in-state graduate tuition plus $116.00 in fees for distance education, technology, and library support. Appendix D provides a copy of the proposed expenses and a spreadsheet of final cost. All participants were directed to register for the distance education section of each course to control for costs. Two participants were billed the out-of-state rate in the spring semester. It was identified that only one of these students lived out-of-state. For the summer semester, that student was deemed ineligible as this project was only provided to participants that lived in-state. All participants paid the $50 registration fee per semester and any costs associated with textbooks.

Course Evaluations

All students in the UNL courses are asked to provide feedback regarding the quality of instruction and course organization. Table 4 below provides a rating of the two courses EDN participants completed. These are ratings from all students that completed the optional course evaluation. It is possible that the EDN-NU-PUP students did not complete the evaluation below because it is anonymous. This rating is based on a 5 point scale with 1 = poor and 5 = excellent. The UNL courses received high ratings from students.

Table 4.

Participant ratings of UNL courses and instructors

TERM	COURSE	MEAN OVERALL RATING	INSTRUCTOR
Spring 2019	SPED 861 Infants with Disabilities and Home Visiting (n = 19)	3.42 / 5 (SD = 1.14)	Dr. Johanna Taylor
Summer 2019	SPED 863 Medically Fragile Infants (n = 5)	5 / 5 (SD = 1.0)	Dr. Kerry Miller

Follow-up Surveys

In exchange for the tuition and fees, participants along with their EDN supervisors, agreed to arrange for a sharing of newfound knowledge or skills with EDN colleagues following completion of the UNL courses. A survey was sent via email to the participants. The survey asked participants to comment on the value of the UNL course offerings and a description of how they shared newfound knowledge and skills with their EDN colleagues. A similar survey was sent to the EDN Supervisors. Appendix F contains a copy of each survey.

Participant Reports of Post-training Competence. All participants completed surveys providing feedback on their experiences with the coursework. Students rated each course outcome through a rating of their confidence in each course objective area (how prepared do they feel after taking the courses). The rating scale ranged from one to five, with five being the most confident. Results indicated students believed they were prepared in the areas noted in the course objectives. Students also reported both courses improved their skills as an Early Intervention provider or services coordinator. See Table 5, 6, and 7 for confidence rating results.

Sharing of Newfound Knowledge. Participants agreed to share newfound knowledge obtained through the completion of the UNL courses with colleagues in their EDN team. Participants reported their sharing sessions were well-received and commented about the interest colleagues showed for the content shared and its application to their job. Participants reported sharing and using the information during team meetings, IFSP meetings, and “lunch and learn” activities. Some reported discussing changes that needed to be made to their program based on the coursework. A few students also reported being able to collaborate and better understand team

members. Others indicated they were better able to implement the transdisciplinary approach with their team members. Detailed feedback is provided in Appendix G.

Table 5.
SPED 861 Infants with disabilities and home visiting participant survey results

COURSE OBJECTIVES (n = 20)	MEAN RATING
Define the key principles for providing early intervention services in the home with families.	4.3
Assess child and parent strengths, needs, and interactions to determine instructional targets and strategies	4.4
Apply an evidence-based coaching framework to teach parents and monitor progress in one of the following areas (play skills, communication skills).	4.6
Demonstrate teamwork to determine parent/child strengths, needs, and instructional targets, measurable IFSP outcomes, and strategies.	4.7
Describe family priorities, strengths, and desires relative to a child's development.	4.5

Table 6.
SPED 863 Infants with disabilities and home visiting participant survey results

COURSE OUTCOMES (n=19)	MEAN RATING
Identify functional outcomes for medically fragile infants.	4.2
Observe an infant and report on the child's behaviors and development.	4.3
Write a developmental care plan (DCP) for an infant transitioning from the NICU to the home environment.	3.8

Table 7.
Participant professional competence rating

COURSE	MEAN RATING
SPED 861 Infants with Disabilities and Home Visiting improved my skills as a professional working in the Early Development Network.	4.3
SPED 863 Medically Fragile Infants improved my skills as a professional working in the Early Development Network.	4.3

Messages for NDE and UNL. Participants offered NDE and UNL high praise for sponsoring the EDN-NU-PUP project. Testimonials point to the benefits of the EDN workforce that accrued from the completion of the course(s). Participants reported they had been interested in coursework and needed tuition support. These waivers provided EDN services coordinators and providers with the opportunity to advance their training and education. The few negative comments provided were related to the design of the online courses and a desire for fewer requirements in graduate courses.

Supervisor Reports of Provider or Services Coordinator Competence. Supervisors completed a total of 13 surveys (52%). Supervisors were asked to their supervisees' performance on the

course outcomes (did the supervisees' performance improve after taking the course). The rating scale provided three choices – no change in performance, stronger performance, or much stronger performance. Results indicated supervisors believed the performance was stronger or much stronger in most areas after taking the coursework. Supervisors also reported on their agreement to the following statement: The provider/services coordinator has improved their skills as a professional working in the Early Development Network by taking the EDN-NU-PUP coursework in the spring and summer. Supervisors responded they *strongly agreed* to this statement for five supervisees and *agreed* for eight supervisees. The supervisors were also asked to share how the supervisee disseminated the content to team members, considerations for future course offerings, how the content helped the supervisee, and professional development topics it would be helpful to include in the future. Most supervisors omitted these questions and did not respond. The responses that were gathered are located in Table 8 and 9.

Table 8.
Supervisors rating of supervisee performance related to course objectives

PERFORMANCE AREA RATED (n = 13)	MUCH STRONGER	STRONGER	NO CHANGE
Defining key principles for providing early intervention services in the home with families	1	12	0
Assessing child and parent strengths, needs, and interactions to determine instructional targets and strategies.	2	11	0
Applying an evidence-based coaching framework to teach parents and monitor progress in one of the following areas (play skills and communication skills).	2	11	0
Demonstrating teamwork to determine parent/child strengths, needs, and instructional targets, measurable IFSP outcomes, and strategies.	3	10	0
Describing family priorities, strengths, and desires relative to a child's development.	3	10	0
Identifying functional outcomes for medically fragile infants.	3	10	
Observing an infant and reporting on the child's behaviors and development	2	10	1
Writing a developmental care plan for an infant transitioning from the NICU to the home environment	2	10	1

Table 9.
Supervisor responses to open-ended feedback questions

FEEDBACK AREA	RESPONSE
Supervisee shared information	[Supervisee] requested to share Medically Fragile and prematurity information at our early childhood meeting so she is on the agenda to do that One on one During team collaboration meetings Small group meetings with the other SCs who were newer to EDN SC.
Considerations for the future	Our ESU offers a mentoring program because almost all of the people arriving newly out of college have little to no knowledge of evidence-based practices in early intervention. From what [supervisee] has said, these classes have contained many components that most undergrad and graduate classes have not had before [Supervisee] shared that she would like a strong focus on regulations and tools. Consider classes that focus on the specific role of the services coordinator. [Supervisee] shared that while it was good information, some of it was not new information for someone who had been doing the job for a while. She thought it would be beneficial to brand new SCs.
Additional comments or feedback	My ratings of stronger for [supervisee] are based on the fact that she was already proficient in many areas before taking the class, so improvement doesn't look as huge as someone who was not using the practices as all. [Supervisee] gained knowledge about Medically Fragile Infants and things to consider when working with these families. The course helped [supervisee] get a preview of the Getting Ready Home Visitation and helped her to understand better the GOLD data her team uses.
Professional development topics	Service delivery options and benefits – family assessment – functional and meaningful goal writing Evidence-based interventions for early childhood

GOAL RESULTS
Below are the results for the six goals that were identified in the EDN-NU-PUP proposal.

Goal 1: Participants will complete one to two UNL-ECSE courses during the Spring 2019 and Summer 2019 semesters with letter grades of B- or better.

As shown in Table 10 below, all students received above grade of B- or better in both courses. In SPED 861, one student (services coordinator) earned a B grade. In SPED 863, three students (two services coordinators and one speech-language pathologist) earned a B grade.

Table 10. *Participants average and range grade*

COURSE GRADES	MEAN	RANGE
SPED 861 Infants with Disabilities and Home Visiting (n = 20)	95.1%	84.79 – 99.28%
SPED 863 Medically Fragile Infants (n = 19)	94.0%	87.04 – 97.68%

Goal 2: Participants will learn the steps to completing a Routines Based Interview (RBI) and will demonstrate the ability to complete with at least one family.

Due to issues that occurred related to video recording (i.e., use of TORSH set-up delayed), students were unable to record interviews with families for instructor review. Instead, each student was required to interview a family as part of an Assessment report assignment. Assessment reports were submitted and graded to provide student performance data on this goal. The following criteria were used to grade the Assessment report:

- Describe at least four child and family routines within the day (should be routines with notable areas that are challenging in the family caring for their child with a disability).
- To receive full points (5) address: child's independence (level of support needed within routines), challenges, and social relationships in these routines. Please end with a paragraph that summarizes "Routine Strengths, Needs & Challenges in Caring for and Raising this Child."

Results indicate that students learned to conduct a family interview that identified routine strengths, needs/challenges for the families as well as the level of independence within daily routines. The mean grade was 4.7/5.0 (94%), with a range of 4.0 – 5.0 (90 – 100%).

Goal 3: Participants will learn to write functional, participation-based desired outcomes for two families and children based on assessment data collected for these children/families.

Please note that changes were made to this goal due to the assessment of student performance**.** A pre-test was completed before students began learning content related to writing functional outcomes. More than fifty percent of the students in the course wrote outcomes that did not meet criteria. The instructor modified the criteria for this assignment, so students focused primarily on child outcomes. All students were provided with other opportunities to practice writing general family targets (in SPED 861) and general child outcomes (in SPED 863).

All students learned to write two functional, participation-based desired outcomes after completing the instructional module in SPED 861. On the pre-test, the mean score was 3.75/5 (75% correct). After completion of the module, the average increased to 4.57/5 (91%) on the post-test

embedding within the Assessment report assignment. The rubric for outcome statements aligned with the EDN outcome quality checklist and included: (a) emphasis on routine, (b) observable indicator, (c) clearly defined time frame for completion, (d) use of family words (jargon-free), and (e) link to family priorities. Students with lower ratings received these scores due to their outcome statements being not measurable or realistic. On the pre-test, only two students wrote outcome statements that did not include the family routine, which indicates most had previous knowledge of the components of a quality outcome statement.

Goal 4: Participants will learn the structure and elements of a quality home visit.

All students learned to write a home visit plan that included the elements of a quality home visit, as evidenced by all students receiving 100% on Home Visit plan #2. Scores on Home Visit plan #1 were similar but slightly lower (see Table 11). The components of a quality home visit plan included:

- **Opening:** establish, re-establish the partnership, discuss strengths/concerns, discuss observations/information since the last visit
- **Main agenda:** evidence-based strategy, IFSP outcome statement addressed, routine, parent-provider roles
- **Determine practice opportunities for the visit**: daily routines/activities, spontaneous teaching opportunities, back-up planned activities
- **Dyadic and triadic behaviors** for caregiver and coach
- **Data collection** and documentation
- **Caregiver use of strategies and communication** in-between visits
- **Closing:** questions, the approximate duration of closing, scheduling of next visit

Participants did well with identifying caregiver/provider dyadic and triadic behaviors; they generally identified evidence-based strategies that the caregiver could implement when the provider was not present. A review of home visit plans indicates that participants need to be provided with additional training on how to monitor and document progress when working with families in the home. Additionally, participants had some difficulty identifying activities for the parent to use in-between home visits.

Table 11.
Goal 4 Participants learn the structure and elements of quality home visit

ASSIGNMENT	AVERAGE GRADE	RANGE
Quality home visit #1	90% 13.4/15	80 – 100% (12 – 15 pts)
Quality home visit #2	100% 15/15	100% (15 – 15 pts)

Goal 5: Participants will learn evidence-based strategies for advancing the effectiveness of parent-child interaction.

Student performance related to Goal 5 was based on the Home Visit Plan #1 and #2 assignments. Students were asked to document three evidence-based strategies they planned to teach the caregiver to implement. The instructor modified the assignment to meet the request of services coordinators to increase applicability to their specific work. Therefore, 17 students completed Home Visit Plan #1 and 16 completed Home Visit Plan #2. Service coordinators completed a

different plan that did not include components related to the use of EBP with caregivers. Strategies included were graded based on a 1 to 3 scale (1 = included 1 strategy, 2 = included 2 strategies and 3 = included 3 strategies). Results indicate that students learned to identify evidence-based strategies as they prepared to support families in the home. The mean grade was 2.8/3.0 (93%), with a range of 2.0 (3students) – 3.0 (17 students).

Goal 6: Participants will learn evidence-based strategies for advancing child development across several developmental domains.

Student performance in Goal 6 was based on the Developmental Care Plan (DCP) developed by students in the final exam of SPED 863 Medically Fragile Infants. Students needed to develop a plan to help the caregiver support his or her child after transition from the NICU to home setting. The DCP was worth 20 points. The mean grade was 18.81/20.0 (94%) with a range of 15.5 – 20.5 (77 – 100%). Students that received a 16 or higher identified at least three strategies to help support the family. Only one student received a grade of 15.5 (lower than 16). Please note the DCP grade curved 0.5 points.

SUMMARY

Reflection

It appears the EDN-NU-PUP project was a success. The majority of participants that completed the coursework improved in their ability to provide support to families of infants with disabilities and their families across these two courses. Some themes emerged which align well with the Division for Early Childhood (DEC) recommended practices that guide the practice of individuals providing early intervention services. Specifically, most participants were already familiar with Early Intervention principles before starting in the class. Some were able to write functional outcome statements prior to instruction and most had a general understanding of the format of the quality home visit. The participants were engaged, enjoyed collaborating and learn to interact with peers across the state.

To identify areas of discussion (and next steps for professional development efforts) the following information has been provided on themes that emerged through discussion and assignments. The information below summarizes the experiences of all students that completed the courses and are services coordinators or early intervention providers (not only the project participants) in the state of Nebraska. This included students working as Deaf educators or Teachers of Students with Visual Impairments (TVIs) that completed the course.

Decision making. Through these courses, students were asked to collaborate with peers through discussion board and Zoom web-conference breakout sessions. In these group meetings students: (a) reviewed case study examples, (b) engaged in decision making, and (c) responded to reflection questions as a team. A few themes emerged. First, students reported it was difficult to make decisions as a group because their EDN teams utilized different strategies for determining the primary service provider (PSP) and dosage of services. Specifically, some students reported their district employed the PSP model, and others reported they did not.

Teaming. The students were also asked to describe challenges with teaming. Students reported that they often struggled to use the PSP approach (role release), conduct joint visits with team members, and communicate effectively (especially when the provider/services coordinator was contracted or when the provider serves birth – school age). They indicated they faced collaboration challenges when providers were contracted and when the two providers from

different disciplines did not agree on the same approach to intervention. Additionally, they struggled to collaborate with the preschool team and desired more training on effective transition practices. Services coordinators reported challenges with scheduling with multiple providers and families, effective communication and traveling long distances to conduct home visits.

Role of early intervention providers and services coordinators. Through the discussion board, students reflected on their role in Early Intervention. The primary theme observed in their responses was that providers in the "special instruction role" reported their title differently. Titles included: (a) special instruction, (b) birth to five early childhood special education teacher, (c) early childhood special education teacher (ECSE), (c) early intervention coach, (d) early intervention teacher, and (f) home visitor. Some reported they did not know exactly what their role was called. Service coordinators reported challenges with not knowing how to help support families that were not openly asking for specific resources.

Progress monitoring. Students were asked to complete two home visit plans during the course. The home visit plan included a section for students to describe data collection and specific strategies the parent would use when the provider was not present. A theme identified in this assignment was that students either briefly reported how progress would be monitored (e.g., the parent will write it down) or did not mention monitoring procedures at all (even when asked to do so). Progress monitoring appears to be an area where students need more training as it was only briefly covered in SPED 861. Specifically, students may benefit from training related to:

(a) identifying measurable outcomes
(b) designing data collection procedures that track progress on outcomes
(c) teaching parents to collect data in the home and community feasibly
(d) using data collection to guide decisions related to intervention strategies

Autism spectrum disorder. Students reported wanting more training and education related to children diagnosed (or verified) with autism spectrum disorder. Specifically, participants wanted information related to:

(a) eligibility decisions related to the verification of autism
(b) how to make decisions related to the PSP and dosage of services
(c) interventions that should be used with children with autism
(d) guidance for how they can support families in accessing additional services (e.g., applied behavior analysis or ABA treatment).
(e) how to talk to the family about the diagnosis of autism
(f) how to support families immediately after their child is diagnosed

Challenges

Although the project was a success, there were a few themes that emerged related to challenges for this group of students. Specifically, some of the participants reported the content in SPED 863 Medically Fragile Infants was too challenging and technical. At times, service coordinators indicated the content was not relevant to them and that they would have liked more guidance and strategies specific to their role with families. Some of the participants reported that the content was repetitive (they were already trained in the content) or that it did not align with EDN guidance. Additionally, the instructor had challenges with video recording and ensuring content was relevant to the various backgrounds of each participant.

Next steps

Upon reflection and analysis of the data, the EDN-NU-PUP project coordinator identified several next steps that may strengthen the experience of professionals that are seeking professional development and working in early intervention.

First, efforts can be made by the project coordinator to better align coursework in the program with the professional development needs of providers and services coordinators. The program coordinator recently shifting into this role in her department; therefore, no changes have been made to the content covered in the courses recently. To help support this effort, the Early Childhood Personnel Center (ECPC) Comprehensive System of Personnel Development (CSPD) state assessment includes a portion that focuses on how higher education programs are collaborating with the lead agency (or agencies). It may be helpful for the project manager to complete this assessment in collaboration with EDN to determine modifications that can be made to the existing graduate-level training program. Furthermore, it may be helpful to examine the content provided in each course related to service coordination. The responsibilities and expectations of services coordinators in early intervention are different than providers; therefore, their professional development needs are different. The current ECSE program at UNL is designed to educate professional to serve in the special instruction role; therefore, to address the learning needs of services coordinators additional content is required.

It is beneficial for the EDN to continue financially supporting the professional development of providers and services coordinators working in early intervention. A suggested modification for future grant proposals may be to decrease the total number of EDN providers and services coordinators that complete the coursework and increase the number of courses they are offered. An example of this may be to fund five students per year to complete a master's degree and coursework leading to the early childhood special education (ECSE) endorsement. EDN may consider requiring signed contracts with the individuals that receive the waiver; agreements that they will serve in leadership roles within their teams to implement effective early intervention practices grounded in research. Additionally, these providers and services coordinators may act as representatives that provide appropriate mentorship and supervision to future ECSE graduate students. This may strengthen the partnership between higher education and EDN and lead to stronger professionals across the state that continue to seek a connection to evidence-based practice in EI.

We look forward to continuing to partner to offer professional learning opportunities to early intervention providers and services coordinators to support children and families with disabilities under three in Nebraska.

Appendix A
Advertisement

NEBRASKA EARLY DEVELOPMENT NETWORK PROFESSIONAL DEVELOPMENT OPPORTUNITY

EARLY CHILDHOOD SPECIAL EDUCATION COURSEWORK OFFERED THROUGH UNIVERSITY OF NEBRASKA-LINCOLN

EARLY CHILDHOOD SPECIAL EDUCATION
Department of Special Education and Communication Disorders

EDN has partnered with UNL to offer tuition waivers for online early intervention coursework for service providers and services coordinators.

SPED 861 INFANTS WITH DISABILITIES AND HOME VISITING (SPRING 2019)

In this course, students will learn how to support children with disabilities birth to age 3 and coach families in home and community settings.

SPED 863 MEDICALLY FRAGILE INFANTS (SUMMER 2019)

In this course, students will learn about issues for infants that are premature or medically fragile from experts in the field. Family support, transition from NICU to home and care plans are addressed.

SPED 860 ISSUES IN EARLY CHILDHOOD SPECIAL EDUCATION (FALL 2019)

In this course, students will learn foundational principles, history and research related to early childhood special education.

Apply now! Deadline: November 15, 2018

Click here or use this link: https://bit.ly/2x1RZlz

to see application criteria and apply

Questions? Contact Johanna Taylor, PhD, BCBA
johanna.taylor@unl.edu

Funding provided through Grant Award: H181A170033

The University of Nebraska does not discriminate based upon any protected status. Please see go.unl.edu/nondiscrimination ©2018

Appendix B
Application Form

NEBRASKA EARLY DEVELOPMENT NETWORK PROFESSIONAL DEVELOPMENT OPPORTUNITY

EARLY CHILDHOOD SPECIAL EDUCATION COURSEWORK OFFERED THROUGH UNIVERSITY OF NEBRASKA-LINCOLN

EDN has partnered with UNL to offer tuition waivers for online early intervention coursework for service providers and services coordinators.

Who can apply? Participants must be employed with a Nebraska Educational Service Unit, school district, or services coordination contracting agency and have assignments with the Nebraska EDN and families/children with Individualized Family Service Plans (IFSPs).

What is offered? Participants can apply to attend up to three early intervention courses (each 3 credits) offered online through UNL's Early Childhood Special Education Program. The courses include: SPED 861 Infants with Disabilities and Home Visiting (Spring 2019 term), SPED 863 Medically Fragile Infants (Summer 2019 term), and/or SPED Issues in Early Childhood Special Education (Fall 2019 term).

What does the waiver cover? The tuition waiver covers the cost of the courses; however, students are required to pay a one time application fee to the Graduate College ($50) and registration fee for each course ($20).

Participation details: This university-based professional development program is intended to enhance Nebraska EDN's abilities to meet the needs of families and young children with developmental delays and enhance collaboration between services coordinators, providers, and families on IFSP teams. In the event there are more applicants than available slots, participants will be selected based upon years of experience as well as previous college coursework. Participants have the option to use the credits they acquire towards a UNL degree/credential if they choose to continue their studies at their own expense (See department website for options) but must maintain a grade of B- or better in the courses. No degree or endorsement will be awarded to participants after attendance in the courses.

Questions? Contact Johanna Taylor, PhD, BCBA at johanna.taylor@unl.edu

Full name

Mailing address

Phone number

Email address

List highest degree (e.g., Bachelors)

Institution attended for highest degree

Major of study at institution attended for highest degree

If applicable, list Nebraska License of Teaching Certification-Endorsements

I have had college coursework related to:

- Child development (ages 0 - 3 yrs)
- Families
- Child development (ages 3-5 yrs)
- Home visiting
- Infants/toddlers with disabilities

List the courses you took in college related to any of the areas listed above (provide title, # credits, college, and year) *This is an OPTIONAL item for applicants to complete.*

List the Planning Region Team # where you are employed

List ESU number, district, and/or Services Coordinators agency where you are employed

List Community where you are employed

How often do you work?

- Full-time (over 20 hrs per week)
- Part-time (11 - 20 hrs per week)
- Part-time (less than 10 hours per week)

Current employment (with children with disabilities birth to age three)

Early Childhood Special Education Teacher	Deaf and Hard of Hearing Teacher
Services Coordinator	Teacher of the Visually Impaired
Physical Therapist	Psychologist
Occupational Therapist	Other
Speech-language Pathologist	

How many years/months have you been employed in this role (total across any change in employers)

List the approximate number of children on your caseload in the past 6-months

Participation options: I wish to complete the following courses with available tuition-waivers. *I understand I will be responsible to pay Graduate College application and individual course registration fees.*

SPED 861 Infants with Disabilities and Home Visiting (Spring 2019 term)

SPED 863 Medically Fragile Infants (Summer 2019 term)

SPED 860 Issues in Early Childhood Special Education (Fall 2019 term)

Appendix C
Frequently Asked Questions

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Department of Special Education and Communication Disorders
Serving People with Special Needs

EDN-NU-PUP GRANT INFORMATION SHEET

If you have not done so already, please move forward with applying for graduate status and enrolling in selected courses using the information below.

APPLICATION PROCESS

For students who plan to enroll in SPED 863 Medically Fragile Infants, complete the process below by the deadlines listed to ensure you are not assessed late fees for course registration.

Students that were enrolled in SPED 861 Infants with Disabilities and Home Visiting:

1. Contact my Graduate Assistant **Hannah Smith (hannah.smith@huskers.unl.edu)** for your individual course code for *SPED 863 Medically Fragile Infants* (You will need this code to register).
2. Use the code to register for the course.

Students that were NOT enrolled in SPED 861:

1. Apply to UNL Office of Graduate Studies at the University of Nebraska-Lincoln (follow the link below) https://wam.unl.edu/gradstudies/apply by April 15, 2019 (or ASAP if you are receiving this after April 15)
   a. Apply as a ''non-degree post-baccalaureate” student.
   b. You will need to submit a transcript to UNL Office of Graduate Studies along with a $50 application processing fee (Grad Studies will accept an unofficial transcript; but we are requiring an official).
   c. If you need help with applying for UNL Graduate Studies or registration, please contact Graduate Studies at 402-472-2875 or graduate@unl.edu

2. Email confirmations should arrive within 48 hours of completing your online application with UNL Graduate Studies. This email will provide you with course registration instructions.

3. After you receive this email confirmation, contact my Graduate Assistant **Hannah Smith (hannah.smith@huskers.unl.edu)** for your individual course code for *SPED 863 Medically Fragile Infants* (You will need this code to register).

4. After you obtain the course code, register for the course using the instructions provided by Graduate Studies. After you register using the code, Dr. Taylor will send you information to prepare you for the course. Classes begin on May 20th.

TUITION AND FEES

Your name will be added to a list of approved students for the EDN-NU-Professional Upgrade Partnership project. This list will be sent to the Registrar's Office. When you register, tuition and fees will be billed to

you. You may receive a billing statement; however, you will see a credit for it after student accounts have all the necessary paperwork. Contact **Johanna Taylor** at johanna.taylor@unl.edu if you have any questions or issues with this.

YOUR COSTS

If you are enrolling in your first course, you will be responsible for the $50.00 application fee (if you are not currently an NU student), any textbooks associated with coursework, and $35.00 fee if enrolling after May 10, 2019. If you are enrolling in your second course through the project, you will be responsible for any textbooks associated with the course content.

IMPORTANT NOTE: We recently determined that students that withdraw from the course will be required to pay some (or all if withdrawing late) of the tuition costs for the course. You will be billed for the payment if you withdraw after the first week of class.

Additionally, if you are issued a UNL ID fee you will be responsible for the $15.00 cost. **NOTE:** *This is slightly different than what was listed on the original application (you will not be responsible for the $20 course fee)*.

Q: How will I get my grades and a transcript to show completion of the courses?

Once you have completed your course, you will be able to go online and check your grade. If you wish an official hard-copy transcript, you will need to contact the UNL Office of Registration and Records.

Q: Can I use these courses toward a degree or teaching endorsement renewal?

All these EDN-NU-PUP courses are graduate credits. Use of these credits toward degrees will depend upon the specific program of study and approval by the degree advisor. Similarly, a specific endorsement program may or may not permit the use of specific courses; students are advised to visit with their endorsement advisor. All of the courses would be acceptable for renewal of Nebraska Teaching Certificates.

ONLINE COURSE INFORMATION

EXPECTATIONS

Before you complete the final application to participate in this project, review the information below to provide you with expectations for the courses. Although they are offered online, the courses are graduate-level and can be challenging for some students. Here is some information to help you make the best decision for you.

INSTRUCTORS

Dr. Kerry Miller will teach the SPED 863 Medically Fragile course in Summer 2019. Dr. Susan Loveall (new ECSE faculty member) will teach SPED 860 Issues in Early Childhood Special Education (ECSE) in Fall 2019.

STUDENTS ENROLLED IN COURSEWORK

All the courses are open to UNL graduate students and will not be limited only to EDN applicants. This may include current ECSE graduate students and students in the Deaf and Hard of Hearing/Visual Impairments program.

OVERVIEW OF ONLINE INSTRUCTION

The design of each online course is dependent upon the course content, length of course, learning objectives and individual instructor's preferences. All courses will use a web-based course organizer called Canvas. You will use a specified User ID and password to access your course online (**NOTE:** Only you can access the course; sharing of User ID and password with other users will result in dismissal from the course). Courses will be asynchronous or synchronous. **Asynchronous** courses are completely online and no specific meeting time with the instructor is required. Students dialogue with the instructor and classmates in a Canvas blog or discussion forum. **Synchronous** courses use Canvas as well but require weekly or occasional phone or webinar meetings with instructor and classmates and may reduce the amount of dialogue online in blogs or discussion forums. Syllabi, readings, assignments, activities, and exams are all available online.

Online classes will be accessed on UNL's Canvas website. Students will be required to regularly log-in to Canvas. In Canvas the students can view their syllabus, view their grades, access course materials, monitor their progress on lessons, and contact professors, classmates and support services. For more information about UNL distance courses visit this website https://online.unl.edu/students

You may want to read one of these websites to decide if distance education is for you!
Are You Cut Out for Distance Education?
Is Distance Learning Right for You?

TIME FOR ONLINE COURSES

Generally, a 3-credit hour graduate course will require 8-9 hours/week time commitment. Periodic assignments may extend weekly reading, studying and synchronous or asynchronous discussions with instructor and classmates. Students should plan to devote time at least three days/week in the spring or fall terms. Summer sessions cover the same amount of material in half the time of a Spring or Fall term, thereby requiring daily online access and devotion to class requirements. Rarely can students successfully complete a graduate online course if the only time they have available are 15-30-minute breaks at work and/or weekends.

COURSE DESCRIPTIONS

SPED 863 Medically Fragile Infants (Summer 2019): Unique needs, family-coping strategies, specialized medical staff and various health care settings for chronically ill infants, toddlers and preschool age children. Overview of etiology, characteristics and developmental implications of selected medical conditions related to developmental disabilities. This course requires:

- All asynchronous (independent) work conducted via Canvas each week.
- No synchronous (face-to-face) sessions via web-conferencing.
- No practicum

COMPUTER REQUIREMENTS

You must be sure you use a computer with high-speed internet connection. You will need to consider:

- Operating System requirements
- Processor speed
- Hard Drive space
- Memory size

- Browser compatibility
- Plug-in requirements
- Java Runtime Environment (for chat and other tools)

Browsers: Not all browsers are compatible with Canvas. Internet Explorer 8 (Internet Explorer 8) has had some compatibility issues. It is suggested to use **latest Mozilla Firefox, Google Chrome or Safari.**

TECH SUPPORT

UNL offers Huskertech Help Center for tech support Monday- Friday 7:30 AM to 7:30 PM (CST) located at Love Library South on UNL's main campus. You can call the Huskertech Help Center at (402) 472-3970 or toll free at 866-472-3970. You can also email mysupport@unl.edu, or visit https://its.unl.edu/helpcenter/
In addition, each Instructor will have access to a departmental tech support person who may be able to troubleshoot course design technical problems. Tech support at UNL, however cannot troubleshoot individual computer or user challenges. If the problem does not originate at UNL, students will need to secure assistance locally from someone familiar with their computer and software. (**NOTE:** Using a computer at your place of employment can result in inaccessibility to some course materials due to firewalls set up by the employer).

HUSKER EMAIL

As an EDN-NU-PUP waiver student we are requiring you register for a Husker email account. This will be the email you will use for the courses. To access the email you first have to sign up. To do so go to http://huskers.unl.edu/liveedu/ and click *request a huskers account*. Follow the steps they provide you to set up your huskers email account.

Q: Who do I contact if I have questions pertaining to the EDN-NU-PUP Grant?

Dr. Johanna Taylor at johanna.taylor@unl.edu or 402-472-3874

Q: Who do I contact if I have interest in other ECSE courses at UNL?

Dr. Johanna Taylor at johanna.taylor@unl.edu or 402-472-3874
Go to: https://cehs.unl.edu/secd/early-childhood-special-education/

Appendix D
Acceptance Letter

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Department of Special Education and Communication Disorders
Serving People with Special Needs

November 30th, 2018

Dear XXX,

Congratulations! You have been selected to receive a tuition-waiver for coursework in the *Early Development Network University of Nebraska-Lincoln Professional Upgrade Partnership* (EDN-NU-PUP). Use this document to guide you on how to apply to UNL Office of Graduate Studies and enroll in courses.

You are eligible to receive waiver funding for the following courses:

- SPED 861 Infants with Disabilities and Home Visiting (Spring 2019)
- SPED 863 Medically Fragile Infants (Summer 2019)

Note: The current grant cycle allows for waiver support of the two courses listed above. We plan to apply for grant funding for the 2019 - 2020 year. A space in the *SPED 860 Issues in Early Childhood Special Education* has been secured for you when grant funding is in place. You will be contacted in the summer of 2019 to update you on the progress of this funding.

As part of the EDN-NU-PUP you will receive:

- Waiver of all tuition costs ($1070.00/course) and course fees ($187.00).
- A UNL transcript showing successful completion of the completed course and grade.

You signed an agreement to:

- The $50.00 application fee (if you are not currently a NU student).
- Textbooks associated with the coursework.
- UNL ID fee (if issued) at $15.00.
- Achieve a letter grade of at least B- in the course (If you do not achieve a B- in the course you will be unable to participate in future course offerings).

As part of your experience, we ask that you:

- Formally share information gained from the course with EDN colleagues within 6 months of completing course(s).
- Complete a pre-course survey before classes begin and a follow-up survey after the course(s).

A copy of this letter is being shared with your EDN supervisor. We encourage you to visit with them as you proceed through the course. Their signature on the application indicated they would support your efforts to successfully complete the course and recognize the added time commitments you will have each week in the spring-winter months of 2019. They also will be eager to plan with you how you might share the information with colleagues.

University of Nebraska Lincoln
COLLEGE OF EDUCATION AND HUMAN SCIENCES
Department of Special Education and Communication Disorders
Serving People with Special Needs

If for any reason you choose not to accept this award, we'd appreciate hearing from you as soon as possible. The funds can be used for other interested EDN providers. Should you begin the course and decide to withdraw, your EDN supervisor will be notified. You may not be eligible for enrollment in future waiver funded course offerings.

I will be your academic advisor during your participation in the EDN-NU-PUP coursework. Feel free to contact me if you have any questions regarding your enrollment at UNL and project specific details. Should you have questions about the project that I cannot address you can contact Cole Johnson at the Nebraska Department of Education, Special Education Planning Region Team (PRT) at 402-471-4318 or cole.johnson@nebraska.gov.

I am pleased you have chosen to join your EDN colleagues across the state in this effort to upgrade your knowledge and skills. I think you will find the investment of time advantageous and enjoyable. I look forward to working with you as you pursue your professional goals.

Sincerely,

Johanna P. Taylor, PhD, BCBA
Assistant Professor of Practice
EDN-NU-PUP Coordinator
johanna.taylor@unl.edu
(402) 472-3874

This project is funded by Grant Award: H181A170033

Appendix E
Proposed and Final Budget

Reporting Period: 3/ 2020
TAYLOR; JOHANNA
Project Start/Finish Dates: 00/00/0000 TO 00/00/0000
Project: NE ED EDN-NU PUP
WBS 26-1710-0189-001 TO WBS 26-1710-0189-001 WBS Start/Finish Dates: 08/13/2018 TO 08/12/2019

UNIVERSITY OF NEBRASKA
WBS Elements: Revenue and Expense Summary
AS OF 09/18/2019

Page: 1
ZWBSSUM2
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User: JCARLSON

Revenue Elements	Plan	Period 3	Year to Date	Life to Date	Commitments	$ Variance	% Uncoll.
460000 Planned Restricted Revenue	81,334.00-	0	0	0.00	0	81,334.00-	100
* Planned Gifts, Grants, Contracts	81,334.00-	0	0	0.00	0	81,334.00-	100
462102 St Grt&C-Prf/Tec ITD	0	0	0	67,179.20-	0	67,179.20	0
* State Grants & Contracts	0	0	0	67,179.20-	0	67,179.20	0
464400 Receivable Revenue	0	0.00	4,747.11	0.00	0	0.00	0
* Private Grants & Contracts	0	0.00	4,747.11	0.00	0	0.00	0
** Total Gifts, Grants, Contracts	81,334.00-	0.00	4,747.11	67,179.20-	0	14,154.80-	17
*** Total Revenue	81,334.00-	0.00	4,747.11	67,179.20-	0	14,154.80-	17

Cost Elements	Plan	Period 3	Year to Date	Life to Date	Commitments	$ Variance	% Remain
511000 Planned Faculty Salaries	3,825.00	0	0	0.00	0.00	3,825.00	100
511100 Faculty - Permanent	0	0.00	250.00	4,075.30	0	4,075.30-	0
* Faculty Salaries	3,825.00	0.00	250.00	4,075.30	0.00	250.30-	7-
513100 Mgr/Profess-Perm	0	0.00	57.70	1,225.01	0	1,225.01-	0
* Managerial/Professional	0	0.00	57.70	1,225.01	0.00	1,225.01-	0
515000 Plan Other Acad Sal	5,845.00	0	0	0.00	0	5,845.00	100
* Other Academic Salaries & Wages	5,845.00	0	0	0.00	0	5,845.00	100
516500 Student Hourly	0	6.00-	27.60	1,110.00	0	1,110.00-	0
* Student Wages	0	6.00-	27.60	1,110.00	0.00	1,110.00-	0
** Total Salaries & Wages	9,670.00	6.00-	335.30	6,410.31	0.00	3,259.69	34
519000 Planned Benefits	2,012.00	0	0	0.00	0.00	2,012.00	100
* Planned Benefits	2,012.00	0	0	0.00	0.00	2,012.00	100
519100 Retirement Contribution	0	0.00	24.60	240.44	0	240.44-	0
* Retirement Contribution	0	0.00	24.60	240.44	0	240.44-	0
519200 FICA Contribution	0	0.00	21.69	387.51	0	387.51-	0
* FICA Contribution	0	0.00	21.69	387.51	0	387.51-	0
519300 Health Ins Contribut	0	0.00	342.99	711.20	0	711.20-	0
* Health Insurance Contribution	0	0.00	342.99	711.20	0	711.20-	0
519400 Life Insurance Contribution	0	0.00	1.37	6.05	0	6.05-	0
* Life Insurance Contribution	0	0.00	1.37	6.05	0	6.05-	0
519700 Unemployment Compensation	0	0	0	1.46	0	1.46-	0
* Unemployment Compensation	0	0	0	1.46	0	1.46-	0
519800 Workers Compensation	0	0	0	20.87	0	20.87-	0
* Workers Compensation	0	0	0	20.87	0	20.87-	0
** Total Benefits	2,012.00	0.00	390.65	1,367.53	0.00	644.47	32
*** Total Personal Services	11,682.00	6.00-	725.95	7,777.84	0.00	3,904.16	33
520000 Plan Tot Operate Exp	59,558.00	0	0	0.00	0	59,558.00	100
526500 Educ Profess Serv	0	0.00	150.00	900.00	0	900.00-	0
* Operating Expenses/Services	59,558.00	0.00	150.00	900.00	0	58,658.00	98
** Total Operating & Supplies	59,558.00	0.00	150.00	900.00	0	58,658.00	98
540000 Planned Travel Expenses	2,700.00	0	0	0.00	0.00	2,700.00	100
541110 Lodging	0	0	0	1,103.30	0	1,103.30-	0
541120 Meals	0	0	0	59.00	0	59.00-	0
541201 Comm Fares-Desig Age	0	0	0	502.08	0	502.08-	0

541700 Travel - Conference Expense	0	0	0	1,000.00	0	1,000.00-	0
541800 Travel - Vehicle Rental	0	0	0	228.43	0	228.43-	0
* Domestic Travel Expense	2,700.00	0	0	2,892.81	0.00	192.81-	7-
** All Travel Domestic and Foreign	2,700.00	0	0	2,892.81	0.00	192.81-	7-
562200 College Training	0	18,866.25-	1,226.25-	53,467.32	0	53,467.32-	0
** Government Aid	0	18,866.25-	1,226.25-	53,467.32	0	53,467.32-	0
*** Total Non-Personal Services	62,258.00	18,866.25-	1,076.25-	57,260.13	0.00	4,997.87	8
**** Total Direct Costs	73,940.00	18,872.25-	350.30-	65,037.97	0.00	8,902.03	12
580000 Plan Indir Cost & Ot	7,394.00	0	0	0.00	0	7,394.00	100
581000 Indirect Cost Charges	0	0.00	1,852.98	8,391.02	0	8,391.02-	0
**** Other Deductions	7,394.00	0.00	1,852.98	8,391.02	0	997.02-	13-
***** Total Expense	81,334.00	18,872.25-	1,502.68	73,428.99	0.00	7,905.01	10

Revenue (over)/under expense	Plan	Period 3	Year to Date	Life to Date	Commitments	$ Variance	% Var.
Revenue (over)/under expense	0.00	18,872.25-	6,249.79	6,249.79	0.00	6,249.79-	0

Appendix F
Certificate of Completion

Certificate of Completion

Early Development Network
University of Nebraska- Lincoln
Professional Upgrade Partnership
2019

Recipient's Name

has successfully completed the graduate-level coursework for **SPED 861 Infants with Disabilities and Home Visiting** as a part of a professional development project aimed at advancing the knowledge and skills of individuals working in the early intervention field who serve the needs of infants and toddlers with developmental delays and disabilities and their families. This knowledge should contribute positively to their ability to develop Individualized Family Service Plans (IFSP) and collaborate with families and colleagues.

EARLY CHILDHOOD
SPECIAL EDUCATION
Department of Special Education and Communication Disorders

EDN-NU-PUP Project Director Date

Appendix G
EDN-NU-PUP Grant Recipient & Supervisor Surveys

Grant Recipient Feedback Survey

Q1 Please fill in the following information:

- ○ First Name ____
- ○ Last Name ____
- ○ Role in Early Intervention ____

Q3 Are you interested in taking more courses through the ECSE program at UNL?

- ○ Degree program
- ○ Graduate certificate program
- ○ 2 or more courses
- ○ 1 more course
- ○ Not at this time

Q4 Answer the following questions for SPED 861. For this set of items please rate each on a scale of 1 - 5 to indicate how the EDN-NU-PUP coursework influenced your overall competence. Very well prepared. Well prepared. Fairly well prepared. Somewhat well prepared. Not prepared at all.

Q5 How prepared are you now to: Define the key principles for providing early intervention services in the home with families

- ○ 5= Very well prepared
- ○ 4= Well prepared
- ○ 3= Fairly well prepared
- ○ 2= Somewhat well prepared
- ○ 1= Not prepared at all

Q6 How prepared are you now to: Assess child and parent strengths, needs, and interactions to determine instructional targets and strategies.

- 5= Very well prepared
- 4= Well prepared
- 3= Fairly well prepared
- 2= Somewhat well prepared
- 1= Not prepared at all

Q7 How prepared are you now to: Apply an evidence-based coaching framework to teach parents and monitor progress in one of the following areas (play skills, communication skills).

- 5= Very well prepared
- 4= Well prepared
- 3= Fairly well prepared
- 2= Somewhat well prepared
- 1= Not prepared at all

Q8 How prepared are you now to: Demonstrate teamwork to determine parent/child strengths, needs and instructional targets, measurable IFSP outcomes and strategies.

- 5= Very well prepared
- 4= Well prepared
- 3= Fairly well prepared
- 2= Somewhat well prepared
- 1= Not prepared at all

Q9 How prepared are you now to: Describe family priorities, strengths and desires relative to a child's development.

- ○ 5= Very well prepared
- ○ 4= Well prepared
- ○ 3= Fairly well prepared
- ○ 2= Somewhat well prepared
- ○ 1= Not prepared at all

Q10 Were there topics you wished SPED 861 Infants and Home Visiting addressed? Share those topics below.

____

____

____

____

____

Q11 Rate your agreement with the following statement: SPED 861 Infants with Disabilities and Home Visiting improved my skills as a professional working in the Early Development Network.

- ○ Strongly agree
- ○ Somewhat agree
- ○ Neither agree nor disagree
- ○ Somewhat disagree
- ○ Strongly disagree

Q20 How did you share the content you learned in the courses with your colleagues?

Q21 As we move forward with offering courses in the future to students currently employed with the Early Development Network is there anything you would like us to consider? Please share any other thoughts here (these responses will be helpful in shaping future opportunities for students).

Supervisor Feedback Survey

Q1 Your name:

____

Q2 List the name of the provider or services coordinator you supervise:

____

Q3 Rate your agreement with the following statement:

The provider/services coordinator has improved their skills as a professional working in the Early Development Network by taking the EDN-NU-PUP coursework in the spring and/or summer.

○ Strongly agree

○ Agree

○ Neither agree nor disagree

○ Disagree

○ Strongly disagree

Q9 Rate the performance of the provider/services coordinator on the following after taking the course.

Defining key principles for providing early intervention services in the home with families.

○ No change

○ Stronger

○ Much stronger

Q10 Rate the performance of the provider/services coordinator on the following after taking the course.

Assessing child and parent strengths, needs, and interactions to determine instructional targets and strategies.

- ○ No change
- ○ Stronger
- ○ Much stronger

Q11 Rate the performance of the provider/services coordinator on the following after taking the course.

Applying an evidence-based coaching framework to teach parents and monitor progress in one of the following areas (play skills and/or communication skills).

- ○ No change
- ○ Stronger
- ○ Much stronger

Q12 Rate the performance of the provider/services coordinator on the following after taking the course.

Demonstrating teamwork to determine parent/child strengths, needs and instructional targets, measurable IFSP outcomes and strategies.

- ○ No change
- ○ Stronger
- ○ Much stronger

Q13
Rate the performance of the provider/services coordinator on the following after taking the course.

Describing family priorities, strengths and desires relative to a child's development.

- No change
- Stronger
- Much stronger

Q14
Rate the performance of the provider/services coordinator on the following after taking the course.

Identifying functional outcomes for infants that are medically fragile.

- No change
- Stronger
- Much stronger

Q15
Rate the performance of the provider/services coordinator on the following after taking the course.

Observing an infant and reporting on the child's behaviors and development.

- No change
- Stronger
- Much stronger

Q16
Rate the performance of the provider/services coordinator on the following after taking the course.

Writing a developmental care plan for an infant transitioning from the NICU to home environment.

- ○ No change
- ○ Stronger
- ○ Much stronger

Q5 How did the provider/services coordinator share content they learned in the course with the team?

____

Q6 As we move forward with offering courses in the future to providers/services coordinators currently employed with the Early Development Network is there anything you would like use to consider? Please share any feedback or comments based on your experience with your provider/services coordinator.

____

Q7 Please share any feedback or comments about how these courses have helped the provider/services coordinator.

____

Q8 For opportunities in the future, what are professional development topics that you would like your staff to have?

____

Appendix I

Participant Methods of Sharing Newfound Information

- *At weekly early childhood team meetings I shared info I had learned. Often I would email out pictures of power point slides that I felt pertained to other members on my team.*
- *I have been sharing some information gained like PTSD for parents and some of the trauma the infants may experience from the NICU with feeding, etc.*
- *I was able to elaborate on the TIPS program and help my teammates during a recent IFSP. In general, during team meetings when we are discussing our caseloads, I feel like I have been able to participate and follow along more easily when some of the terms, etc. are used.*
- *I have talked with several of my colleagues about our current program and things that need to be changed. I have also talked to my supervisor about coming up with a plan to make it more of a transdisciplinary approach.*
- *We have lunch and learn opportunities throughout the school year and a weekly meeting where we can share information from courses, conferences or conventions. We will be put on the list to share out what we have learned.*
- *I shared information from this class very often. It not only helped my knowledge but also my confidence as a team member serving children with these issues. I have always found the medical aspect fascinating, and really appreciated more information to help understand the terms and implications.*
- *I have been able to collaborate with my team better and provide more insight in the plans we write for our families. I have been able to make better observations at my initial visit to provide more insight to my colleagues*.

Appendix J

Feedback for the Early Development Network and the University of Nebraska-Lincoln

- *I am very grateful to have had the opportunity to take these EDN PUP classes! Overall, all of the content covered thus far will have a positive impact on the way I serve children and families on my caseload. It was difficult to keep up with the module requirements during the first part of the semester of SPED 861 class; however, the requirements did become more manageable during the second half of the semester.*

- *I have thoroughly appreciated the opportunity to take these courses. The direct connection to infants and toddlers has been amazing and made these courses more relevant than many I have taken in the past. In addition, the opportunity to interact and network with others in similar yet different fields has also been very helpful.*

- *I think that this [SPED 863 Medically Fragile Infants] was a wonderfully in depth course. That being said, I can see how it might have been extremely difficult for the service coordinators that don't have as much education especially in the medical field. I felt I had an edge because of my Occupational Therapy degree and experience with medical terminology, etc. As a graduate course, I feel like it is better geared toward students with at least a bachelor's degree as the requirements were definitely aligned with graduate work. I definitely would not want to make the course easier. I just am not sure it's a good fit for those with minimal higher education.*

- *First, this has been a great opportunity for me and I greatly appreciate it. I have learned a lot and look forward to continuing my education. I feel it is important to remember that all students are coming from very different backgrounds and experiences.*

- *I have thoroughly enjoyed the classes I have taken so far. I feel I am a much better educator because of it. I would really be interested in leadership/administration classes in Early Childhood.*

- *I would be so appreciative of further courses offered. This is such a unique and specialized population (birth-3) I am very grateful for this grant that made me a better provider.*

- *I like that we have the opportunity to take upper level classes and not have to try to find funding for it, but it, is important to grow professionally.*

For UNL:

- *Because the information around processes such as Getting Ready were new to me, it would be great to have another class or session to follow-up on how this looks in our work after we are given a length of time to practice (more than just a few weeks that would be allowed in a one semester class). Also, in response to the questions regarding how prepared I am to address the course contents, the responses have more to do with practicing the information in real life versus the content or how it was presented. I learned a great deal from the course!*

- *Yes, I loved this class. I loved all of the different strategies we were given to work with families. I also felt having a framework for home visiting was very beneficial to me. Now I have many resources to use.*

- *More in depth specific strategies for home based intervention, other than "use evidence based strategies" where do I find these? Longer amount of time spent on assessing language and play- would have liked to be able to do both instead of pick.*

- *I wish there would have been a topic on home visiting and day cares. With many families having 2 parents working a lot of visits are often done in day cares so I would have like to have seen strategies to address that as well as additional information on the PSP model and working with children diagnosed with autism.*

- *My plan was that this course was aligned with the home visiting plan that the state trained us on this summer, so that I would have that experience to help my team adjust to the new protocol. It did not align with that, so I will now end up doing the work twice. Of course, any knowledge is beneficial, but it was disappointing to work so hard and find out it would need to be done again.*

- *I enjoyed the course. It was challenging for me, but I learned a lot. It gave me a lot of good information for home visiting that I have been able to use in some of my visits. I feel I am a more effective service coordinator at my job, and I look forward to learning more.*

- *More scenarios and examples of putting coaching into practice.*

Appendix CC: Part C Quality Home Visit Practices Report

University of Nebraska Medical Center
MUNROE-MEYER INSTITUTE

Part C Quality Home Visit Practices

Evaluation Report

February 14, 2020

Collaborate. Evaluate. Improve.
Interdisciplinary Center for Program Evaluation

Nebraska Results Driven Accountability (RDA)- Part C

QUALITY HOME VISIT PRACTICES

The Nebraska Department of Education and the Nebraska Department of Health and Human services have developed a State Systematic Improvement Plan (SSIP) to improve State Identified Measurable Results (SIMRs) related to increasing the number and percentage of infants and toddlers enrolled in Part C (early intervention) services who demonstrate progress in the acquisition and use of knowledge and skills. In order to impact these results, Nebraska has identified three improvement strategies: (1) Implementation of the Routines-Based Interview (RBI) as the recommended child and family assessment process; (2) Development of meaningful and measurable child and family outcomes using information obtained from the RBI; and (3) Implementation of quality routines-based home visits. The implementation of the RBI and the development of meaningful and measurable child and family outcome strategies are being actively promoted across the state via training and technical assistance.

Prior to the implementation of training to address quality home visit practices, a program evaluation was conducted in 2016 to identify the remaining statewide training needs related to quality home visits, a sample of home visits was reviewed to explore the current status of home visitation practices. Three groups with varying levels of RBI training submitted video recorded home visits for review: (1) providers with two to three years of experience with RBI and functional outcomes (2) providers recently trained in RBI and functional outcome practices and (3) providers with no RBI or functional outcomes training. Evaluation results suggested the need for quality home visit implementation training and technical assistance to include supporting early intervention providers in:

- Actively engaging both the parent and child in daily routines and activities during home visits
- Promoting and facilitating positive parent-child interactions during home visits
- Collaborating with parents to support their child's development in daily routines and activities outside of home visits

In response to these identified needs, the Getting Ready intervention was adopted to use with Part C programs across the state. This intervention (Sheridan, Knoche, Edwards, Bovaird, & Kupzyk, 2010; Sheridan, Knoche, Kupzyk, Edwards, & Marvin, 2011; Sheridan, Marvin, Knoche, & Edwards, 2008) was designed to provide an integrated, ecological, strengths-based approach to school readiness for families with children from birth to 5 years who are participating in early education and intervention programs. The Getting Ready intervention promotes a joining of expertise of parents with that of the early childhood professional, bringing together family contributions about culturally relevant experiences and professional contributions about developmentally important activities.

The first cohort to receive Getting Ready training had been fully implementing the strategies for one year in the fall of 2018. In order to evaluate the influence of the Getting Ready intervention on the quality of home visit practices, an evaluation to investigate the influence of the implementation of a quality routines-based home visits approach on the quality of home visit practices was planned. The objective of the evaluation was to examine how the home visiting behaviors of providers vary between two groups, Getting Ready trained and non-trained in Getting Ready.

The co-leads actively recruited from two groups, Part C early intervention (EI) providers from the Getting Ready trained and non-trained in Getting Ready EI providers, for participation in the evaluation with a target of 20 participants per group. The elective nature of the evaluation influenced the number of willing participants from each group. Recruitment yielded seven participants from the Getting Ready trained group and no participants from the non-trained group; therefore, it was not feasible to answer the comparative evaluation question.

About the Early Intervention Providers

A total of seven EI providers, from three planning region teams, participated in the home visit practices evaluation. Demographic data was gathered through surveys submitted by the EI providers. Five of the providers identified themselves as Early Childhood Special Education teachers, one as an Occupational Therapist, and one as a Physical Therapist. Of the seven providers, five indicated that they were trained as a coach for the Getting Ready intervention. Experience level of the providers varied. Two providers had more than 10 years of early intervention experience, one had 5-10 years of experience, three providers had 3-5 years of experience, and one had 1-2 years of experience.

Where were the services provided and who were the families?

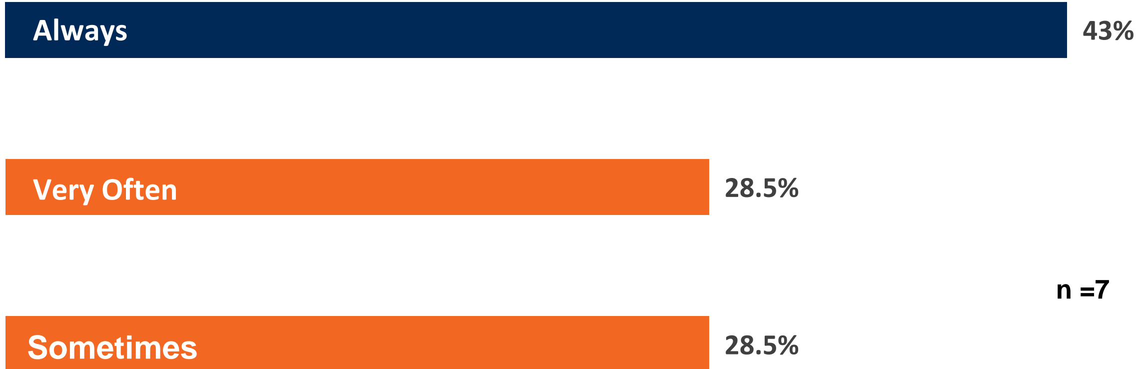
Information related to the provision of Part C services was gathered via survey from each participant. All of the visits took place in the child's home. One of the providers had been providing services to the family for over 24 months, three for 12-18 months, two for 6-12 months, and one for less than 6 months. The mean number of visits per month for the families in the videos was 2.57 visits (range 2-4). The majority of the visits occurred with the child's mother present, two also included the father, and one was completed with the child's grandmother. The mean age of the children in the submitted videos was 26.8 months (range 13-41 months).

What did the early intervention providers tell us about their visit and the Getting Ready intervention?

The majority (86%) of the EI providers were overall satisfied with the visit that they submitted. The EI providers were asked how often they use the Getting Ready intervention to guide their home visits. They reported varying levels of use, 28.5% reported *always* using the intervention, 43% reported using the intervention *very often*, and 28.5% reported that they *sometimes* use the intervention. When asked about their satisfaction with the Getting Ready intervention for use in their home visits, the providers reported being either very satisfied (43%) or slightly satisfied (57%).

EI providers use the Getting Ready intervention at varied levels.

All providers reported using the intervention at least sometimes to guide their home visits.

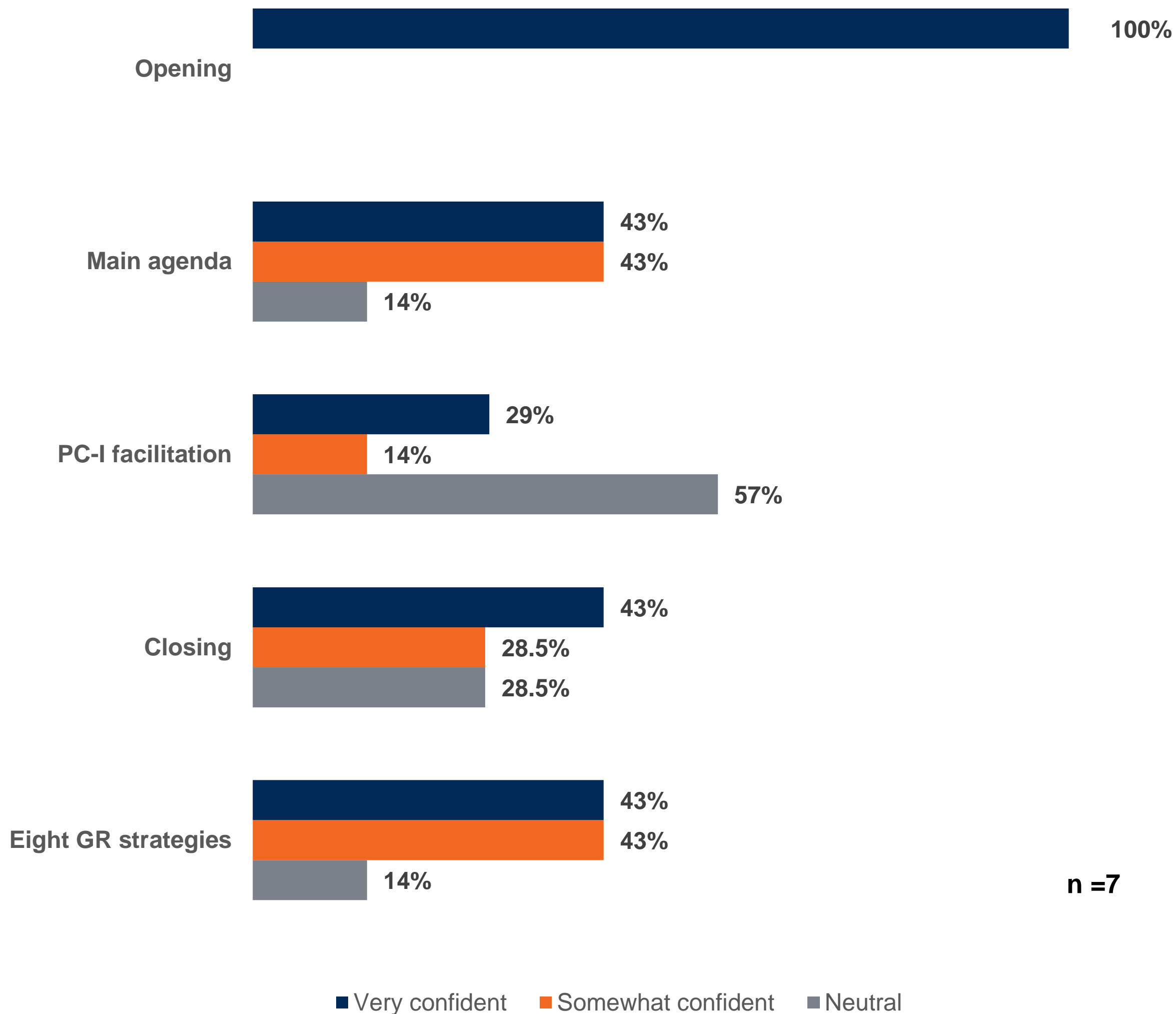


n =7

The Getting Ready intervention structures home visits into three key components; the opening, the main agenda, and the closing. Within these components, providers are expected to incorporate key elements (e.g. co-establish purpose of the visit, support parent-child interactions) and implement the eight Getting Ready Strategies within the visit. These strategies include; communicate openly and clearly; encourage parent-child interactions; affirm parent competencies; make mutual/joint decisions; focus parents' attention on child strengths; share developmental information and resources; use observations and data; and model and/or suggest. The EI providers were asked to rate their confidence for the three structure components, facilitation of parent-child interactions, and use of the eight Getting Ready strategies for the visit they submitted. Reported confidence levels varied. All of providers reported being very confident in the opening of their visits and the majority reported very or somewhat confident in the main agenda (96%), closing (71.5%), and implementing the Getting Ready Strategies (96%); however, fewer (28%) reported confidence in their facilitation of parent-child interactions during the visit.

EI providers are confident in the opening of their home visits.

Many providers are neutral about their confidence in facilitation of parent-child interactions.



What was the quality of home visitation practices?

The *Home Visit Rating Scales-Adaptive and Extended* (HOVRS-A+ v.2.1) assesses the quality of home visitation practices based on a video of a home visit. The observational measure is scored on a 7 point scale, with 7 indicating high quality. The HOVRS-A+ v.2.1 results are reported in two domains. The first domain, *Home Visit Practices*, measures the home visitor's responsiveness to the family and how the visitor facilitates parent-child interaction, builds relationships with the family, and uses non-intrusive approaches. The second domain, *Family Engagement*, measures parent-child interaction and the level of parent and child engagement within the activities of the home visit.

The *Home Visit Rating Scales- Adapted and Extended* (HOVRS-A+ v.2.1) was utilized for the 2016 evaluation and for the current evaluation. The HOVRS-A+ v.2.1 assesses the quality of home visit practices and levels of family engagement during home visits based on a 30 to 60 minute video recording. HOVRS-A+ v.2.1 is scored on a 7-point scale, with seven indicating high-quality home visitation practices.

The results of the assessment are reported in two domains. The first domain, Home Visit Practices, measures the family engagement specialist's responsiveness to the family's strengths and culture, how the visitor builds relationships with the family, the effectiveness of the family engagement specialist at facilitating and promoting positive parent-child interactions, and non-intrusive approaches utilized by the visitor that support effective collaboration.

The second domain, Family Engagement, examines the nature of the parent-child relationships and interactions, as observed during the home visit, and the level of parent and child engagement within the activities of the home visit.

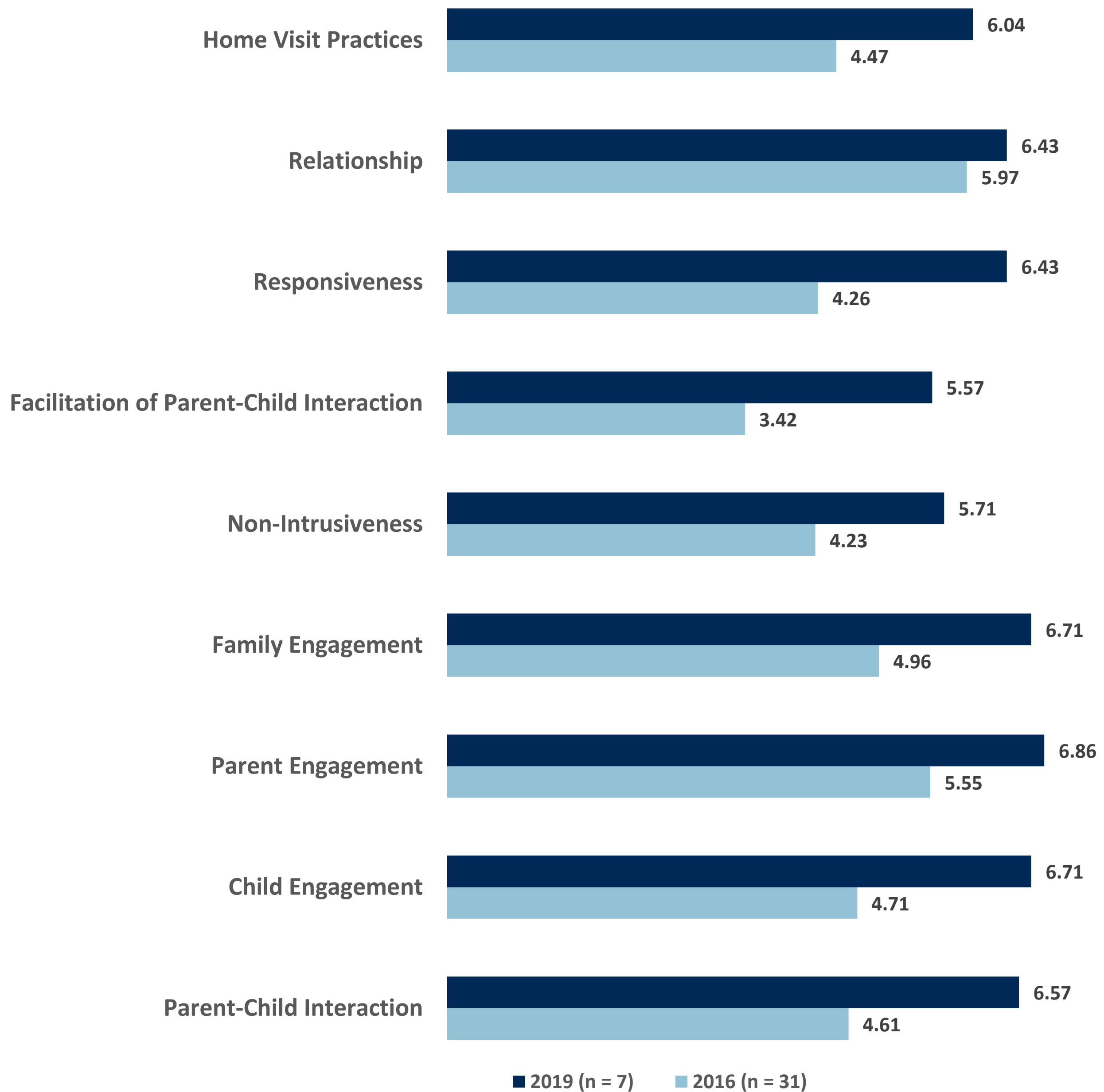
In 2016, HOVRS- A+ v 2.1 data were available for 31 Part C EI providers with varying levels of training and implementation of improvement strategies one (RBI) and two (functional outcomes). In 2019, HOVRS- A+ v 2.1 data were available for 7 EI Part C providers. These providers were fully implementing all three improvement strategies (RBI, functional goals and outcomes, and Getting Ready intervention). The mean scores for the Home Visit Practices and Family Engagement domains and each of the subscales are shown in the table below.

Descriptive analyses comparing the HOVRS- A+ V 2.1 from 2016 with the HOVRS- A+ V 2.1 from 2019 revealed improvement in the mean ratings for both the Home Visit Practices scales and Family Engagement scales and each subscale. Due to the small size of the 2019 sample, additional analyses measuring statistical significance between the group means were not feasible and there was no consistency between the 2016 and 2019 EI providers; therefore, direct comparison cannot be completed.

For providers who participated in all three improvement strategies, the results suggest that this group demonstrated high-quality home visit practices and high levels of family engagement during their home visits, and the providers demonstrated strength in the targeted improvement areas that were identified through the 2016 Home Visit Practices evaluation. The providers established active engagement with both the parent and child during the home visit, promoted and facilitated positive parent-child interactions during the home visit, and collaborated with parents to support their child's development outside of the home visit.

Home Visit Practices and Family Engagement ratings increased from 2016 to 2019.

The largest increases were in the provider's responsiveness to the family and facilitation of parent-child interactions.



RDA STRATEGY IMPLEMENTATON AND PARENT SELF-EFFICACY

Each state is required to report on the percentage of families participating in Part C early intervention who report that their services have helped their family to (1) know their rights, (2) effectively communicate their needs, and (3) help their children develop and learn. Nebraska collects family outcome data via a family survey developed by the National Center for Special Education Accountability Monitoring (NCSEAM). The family survey contains a section of questions related to parent self-efficacy. To evaluate the influence of the implementation of the three improvement strategies on parent's perceptions of their self-efficacy, this study conducted an evaluation of parent perceptions of self-efficacy across three groups: (1) full implementation of all 3 strategies; (2) not yet trained in the Getting Ready intervention; and (3) implementing only RBI groups.

The NCSEAM family survey measures three categories; family empowerment, family and professional partnerships, and community resources and coordination. To identify items with impact on parent self-efficacy, the family survey was cross-walked with *The Early Intervention Parenting Self-Efficacy Scale* (EIPSIS; Guimond, et al., 2008). All items were categorized into the three focus categories of the family survey and parent self-efficacy impact items were identified for each of the groups from the family survey. Twenty-two impact items were identified. Data collected in the spring of 2019 for the twenty-two items were included in a retrospective comparison analyses between the three groups. The family survey items are rated on a 1 = *very strongly disagree* and 6 = *very strongly agree* gradient. Data were included for participants who completed 80% of the items of interest, and a mean composite score was calculated for each participant and each of the three strategy implementation groups. The mean composite scores for each implementation group is shown in the table below.

	Mean (*SD*)
Group 1 (full implementation of all three strategies); *n* = 252	5.39 (*.88*)
Group 2 (implementing strategy one [RBI] and two [functional outcomes]); *n* = 135	5.45 (*.81*)
Group 3 (implementing strategy one [RBI]); *n* = 516	5.43 (*.83*)

Analyses were completed to determine if there were differences in self-efficacy outcomes based on provider participation in one of the three implementation groups. Level of strategy implementation influenced the levels of parent reported self-efficacy. Mean comparisons were made between groups (group one, group two, and group three) using a one-way analysis of variance (ANOVA). The results of these analyses indicated there were no significant differences in the scores between groups [$F(2,900) = .295$, *ns*]. Additional analyses were conducted at the item level. A mean score was computed for each item and mean comparison were made for each item between groups (group one, group two, and group three) using a one-way analysis of variance (ANOVA). The results of these analyses indicated there were no significant differences between groups at the item level.

Nebraska family survey data collected in spring of 2019 for items related to parent self-efficacy yielded high mean scores on the gradient scale with minimal variability. These high scores suggest that, regardless of level of strategy implementation, parents had high levels of perceived abilities to produce positive change in their child and promote their child's development.

SUMMARY

Nebraska has identified three improvement strategies for Part C services: (1) Implementation of the Routines-Based Interview (RBI) as the recommended child and family assessment process; (2) Development of meaningful and measurable child and family outcomes using information obtained from the RBI; and (3) Implementation of quality routines-based home visits. Training and implementation support for these strategies have been the focus of statewide efforts related to Results Driven Accountability. Previous evaluation results suggested the need for quality home visit implementation training and technical assistance to support EI providers; therefore, the Getting Ready intervention was adopted for use in Part C home visitation. Evaluation of EI providers, with varied level of experience, found that providers from this small sample, who participated in all three improvement strategies demonstrated high-quality home visit practices and high levels of family engagement during their home visits.

All of the EI providers demonstrated strengths in the areas identified as needing improvement through the 2016 Home Visit Practices evaluation. The quality of facilitation of parent-child interactions increased from 3.42 in 2016 to 5.57 in 2019 suggesting that EI providers *promoted positive parent-child interactions* during their home visit. Despite many of the providers reporting neutral confidence in their ability to facilitate parent-child interactions, the results suggest that the providers demonstrated moderate to high-quality practices in this area. Scores on the responsiveness to family subscale increased from 4.26 in 2016 to 6.43 in 2019. The most recent scores suggest the EI providers demonstrated high-quality practices in *collaborating with parents to support their child's development in daily routines and activities outside of home visits*. Family Engagement scale scores increased from 4.96 in 2016 to 6.71 in 2019. High scores on this scale suggest high levels of *active parent and child engagement in activities during the home visit*. The recent evaluation results suggest EI providers made gains in the areas of need identified by the 2016 evaluation; however, due to the small sample size, future evaluation of the influence of the Getting Ready intervention on the quality of home visitation practices is needed.

Nebraska family survey data related to parent self-efficacy yielded high scores across the three levels of strategy implementation. The minimal variability across groups suggests that the level of strategy implementation does not influence parent's reported levels of self-efficacy.

NEXT STEPS

A larger evaluation of the influence of the Getting Ready intervention is recommended and should include a comparison of groups who are fully implementing the intervention and groups who are not yet implementing the intervention.

The participating EI providers reported varied levels of use of the Getting Ready intervention. Future evaluation examining the level of implementation and reasons for the varied levels implementation would benefit future training and intervention implementation supports.

Given that many providers reported neutral confidence in promoting and facilitation parent-child interactions, methods to provide support and feedback focused on this home visit practice should be considered for future training and technical assistance for those who are trained in and implementing the Getting Ready intervention.

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Evaluation Report prepared by
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Interdisciplinary Center of Program Evaluation
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A University Center of Excellence for Developmental Disabilities

Appendix DD: Evaluation of Quality Early Intervention Home Visitation in Nebraska Executive Summary and Full Report February 2020

Evaluation of Quality Early Intervention Home Visitation in Nebraska: Executive Summary

Purpose and Research Questions

A qualitative study was conducted to better understand family, service coordinator (SC), and Early Intervention (EI) service provider experiences with Nebraska's third Results Driven Accountability strategy—professional development for implementation of the *Getting Ready* framework to influence the quality of EI home visits. High quality home visits have the potential to enable EI service providers and SCs to focus on supporting child and family progress toward achieving Individualized Family Service Plan (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 parents' 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) parent-provider communication between visits, and (f) parent-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 parents' access to desired services and resources, (c) implementation of the home visit plan between visits, (d) parent-provider communication between visits, and (e) parent-professional collaborations to monitor child and family progress on IFSP outcomes?

Twelve EI service providers, seven SCs, and 22 family members from pilot site Planning Region Teams (PRTs) participated in semi-structured interviews about their experiences with EI services utilizing the *Getting Ready* framework of home visiting. In addition, 11 completed, de-identified home visit plans from across these PRTs were analyzed. The sample, chosen as representative of usual home visit plans, included documents completed by EI service providers ($n = 7$) and SCs ($n = 4$).

Key Findings

Theme 1: Engaging families to achieve IFSP outcomes. Participants described robust partnerships between professionals and family members and the presence of the following family-centered, participatory-building practices:

Coaching. Joint problem-solving, offering suggestions, modeling, and providing feedback during home visits.

Practice. Numerous and widespread reports that "practice" occurred within family routines during the home visits.

Home visit action plans. Consistently used. Often included updates on child/family progress, the IFSP outcome of focus for the current visit, a strategy or idea to address the outcome, routines chosen by the family for using the strategy, and a family-professional communication plan. Not all teams used plans with all key components.

Communication between visits. Increased frequency of communication. Variety of methods used: text messaging, phone calls, emails, and Facebook Messenger.

Theme 2: Accountability-- gains and gaps. Prompts within the *Getting Ready* framework have the potential to heighten the accountability of all team members by strengthening the focus on families' priority IFSP outcomes.

Gains in accountability. Families increasingly taking ownership both of the agenda of each home visit and of the collaboratively developed strategies or ideas to achieve IFSP outcomes.

Gaps in accountability. Monitoring and documentation of progress toward IFSP outcomes often conducted informally and infrequently. Families inconsistently partners in the process. Redundant documentation systems (particularly for SCs).

Theme 3: Implementation challenges.

Communication. These included: (a) use of personal cell phones, (b) managing communication with high caseloads, (c) unclear professional boundaries, (d) technology barriers, (e) family preference of communication method not matching the needs of the professional, and (f) communication when interpreter needed.

Diversity of families. Need for additional training to address partnering with families whose first language is not English and caregivers with disabilities or mental health concerns.

Roles of SCs. Some SCs reportedly comfortable utilizing the *Getting Ready* framework to carry out their roles on the teams, while others expressed uncertainty about the utility of *Getting Ready* as applied to the express purposes of services coordination.

Implications for Practice in Nebraska Early Intervention Programs

1) Encourage EI providers to strengthen their knowledge of and ability to coach families to use evidence-based interventions and the steps needed to effectively implement these.

2) Consider future RDA initiatives focusing on training, tools, and technical assistance for effective monitoring and documentation of progress toward achieving child and family IFSP outcomes within a data-driven decision making process.

3) Develop policies and best practices to guide family-professional communication. Explore technological supports for these efforts. Promote PRT inclusion of key components in home visit action plans.

4) Clarify the role and expectations of SCs as teams expand the use of the *Getting Ready* framework. Make adjustments or provide follow-up training as warranted.

Kuhn, M., & Higgins, J. (2020). *Evaluation of quality early intervention home visitation in Nebraska.* (Report). Lincoln, NE: Early Development Network.

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Evaluation of Quality Early Intervention Home Visitation in Nebraska

Submitted to the Nebraska Department of Education and

Department of Health and Human Services

February 3, 2020

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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.

Evaluation of quality Early Intervention home visitation in Nebraska

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 (n = 22)	Children (n = 20)	Professionals (n = 19)
Age	x = 30.91 years SD = 5.45	x = 33.55 months SD = 7.72	x = 37.21 years SD = 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%		---

9th – 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!