Herman Family Scenario: Facilitator’s Guide

July 2016

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The contents of this document were developed under a grant from the U.S. Department of Education, # H373Z120002, and a cooperative agreement, #H326P120002, from the Office of Special Education Programs, U.S. Department of Education. However, those contents do not necessarily represent the policy of the U.S. Department of Education, and you should not assume endorsement by the Federal Government. DaSy Center Project Officers, Meredith Miceli and Richelle Davis and ECTA Center Project Officer, Julia Martin Eile.



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Herman Family Scenario: Facilitator’s Guide

Communicating with Families: A Scenario Approach

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**Herman Family Scenario: Facilitator’s Guide**

Communicating with Families: A Scenario Approach

# Introduction

## Purpose

The purpose of *The Herman Family Scenario Facilitator’s Guide* is to assist program administrators and technical assistant providers use *The Herman Family Scenario* as a companion to the COS – Team Collaboration (COS-TC): Toolkit (Younggren, N., Barton, L., Jackson, B., Swett, J. & Smyth, C., 2016). Facilitators should have a strong understanding of the COS-TC quality practices, Agreed Upon Practices, and DEC recommended practices to support rich conversations with early intervention and early childhood providers about the challenges and opportunities demonstrated in *The Herman Family Scenario.*

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## Background of the Scenario

The scenario was developed to address the need in the field to (1) to effectively engage families as full partners in the assessment and COS rating processes, and (2) to effectively incorporate quality practices in the COS rating process. The participants are teams involved with the COS process. The scenario describes a 2 year old child entering early intervention services.

The two activities in *The Herman Family Scenario Facilitator’s Guide* designed to help TA providers engage training participants in an analysis of quality practices aligned with Agreed upon Practices, DEC recommended practices and COS-TC. Challenging situations in this scenario result in less than optimal practices and will allow the group to explore multiple alternative strategies, by benefitting from the collective expertise of participants. Specific facilitation experiences that are found in *The Herman Family Scenario Facilitator’s Guide* include:

The scenario presents examples of challenging situations (e.g., communicating difficult information to families, determining ways to engage families when they have limited time or availability, finding ways to fully understand children’s functional abilities beyond conventional testing alone, etc.) to provide opportunities for participants to problem solve and identify effective strategies that could be used in their work.

## Uses of the Scenario

This scenario can be used in several ways with providers:

* In small or large group discussions as part of a COS Process training
* Role playing to practice interactions with families
* As part of a review and reflection of current program practices

## Contents of this Facilitator’s Guide:

* COS-TC Quality practice (supported by DEC recommended practices and Agreed Upon practices) checklists with rating opportunities for individuals or small groups
* Detailed explanations of recommended ratings with number-matched instances in the scenario content
* Discussion “Points to Consider” and “Questions to Ponder” for COS-TC Quality Practices as addressed in the Scenario
* Guided discussion questions designed to evaluate strengths and needed improvements of the Scenario team collaboration process
* Recommended communication efforts that could be used in future team meetings and role-playing exercises
* Deeper analysis of the connection between the COS-TC Quality Practices and the DEC Recommended Practices and the Agreed Upon Practices
* Reflection question guidance

## Additional Resources

These resources provide supporting materials that could be used to enrich training content. Facilitators can use the resources to gain more in-depth background knowledge on information that formed the basis of the scenario activities.

Print Resources

Division for Early Childhood. (2014). *DEC recommended practices in early intervention/early childhood special education 2014*. Retrieved from<http://www.dec-sped.org/recommendedpractices>

Harvard Family Research Program. (2013). Many of the Assessment and Family practices have been incorporated into the training checklists

The DEC recommended practices, first developed by the Division for Early Childhood (DEC) in 1991, emphasize practices that have been shown to result in better outcomes for young children with disabilities and their families. The practices are intended to be used by individuals providing services to young children with disabilities or delay. In the Herman Family Scenario Facilitator’s guide, users will observe the extent to which DEC recommended practices are present in the scenario.

*Tips for administrators, teachers, and families: How to share data effectively*. Harvard, MA. Facilitators will find more information about sharing data with families at: <http://www.hfrp.org/publications-resources/browse-our-publications/tips-for-administrators-teachers-and-families-how-to-share-data-effectively>

This resource is a set of tip sheets intended to help teachers and administrators discuss student data with families in an understandable and accessible way. After using the Herman Family Scenario Facilitator’s guide to learn quality and recommended practices for engaging families, providers can refer to *Tips for administrators, teachers and families* for specific tips on facilitating ongoing formal and informal conversations with families about student data.

National Parent Technical Center at the PACER Center in collaboration with Early Childhood Technical Assistance (ECTA Center). (2013). *A family guide to participating in the child outcomes measurement process*. Facilitator will find more information about family participation at: <http://olms.cte.jhu.edu/olms2/data/ck/sites/2865/files/FamilyGuide_ChildOutcomes_PACER_2013(1).pdf>

This family guide provides families with a foundational understanding of the Child Outcomes Summary (COS) process, including information about the three outcomes, why states’ measure progress, and how families can be involved. Providers can share this resource with families to more fully engage them in COS team collaboration.

Work Group on Principles and Practices in Natural Environments. (2008). *Agreed upon practices for providing early intervention services in natural environments*. OSEP TA Community of Practice-Part C Settings. Additional information on early intervention practices can be found at: <http://www.ectacenter.org/~pdfs/topics/families/AgreedUponPractices_FinalDraft2_01_08.pdf>

The agreed upon practices use evidence-based research to suggest a series activities for providers to implement during each part of the IFSP process, including first contact with families, the IFSP meeting, and ongoing intervention activities. In this guide, users will rate the extent to which providers in the Herman Family Scenario implement the agreed upon practices throughout the initial meeting with the Herman family and the assessment process.

## Video Resources

Child Outcomes Summary-Team Collaboration video guides. (in press).

The COS-TC video guides are excerpts of real-life scenarios in which providers are interacting with each other and families at various points in the COS process. While watching these video clips, viewers apply their learning of COS-team collaboration by answering guiding questions and rating the extent to which providers in the video implement COS-TC quality practices.

Desired Results Access Project. (2014). Harpers Hope: A Parent’s View of the Power of Early Intervention. More information can be found at: <http://draccess.org/videolibrary/harperhope.html>

This video provides deep insight into one family’s experience, first, discovering that their newborn baby, Hope, will need early intervention. Then, the family describes their relationship with their early intervention provider and how the early intervention process has given them tools to help Hope progress. This video is a useful resource to share with families who are, or will be, receiving early intervention services.

# Herman Family Scenario – Part 1: Gathering Assessment Information as Part of the Eligibility Process

**Activity Suggestions**

## Purpose

The Herman Family Scenario Part 1 provides an illustration of an early intervention team’s assessment practices. In training, participants review the team’s approach and critically examine the extent to which it reflects quality practices. Key ideas are from the Division for Early Childhood (DEC) Recommended Practices (DEC, 2014) and the Agreed Upon Practices (Work Group on Principles and Practices in Natural Environments, 2008). The scenario intentionally presents a range of positive practices and missed opportunities in order to generate a lively discussion.

## Target Audience

Administrators and providers who deliver early intervention services (birth to age 3).

## Learning Objectives

* Apply recommended practices to planning and implementing early intervention assessments.
* Identify assessment practices that are family-centered, functionally based, and reflect collaborative teaming.
* Adopt effective communication skills in relaying assessment findings to parents.

## Activity One: Is there a problem?

**Activity time:** 40–60 minutes

**Preparation time:** 30 minutes

**Participant handout:** Herman Family Scenario: Part 1

**Purpose:** The purpose of this activity is for participants to review the assessment process for the Herman family in light of quality practices. Based on the description provided, participants will rate whether specific practices were observed or evident, observed to a limited extent, or not observed/can’t tell.

**Activity description:**

**Step 1:** Invite participants to read each section and use the scale in the scenario to rate each item and jot down notes on what could be improved and which practices they would want to adopt in their work.

**Step 2:** Have the participants discuss both the strengths and the areas that could be enhanced for each section of the outlined quality practices, using their ratings and notes. The charts in Appendix A include a key of the ratings as well as additional points to ponder. These are provided for the facilitator to use during the group discussion.

**Step 3:** Use the following questions to guide the group discussion.

***Based on your ratings, what were the team’s strengths in completing the assessment process with the family?***

Examples:

* The team observed Lily’s skills and behavior across multiple settings.
* The providers identified the parents’ concerns.
* The providers acknowledged the parents’ wishes to assess Lily at her grandmother’s house and at school.

***What could have been improved in the assessment process? (Think about what the contributing factors were.)***

Examples:

* Although the team respected the family’s wishes to schedule the assessments in community settings, the providers should have determined with the family some other strategies to obtain their input.
* At the team meeting, the family was not asked about their concerns and what they wanted to gain from the multidisciplinary team (MDT).
* The providers could have described some of the social-emotional behaviors they saw (or were concerned about) and determined if these align with behaviors the family sees at home. This would have helped to validate the assessment. This would also allow the providers an opportunity to discuss typical development and compare that to what the team is seeing and why these behaviors are a concern.
* A better explanation as to why the Modified Checklist for Autism in Toddlers (M-CHAT) was used as a screener.
* The providers inappropriately diagnosed Lily as having autism.
* Since the family was not part of the assessment process, the team had limited time to build a trusting relationship with the family.
* During the eligibility process, the family was not included as part of the discussion, limiting their voice and role in the decision-making process. For example, engaging the parents could include discussing what the family sees with respect to Lily’s social-emotional skills, talking about typical expectations for children her age, together interpreting what the differences mean, and determining together the next steps.

***What words could you use to support the family in understanding the team’s concerns regarding Lily’s development?***

Examples:

* The providers may want to use words such as, “We have some concerns about her social‑emotional skills. It sounds like what we saw is similar to what you see at home, where frequently it is hard to engage her in social interactions and where she enjoys more solitary play. The screener you completed also suggests that further assessment is needed in this area. It does not mean that she has autism. Often an evaluation by a developmental pediatrician will help to answer those questions. How does this information fit for you? Do you need any more information to help you decide what next steps you want to take?”

***What steps would you recommend the team take next?***

**Activity variation:** This activity could be done with administrators and/or supervisors. Have the supervisors review the scenario and discuss the feedback or approach they would use with the team.

## Activity Two: What words should I use?

**Activity time:** 30­–40 minutes

**Preparation time:** 20 minutes

**Participant handout:** Herman Family Scenario: Part 1

**Purpose:** The purpose of this activity is to have participants practice their communication skills as they partner with parents in the assessment process.This activity could build on Activity One or can be used as a standalone activity.

**Activity description:**

**Step 1:** Have the participants individually read each section of the Herman Family Scenario: Part 1 and identify areas that could be enhanced. Invite large group discussion to identify key areas to be improved.

**Step 2:** Based on areas they target for improvement from the scenario, have the participants “try another way” of communicating with the family that better reflects DEC and family-centered care practices. Role plays could occur in multiple ways depending on the size of the group. Here are some possible strategies:

* Divide into groups with each group taking one of the sections. Have two individuals volunteer to role play [e.g., taking the roles of a parent and a speech/language pathologist, (SLP) or developmental specialist], identifying the areas needing improvement, and ask the group if they need support finding the words to say.
* Divide the participants into groups of three. Assign the roles of parent, provider, and observer to each of the three in the group. Have each parent-provider pair role play the areas identified that could be enhanced. Then have each observer reflect on the role play and offer suggestions and comments.

**Step 3:** Have the group reflect on their experiences. How did it feel? What went well? What was difficult?

# Trainer Resources for Part 1: Gathering Assessment Information as Part of the Eligibility Process

## Quality Practice Ratings, Facilitator Points to Consider, and Questions to Ponder

The trainer resources for part one provides the facilitator with the ratings for each of the items in the scenario. The scenario is displayed with numbered lines that facilitators can refer to as a rationale for decisions about ratings. The facilitator can use these segments as examples during the training. Below each rating table is a space for facilitators to create their own notes with points they will want to make during the training.

### Meeting with the Family

The Hermans called the early intervention program because their pediatrician expressed concern regarding Lily’s communication skills. Lily was 26 months old and an only child. The service coordinator, Amber, met with the family to provide them with information about the program and the evaluation/assessment process that would be used to determine if Lily would be eligible for services, and to identify her strengths and needs. The Hermans were interested in having Lily evaluated, mostly because of their pediatrician’s concern about her language development. The service coordinator and family discussed the family's questions about Lily's development beyond what the pediatrician stated. The Hermans were worried about Lily’s communication but otherwise did not have any concerns. They were proud that she could already play videos on the iPad and could complete simple puzzles. She played well by herself, although sometimes it was difficult to get her to transition and play something new, like interacting with her parents as they read books to her. They shared that Lily uses 10–20 words, but mostly imitates these words and does not use words to communicate what she wants; rather she tends to use gestures to lead her parents where she wants to go, like to the snack cupboard or to the shelf where the iPad is kept.

The service coordinator thanked the family for their descriptive information about Lily and described that the first step would be to complete the assessment process. The team would set up several appointments to evaluate Lily’s skills across all developmental areas. If Lily were found to be eligible, the early intervention program would provide the services she needed. Amber explained that services and supports would be available to Lily and her family and could be provided either in their home or in a child care setting, whichever worked best for the family. The parents said that they would like the assessments to take place as soon as possible but that they also had limited time to meet with the team. They indicated that they both had busy work schedules and asked if the assessments could be completed at Lily’s grandmother’s home or at the child care center where Lily spends the day. Amber gave the parents two forms to complete, the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers (M-CHAT). She briefly explained that this information would help the team have a better understanding of Lily’s skills at home.

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| **Meeting With the Family**  *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent , and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| --- | --- | --- | --- | --- | --- | --- |
| DEC Recommended Practice | No | Partly | Yes | Points to Consider | Questions To Ponder | Line # from scenario that supports rating |
| A1. Practitioners work with the family to identify family preferences for assessment processes. |  |  | x | This family chose not to be actively involved in the assessment process. |  | 20-23 |
| F1. Practitioners build trusting and respectful partnerships with the family through interactions that are sensitive and responsive to cultural, linguistic, and socio-economic diversity. | x |  |  | Team was respectful of the parents’ request for the assessment settings. However, the team did not build a trusting relationship with the parents. To do so, they might have provided the family with information as to why they were having the family complete the M-CHAT so the family would not be caaughtoff0guard later when the team mentions autism. | How could you approach the parents regarding concerns about Lily’s autistic-like behaviors that would be more helpful? | 24-26 |
| Agreed Upon Practice for Providing Early Intervention Services in  Natural Environments | No | Partly | Yes | Points to Consider | Questions To Ponder | Line # from scenario that supports rating |
| 1. Become acquainted and develop rapport. |  | x |  | Brief interaction with family limited the provider’s ability to develop rapport. | What strategies could have been used to help build rapport in light of this choice? | 20-23 |
| 2. Engage in conversation to find out why the family is contacting early intervention and to identify the next appropriate steps in the referral process. |  |  | x | Family indicated why they were concerned and contacted early intervention. |  | 1-2, 5-8, 15-16 |
| 3. Describe early intervention as a system of supports and services for families to assist them in helping their children develop and learn. |  | x |  | The service coordinator said “the program could provide the services the child needs,” but it could be expanded. | What additional information would be helpful to include about early intervention that would inform the parents about their options? | 17-18 |

Facilitator Notes:

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### The Assessment Process

Based on family preference, the majority of the assessments were completed at Lily’s child care center and through an interview with her grandmother. The assessments took two weeks to schedule and complete. The multidisciplinary assessment team (MDT) included the psychologist, speech/language pathologist (SLP), and developmental specialist. The team members worked together to schedule times to complete their assessments with Lily’s child care center staff and grandmother. They gathered information about Lily’s functional skills during daily routines, through interviews with Lily’s grandmother and a short interview over the phone with her parents. Two standardized assessments [i.e., the Preschool Language Scale 4 and Bayley Scales of Infant Development-III (BSID-III, cognitive subscale)] also were completed. The team had a difficult time collecting assessment information because it was hard to engage Lily in the activities. Lily attended to the activities she chose, frequently repeating the activity over and over (e.g., repeatedly putting the puzzle pieces in and out). Even during preferred activities, such as playing with an iPad or shape boxes, Lily did not typically look at the adult or imitate adult actions. The child care staff reported seeing similar behavior from Lily in their program. They reported that Lily most often played by herself without initiating interactions with her peers and without imitating peers’ play. The child care staff also reported she rarely used words to communicate what she needed or to interact with the other children. The assessment team will synthesize the information gathered across these settings and from the people who know Lily best and will share it at the multidisciplinary team meeting with the parents.

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| **The Assessment Process**  *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| DEC Recommended Practice | No | Partly | Yes | Points to Consider | Questions to Ponder | Line # from scenario that supports rating |
| A2. Practitioners work as a team with the family and other professionals to gather assessment information. |  |  | x | The parents provided some input on people who could be included in the assessment process.  Team worked with others to gather assessment information. | Was there other information that should have been gathered that would be helpful to the decision-making process (e.g., physician, additional information from the parents)? | 1-5 |
| A3. Practitioners use assessment materials and strategies that are appropriate for the child’s age and level of development and accommodate the child’s sensory, physical, communication, cultural, and social and emotional characteristics. |  |  | x | Strategies are appropriate and observations of preferred activities imply use of authentic assessment. |  | 7-9 |
| A6. Practitioners use a variety of methods, including observation and interviews, to gather assessment information from multiple sources, including the child’s family and other significant individuals in the child’s life. |  |  | x | Early intervention team used a variety of strategies including interview, observation, and direct assessment. |  | 5-9 |
| A7. Practitioners obtain information about the child’s skills in daily activities, routines, and environments such as home, center, and community. |  | x |  | Gathered some information on daily activities through interviews, but needed to also complete observations across settings. | What other settings would you recommend gathering information regarding daily routines? | 5-7 |

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| DEC Recommended Practice | No | Partly | Yes | Points to Consider | Questions to Ponder | Line # from scenario that supports rating |
| A8. Practitioners use clinical reasoning in addition to assessment results to identify the child’s present levels of functioning and to determine the child’s eligibility and plan for instruction. | x |  |  |  | In what ways does your team integrate clinical reasoning with assessment findings? | 16-18 |
| Agreed Upon Practice for Providing Early Intervention Services in  Natural Environments | No | Partly | Yes | Points to Consider | **Questions to Ponder** | Line # from scenario that supports rating |
| 10. Evaluate and assess the functional needs and strengths of the child. |  | x |  | The team was beginning to assess functional skills, however needed to complete the assessment across additional settings and routines. | What other settings would you recommend would add information regarding Lily’s functional skills? | 9-13 |
| 11. Throughout the assessment process, observe and ask the family about their teaching and learning strategies with their child. | x |  |  | The team interviewed the grandmother, but did not observe her teaching and learning strategies for Lily. | What interview questions could be added to that would provide more information on the parent’s or grandmothers learning strategies? | 5-7 |

Facilitator Notes:

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### Joining with the Family to Review the Results of the Initial Assessment

The service coordinator briefly talked with Lily’s mother over the phone to schedule the meeting to discuss the results of the assessments. Amber shared that the providers completed standardized assessments with Lily and observed her at the child care center and at her grandmother’s home. She asked Mrs. Herman if she had any questions about the process; Mrs. Herman indicated that she did not have questions. Together they coordinated a time for the meeting; it was scheduled for the next time the team had an opening, which was the following week.

At the meeting, the team greeted the family and then the service coordinator began the meeting by describing the assessments and observations that were completed. The psychologist described the results of the standardized assessment, the BSID-III, including the cognitive and language domains. She explained that this assessment is designed to evaluate how Lily is doing compared to other children her age and that it provides one source of information on her strengths and areas that are less well‑developed. Her strengths on this assessment were in the area of her learning or cognitive skills. For example, areas of strength for Lily were her problem solving skills (e.g., she tried a number of different strategies to place puzzle pieces into a form board) and matching skills (e.g., Lily matched pictures to pictures). The psychologist reported that overall Lily is doing well in the area of cognitive skills. Lily’s score of 92 places her within the average range, which includes scores from 85 to 115.

The speech/language pathologist (SLP) reported the main area of concern seen in the assessment results matched what the parents had described: how Lily has limited functional use of language when interacting with others. She indicated that the results of the standardized assessments and the informal observations at the child care center and grandmother’s home found that Lily is demonstrating significant communication delays, with scores in the low 70s. (Lily’s overall score on Receptive Language Skills was 72 in Expressive Language Skills, Lily scored 74 overall). These scores are significantly below the average range (i.e., 85-115). These assessments confirmed the parents’ observations that although Lily knew and could express several words, she typically did not use them to communicate with others. Based on her delays in language development, Lily would be eligible for early intervention services in our program. In addition, the psychologist indicated, “Lily is also demonstrating delays in the ways she socializes which interfered with how she interacted with adults and children during our observations. The behaviors we saw were consistent with children with autism. In addition, your completion of the M-CHAT indicates behaviors associated with autism. We would suggest that you make an appointment with your pediatrician to confirm our suspected diagnosis.” The team then asked the family if they had any questions.

The family was stunned and did not immediately respond. Mrs. Herman began to cry. Mr. Herman asked, “Don’t most 2 year olds act like Lily?” He did not see any problem with her behavior. The parents said they were only concerned about her language. It didn’t seem like Lily could have autism: “Wouldn’t our pediatrician have suggested this was a problem?” Mr. Herman said that he wanted to get a second opinion. The family expressed that they needed time to talk together about the news they heard. They wanted to go back and discuss the findings with their physician, with whom they had a good relationship, and they would follow up with the service coordinator later (maybe) by calling her to let her know the next steps they wanted to take. The service coordinator indicated that she would call the Hermans the following week.

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| Joining with the Family to Review the Results of the Initial Assessment *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

| DEC Recommended Practice | No | Partly | Yes | Points to Consider | Questions to Ponder | Line # from scenario that supports rating |
| --- | --- | --- | --- | --- | --- | --- |
| A11. Practitioners report assessment results so that they are understandable and useful to the family interests. |  | x |  | Purpose and results of this assessment provided information but could be expanded.  Language assessment was described with results and triangulated with parents’ descriptions.  The information was not understandable for the family; Providers used jargon. Instead providers needed to use descriptive examples (e.g. Lily frequently named objects and used a reach to request what she needed.) |  | 7-12  19-22 |
| F1. Practitioners build trusting and respectful partnerships with the family through interactions that are sensitive and responsive to cultural, linguistic, and socio-economic diversity. | x |  |  | The team needed to provide more description of the assessments used and specific descriptions of the behaviors Lily demonstrated.  There was no discussion on what autism is. The family did complete the M-CHAT.  The team did not provide a sensitive approach to describing these results. The providers had not developed a relationship with family in delivering these results. | How could the team use the M‑CHAT information to help the family understand their concerns in this area? Are there other ways that the team could have helped the parents confirm whether or not their observations were consistent with the team’s observations?  What could the speech pathologist have added to her discussion of the results that would have made it more meaningful for the parents? | 28-30 |
| F2. Practitioners provide the family with up-to-date, comprehensive, and unbiased information in a way that the family can understand and use to make informed choices and decisions. | x |  |  | Providers presented the assessment results but did not give concrete examples that would help the family get a clear picture of why the team was concerned (e.g., examples from the M-CHAT). | Should early intervention teams be making a diagnosis of autism?  Suggest other ways the providers could have handled sharing their concerns with the parents. | 19-21, 26-27 |

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| Agreed Upon Practice for Providing Early Intervention Services in Natural Environments | No | Partly | Yes | Points to Consider | Questions to Ponder | Line # from scenario that supports rating |
| 10. Give equal weight to the family’s observations and reports about their child’s behaviors, learning, and development. | x |  |  | This was a very provider‑directed discussion. The parents were not engaged in the conversation in a meaningful way. |  | No Evidence |
| 11. In order to make the eligibility decision, review and summarize findings, sharing perspectives among the team, which includes the family. |  | x |  | The team did not get any perspectives from the family that would engage them as an equal partner in the discussion (e.g., such as asking, “How does this fit with what you are seeing at home?”) | What could have been done differently to support the parents in sharing their perspectives? | 28-31 |

**Reflection questions:**

What would you suggest to improve this team’s practices?

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Are there practices here you would like to incorporate in your practices?

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Facilitator Notes:

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# Herman Family Scenario – Part 2: Determining the Child Outcomes Summary (COS) Rating at Program Entry

## Purpose

The purpose of Herman Family Scenario – Part 2 is to provide participants an opportunity to view how a team determines the COS ratings within the context of an Individual Family Service Plan (IFSP) meeting. This scenario provides participants an opportunity to reflect on quality practices using the Child Outcomes Summary-Team Collaboration (COS-TC) Toolkit (Younggren, Barton, Jackson, Swett, Smyth, 2016), DEC Recommended Practices (DEC, 2015), and Agreed Upon Practices (Work Group on Principles and Practices in Natural Environments, 2008). Part 2 intentionally presents a range of positive and more challenging practices in order to generate a lively discussion. In Part 2, questions and ratings are only provided for Outcomes 1 and 3, in order to streamline the discussion. The following activities are intended to be used in training.

## Target Audience

Administrators and providers who deliver services in early intervention (birth to age three) and other interested stakeholders.

## Learning Objectives

* Identify the assessment practices that promote quality practices during the COS rating process.
* Apply DEC recommended assessment practices to the COS rating process.
* Improve communication skills so providers can partner with families during the COS rating process.

## Activity One: Is there a problem?

**Activity time:** 40–60 minutes

**Preparation time:** 30 minutes

**Participant handout:** Herman Family Scenario: Part 2

**Purpose:** The purpose of this activity is to provide participants an opportunity to review a COS entry rating process at an IFSP meeting while considering the Child Outcomes Summary-Team Collaboration (COS-TC, Younggren, 2015) framework. The participant ratings will form the basis for the group discussion using the questions at the end of each session and the end of the scenario.

**Step 1:** Invite participants to read each section and rate the COS-TC practices

.

**Step 2:** Based on the ratings of the COS-TC practices, facilitate a group discussion of both the strengths and the areas that could be enhanced for each section. The charts in Appendix B also include the ratings, key points, and questions to ponder that the facilitator can bring forward if they do not emerge during the group discussion.

**Step 3:** Facilitate a group discussion based on the questions provided for each session and at the end of the scenario.

**Activity variations**: This activity could be done with administrators/supervisors. Review the scenario as a group and discuss what feedback or approach participants would use with the providers.

## Activity Two: What words should I use?

**Activity time:** 40–60 minutes

**Preparation time:** 30 minutes

**Participant handout:** Herman Family Scenario: Part 2

**Purpose:** The purpose of this activity is to have participants practice their communication as they partner with parents in the COS rating process. This activity could either build on the first activity or can be an activity by itself.

**Step 1:** Have the participants read each of the sections and identify quality practices and areas that could be enhanced.

**Step 2:** Based on the ratings from the checklist in Part 2 handout, have the participants “try another way” of communicating with the family that reflects quality practices. Role plays could occur in multiple ways depending on the size of the group. Here are some possible strategies:

* Divide into groups with each group taking one of the sections. Have two individuals (parent and provider roles) volunteer to role play the areas identified as needing improvement and tag team with the group if they need support in finding the words to say.
* Divide participants into groups of three. For each group, assign a participant to role play a parent, a provider, and an observer. Have the parent and provider role play the areas identified that could be enhanced. Then have the observer reflect on the role play and offer suggestions and comments.
* **Step 3:** Have the group reflect on their experiences. How did it feel? What went well? What was difficult?

**Activity variation:** The supervisors/administrators could read the areas identified for improvement and practice how the administrators would communicate with the team in a role play situation.

# Trainer Resources for Part 2: Determining the Child Outcomes Summary (COS) Rating at Program Entry

## Ratings, Quality Practices to Consider, and Questions to Ponder

The trainer resources for part two provides the facilitator with the ratings for each of the items in the scenario. The scenario is displayed with numbered lines that facilitators can refer to as a rationale for decisions about ratings. The facilitator can use these segments as examples during the training. Below each rating table is a space for facilitators to create their own notes with points they will want to make during the training.

## Child Outcomes Summary (COS) Rating at Program Entry

## Ratings for Herman Scenario

### Planning for the COS

The developmental specialist and SLP met to review the assessment data that had been gathered. They had data from the original multidisciplinary team assessment observations of Lily from the child care center and her grandmother’s home, as well as information from an interview that was completed with Lily’s grandmother. The following is a summary of these data:

The team had gathered information about Lily’s functional skills during daily routines, through interviews with Lily’s grandmother and a short interview over the phone with her parents. The team split up, with some completing observations at Lily’s grandmother’s home and others at the child care center. Two standardized assessments, the Preschool Language Scale 4 and Bayley Scales of Infant Development-III (BSID-III), were also completed. The team had a difficult time collecting assessment information because it was hard to engage Lily in the activities. Lily attended to the activities she chose, often repeating these activities over and over. Even during preferred activities, such as playing with an iPad or shape boxes, Lily did not typically look at the adult or imitate adult actions. The child care staff reported seeing similar behavior from Lily in their program. They reported that Lily most often played by herself without initiating interactions with her peers and without imitating peers’ play.

The SLP and developmental specialist discussed Lily’s skills and behavior based on these evaluation data. They discussed Lily’s strengths and areas that they were concerned about, such as her lack of social interaction across settings.

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| 1. Planning for the COS   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed.*  *‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| --- | --- | --- | --- | --- | --- |
| **Quality Practice** | **No** | **Partly** | **Yes** | **Points to Consider** | **Line # from scenario that supports rating** |
| 1. Providers **review COS background information**, including the meaning of the three outcomes, the rating criteria, the decision tree, the descriptor statements, and the COS process *(as needed)*. | x |  |  | The providers did not review COS background information. | No Evidence |
| 1. Providers **review age-expected growth and development** for the age of the child *(as needed)*. | x |  |  | The providers did not review age-expected growth. | No Evidence |
| 1. Providers ensure that **multiple sources** of information about the child’s **current** functional skills are available for review *(e.g., parent report, child care provider, observation, evaluation, progress reports, specialists, and others who know the child)*. |  |  | x | Interview with parents, grandmother, observations at childcare center, at grandmother’s home. Assessment information from parents. | 1-4  8-9, 13 |
| 1. Providers confirm there is information about the child’s functioning for each of the **three child outcomes**. | x |  |  | The providers covered some information, but not across all outcomes. | No Evidence |
| 1. Providers confirm there is information about the child’s **current** functioning **across settings and opportunities**. |  | x |  | The providers only covered some areas of functioning. | 5-6, 13,  17-18 |
| 1. Providers consider the child’s functioning in terms of **AE-IF-F** with reference to **age-anchoring** tools and resources *(AE-age-expected, IF-immediate foundational, F-foundational)*. | x |  |  | The providers did not reference age-anchoring tools. | No Evidence |
| 1. Providers review plans for sharing information about the COS and how to engage the family in the COS decision-making process. | x |  |  | Providers did not talk about how to engage parents when they met. | No Evidence |

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| COS-TC Quality Practice to Consider | Questions to Consider |
| I.7 Providers review plans for sharing information about the COS and how to engage the family in the COS decision-making process. | What strategies could the team use to engage the parents in the process when they have limited time(e.g., make a list of lingering questions, note key things to explain to the family, etc.)? *For additional information, see the* More about it *section of quality practice I.7 in COS-TC Toolkit Descriptions and Examples.* |
| Questions to consider for group discussion:   * *What were the positive aspects of the pre-planning process?* * *What would you do to improve the pre-planning process?* | |

Facilitator Notes:

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### Background-Explaining the COS Process to Families

The service coordinator called the family to discuss the purpose of the upcoming meeting: to develop an Individualized Family Service Plan (IFSP) to support Lily and her family. She indicated that, “We will also have to come up with a rating of Lily’s functional skills to decide the extent to which Lily displays behaviors and skills expected for her age related to each of the three functional outcomes. This entry data rating is a requirement for our federal reporting.” The family expressed an understanding of the information about the child outcomes that was shared earlier.

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| 1. Explaining the COS Process to Families   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed,, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| --- | --- | --- | --- | --- | --- |
| **Quality Practice** | **No** | **Partly** | **Yes** | **Points to Consider** | **Line # from scenario that supports rating** |
| 1. Providers **explain to the family why** outcomes data are collected and **how** they are used. | x |  |  | The providers needed to describe that the data was being collected to report to the Office of Special Education Programs in order to see if the services make a difference in the child’s development and for program planning and improvement. | 4-5 |
| 1. Providers **describe the three child outcomes that** are measured. | x |  |  |  | No Evidence |
| 1. Providers **describe how** the outcome data are collected. | x |  |  |  | No Evidence |
| 1. Providers **check for family understanding** before moving on. |  | x |  | Although the parents indicated they understood the process, there were no follow-up questions to help determine their understanding of why the child outcomes data are collected. | 5-6 |

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| COS-TC Quality Practice to Consider | Questions to Consider |
| II.1 Providers **explain to the family why** outcomes data are collected and how they are used.  II.2 Providers **describe the three child outcomes that** are measured.  II.3 Providers **describe how** the outcome data are collected. | What could the team have done differently to better inform the parents about the COS rating and IFSP process (e.g., share written information, clarify each of the three outcomes, etc.)? *For additional information, see quality practices II.1 & 2 in COS-TC Toolkit Descriptions and Examples.* |
| II.4 Providers **check for family understanding** before moving on. | What words or phrases could the team have used to check the parent’s understanding of the process (e.g., ask what questions parents have or what else would be helpful)? *For additional suggestions, see Norton and Emanuel examples in quality practice II.4 in COS-TC Toolkit Descriptions and Examples.* |
| Question: to consider for group discussion   * *What additional information would have been helpful for the family to understand the COS process?* | |

Facilitator Notes:

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### Child Outcomes Summary (COS) – Understanding Child Functioning and Building Consensus for a High-Quality Rating

After introductions and a review of the purpose of the IFSP meeting, the developmental specialist and SLP engaged the family in a conversation. Together they discussed how Lily interacted with familiar and unfamiliar adults, her understanding of social rules, such as “sharing,” to what extent she understood routines and transitions, and how she played and socialized with other children (e.g., did she sit next to a child and exchange toys or imitate the child’s actions?). The providers were interested in whether her parents saw any differences in Lily’s interactions with others at home versus at child care. They explained that these are the types of skills that are related to the positive social relationships outcome. Lily’s parents described how these behaviors were often different at child care and at home, specifically Lily’s interactions with adults. At home she was more likely to hand her parents a toy she needed help with (e.g., turning on the iPad), but child care staff rarely saw this type of request. Across settings, Lily primarily imitated words, but she did not typically use words to request what she wanted (e.g., use a sign or say, “More” to make a request). The SLP indicated that we would expect two year olds to use short phrases to communicate and use language in social conversations. The SLP added she had seen, both at the grandparent’s home and child care that Lily also didn’t make much eye contact or engage in social games (e.g., “five little monkeys”). The providers reaffirmed what the parents had observed, as Lily displayed a higher level of social skills at home or at her Grandmother’s home than at child care. At the conclusion of this discussion, the developmental specialist suggested that, based on the observations and information presented, Lily was demonstrating many skills like those of a younger child in the area of positive social relationships and demonstrated fewer skills at age level. The team reached consensus that, in this outcome area, Lily demonstrates some age-expected functioning, with more skills that come in just before age-expected functioning (i.e., immediate foundational functioning).

The parents and providers agreed that this description defines Lily’s functional skills in this area.

The team then discussed the second outcome, use of knowledge and skills, following a similar process. For third outcome, taking appropriate action to meet needs, the development specialist lead the discussion. She reviewed the results of Lily’s gross and fine motor screening assessment, which was completed at the child care center. She provided many examples of the skills Lily was able to perform, e.g., stringing beads, throwing a ball, and standing on one foot with support. She indicated that on the Child Outcomes rating for Outcome 3, she would rate Lily at a level 7. She asked the parents if they had any input about that rating. They said they agreed with the test results. Following this discussion, the team began to plan the IFSP outcomes. They used the descriptive information from the discussion to identify Lily’s strengths and needs as well as other concerns the family raised to determine the outcomes for the plan.

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| 1. Understanding Child Functioning   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.*  *O1 refers to COS Outcome 1; O3 refers to COS Outcome 3.* |

| **Quality Practice** | **O1**  **No** | **O1**  **Partly** | **O1**  **Yes** | **O3**  **No** | **O3**  **Partly** | **O3**  **Yes** | **Points to Consider** | **Line # from scenario that supports rating** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Team members discuss the full **breadth of each outcome** (i.e., across the range of functioning pertinent to each outcome). |  | x |  | x |  |  | The developmental specialist provided information that was based on discreet skills, rather than functional skills.  Beginning conversation about content of O1.  No Evidence for O3. | 5-7  26-27 |
| 1. Providers invite the **family to share information** about their child’s functioning for each outcome area. |  |  | x | x |  |  | Parents provided input about what they were seeing in O1.  No Evidence for O3. | 8-12  23-24 |
| 1. Team members discuss the child’s **current functioning** in each outcome area. |  |  | X | x |  |  | Providers presented information about skills related to O1.  No Evidence for O3. | 10-11  27-29 |
| 1. Team members discuss **information from multiple sources** (e.g., family input, other observations, assessments, progress monitoring, child care providers, specialists, and neighbors) for each outcome. |  | x |  | x |  |  | There was limited information from child care providers about daily routines.  No evidence for O3. | 13-15 |
| 1. Team members discussthe child’s functioning **across settings and situations.** |  |  | x | x |  |  | Providers discussed Lily’s functioning at home and childcare for O1.  No evidence for O3. | 8-12 |
| 1. Team members discuss the child’s functioning for each outcome in sufficient **depth** to describe how the child uses skills in meaningful ways. |  |  | x | x |  |  | SLP began the discussion on a number of aspects of O1, but could have expanded the discussion, e.g. describing typical skills of 2-year-olds related to social games, or describing Lily’s interaction with other children. | 18-19 |
| 1. Team members focus onthe child’s **functional use of skills** versus discrete skills. | x |  |  | x |  |  | Limited discussion of functioning related to O1.  No Evidence for O3. | 9-12 |
| 1. Team members discuss **skills the child has and has not yet mastered.** |  |  | x | x |  |  | SLP described how Lily was using her functional skills in this area.  Parents indicated that Lily does not yet use words to initiate interactions but uses gestures.  No Evidence for O3. | 10-12  13-16 |
| 1. Team members discusshow the child’s **current use of skills** **relates to age-expected development** (AE-IF-F). |  |  | x | x |  |  | SLP described functional skills that Lily was not yet using for O1.  No Evidence for O3. | 19-21 |

Facilitator Notes:

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| COS-TC Quality Practice to Consider | Questions to Ponder |
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| III.2 Providers invitethe **family to share information** about their child’s functioning for each outcome area. | How could the team better engage the family to share information about their child at the meeting? (e.g., questions such as: What does that behavior look like? Does that describe his actions all the time?) *For additional suggestions, see Norton and Emanuel examples in quality practice III.2 in COS-TC Toolkit Descriptions and Examples.* |
| III.6 Team members discuss the child’s functioning for each outcome in sufficient **depth** to describe how the child uses skills in meaningful ways. | What prompts could be provided so a broader picture of the outcome emerged? (e.g., what happens when Lily makes eye contact? Which social games does she like most? Least?) *For additional suggestions, see Norton and Emanuel examples in quality practice III.6 COS-TC Toolkit Descriptions and Examples)* |
| III.5 Team members discussthe child’s functioning **across settings and situations.**  III.7 Team members focus onthe child’s **functional use of skills** versus discrete skills.  III.8 Team members discuss **skills the child has and has not yet mastered.** | How could they have better tied their observations and findings to a description of functional skills? (e.g., for Outcome 3, describe Lily’s skills in the context of meaningful everyday activities and routines.) *For additional information, see quality practices III.5, III.7 & III.8 in COS-TC Toolkit Descriptions and Examples.* |
| III.9 Team members discusshow the child’s **current use of skills** **relates to age-expected development** (AE-IF-F). | What strategies could you use to help parents compare and contrast Lily’s development with that of a 26 month old? (e.g., use of age anchoring tools and/or descriptions of actions for age-expected development.) *For additional information, see quality practice III.9 in COS-TC Toolkit Descriptions and Examples.* |

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| 1. Building Consensus for a High Quality COS Rating   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.*  *O1 refers to COS Outcome 1; O3 refers to COS Outcome 3.* |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Quality Practice** | **O1**  **No** | **O1**  **Partly** | **O1**  **Yes** | **O3**  **No** | **O3**  **Partly** | **O3**  **Yes** | **Points to Consider** | **Line # from scenario that supports rating** |
| 1. Team members discuss **key decisions** about the child’s functioning shown on the **decision tree** using all they know about the child’s mix of skills. |  | x |  | x |  |  | Providers began to anchor with age expectations.  No Evidence for O3. | 12-13 |
| 1. Team members discuss the **rating for each outcome in descriptive terms,** not simply as a number. |  | x |  | x |  |  | Providers discussed a number of skills in O1.  No Evidence for O3. | 12-19 |
| 1. Team members **reach consensus** for each outcome rating. |  |  | x | x |  |  | Providers used descriptive terms for O1.  No Evidence for O3. | 19-22 |
| 1. The COS **ratings are consistent with rating criteria** for all the information shared and discussed. |  | x |  | x |  |  | Limited engagement with the parents.  No Evidence for O3. | 22 |

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| Quality Practice to Consider | Questions to Ponder |
| IV.1 Team members discuss **key decisions** about the child’s functioning shown on the **decision tree** using all they know about the child’s mix of skills.  IV.2 Team members discuss the **rating for each outcome in descriptive terms*,*** not simply as a number. | Consider ways of talking about the ratings as a continuum. What words could the team have used to describe age-expected or immediate foundational or foundational skills? (e.g., abilities typical of her age, abilities that come in just before her age, etc.) *For more examples, see quality practice IV.1 in COS-TC Toolkit Descriptions and Examples.*  How could the team have integrated the information within each outcome? (e.g., use the decision tree to identify where she lies on the continuum of skills). *For more information, see quality practice IV.2 in COS-TC Toolkit Description and Examples.* |
| IV.3 Team members **reach consensus** for each outcome rating.  IV.4 The COS **ratings are consistent with rating criteria** for all the information shared and discussed. | The parents agreed with the ratings. What strategies might have supported them as a full partner in the rating discussion? (e.g., use prompts such as: What does everyone think about this rating? Is this an accurate recap of her functioning?) *For more information, see quality practices IV.3 & IV.4 in COS-TC Toolkit Description and Examples.* |
| Questions to Consider for Group Discussion   * *To what extent do you think the family got a full picture of Lily’s functioning across situations and from multiple sources? How much of this came across in the meeting?* * *Contrast the team approach discussion on Outcomes 1 and 3.* * *How could this have been handled in a different way that may have resulted in a more inclusive team decision-making process?* | |

Facilitator Notes:

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Appendix A  
Herman Family Scenario  
Communicating with Families in Early Intervention:   
A Scenario Approach

## Purpose

The Herman Family Scenario was developed as a training tool to help providers evaluate and reflect upon communication and partnership practices with families during the team assessment and Child Outcome Summary (COS) rating processes. The primary target audience for this training is early intervention providers. This scenario can be incorporated into trainings as an activity to enhance providers’ communication skills with families and to support partnerships with families in the COS rating process.

The scenario describes a family that has concerns about their two-year-old child’s development. It follows their journey through the assessment and IFSP processes. Part 1 provides a description of the assessment process and Part 2 briefly recaps the assessment process and illustrates a team working with the parents to establish the COS rating for their child. Training participants will read each narrative section and then rate the content based on set criteria. This scenario intentionally illustrates both best practice approaches and those that are less than ideal and could be improved.

## Background

Two training needs were identified in the field: (1) to effectively engage families as full partners in the assessment, and (2) to effectively incorporate quality practices in the COS rating process (DEC, 2014; Work Group on Principles and Practices in Natural Environments, 2008).

The scenario strategically identifies examples of challenging situations (e.g., communicating difficult information to families, determining ways to engage families when they have limited time or availability, finding ways to fully understand children’s functional abilities beyond conventional testing alone, etc.) to provide opportunities for the participants to problem solve and identify effective strategies that could be used in their work. The scenario was developed in part as a companion with the COS – Team Collaboration (COS-TC): Toolkit (Younggren, Barton, Jackson, Swett, Smyth, 2016).

## Part 1. Gathering assessment information as part of the eligibility process

**Meeting with the family.** The Hermans called the early intervention program because their pediatrician expressed concern regarding Lily’s communication skills. Lily was 26 months old and an only child. The service coordinator, Amber, met with the family to provide them with information about the program, the evaluation/assessment process that would be used to determine if Lily would be eligible for services, and to identify her strengths and needs. The Hermans were interested in having Lily evaluated, mostly because of their pediatrician’s concern about Lily’s language development. The service coordinator and family discussed the family's questions about Lily's development beyond what the pediatrician stated. The Hermans were worried about Lily’s communication, but otherwise did not have any concerns. They were proud that she could already play videos on the iPad and could complete simple puzzles. She played well by herself, although sometimes it was difficult to get her to transition and play something new, like interacting with them as they read books to her. They shared that Lily uses 10–20 words, but mostly imitates these words and does not use words to communicate what she wants, rather she tends to use gestures to lead her parents where she wants to go, like the snack cupboard or to the shelf where the iPad is kept.

The service coordinator thanked the family for their descriptive information about Lily and described that the first step would be to complete the assessment process. The team would set up several appointments to evaluate Lily’s skills across all developmental areas. If Lily were found to be eligible, the early intervention program would provide the services she needed. Amber explained that services and supports would be available to Lily and her family and could be provided either in their home or in a child care setting, whichever worked best for the family. The parents said that they would like the assessments to take place as soon as possible but that they also had limited time to meet with the team. They indicated that they both had busy work schedules and asked if the assessments could be completed at Lily’s grandmother’s home or at the child care center where Lily spends the day. Amber gave the parents two forms to complete, the Ages and Stages Questionnaire and the Modified Checklist for Autism in Toddlers (M-CHAT). She briefly explained that this information would help the team have a better understanding of Lily’s skills at home

*After reading the section above, please rate the extent to which the following best practice approaches were illustrated.*

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| **Meeting With the Family**  *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent; and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| --- | --- | --- | --- |
| DEC Recommended Practice | No | Partly | Yes |
| A1. Practitioners work with the family to identify family preferences for assessment processes. |  |  |  |
| F1. Practitioners build trusting and respectful partnerships with the family through interactions that are sensitive and responsive to cultural, linguistic, and socio-economic diversity. |  |  |  |
| Agreed Upon Practice for Providing Early Intervention Services in Natural Environments | No | Partly | Yes |
| 1. Become acquainted and develop rapport. |  |  |  |
| 2. Engage in conversation to find out why the family is contacting early intervention and to identify the next appropriate steps in the referral process. |  |  |  |
| 3. Describe early intervention as a system of supports and services for families to assist them in helping their children develop and learn. |  |  |  |

**Reflection questions:**

What would you suggest to improve this team’s practices?

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Are there practices here you would like to incorporate in your practices?

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The assessment process. Based on family preference, the majority of the assessments were completed at Lily’s child care center and through an interview with her grandmother. The assessments took two weeks to schedule and complete. The multidisciplinary assessment team (MDT) included the psychologist, speech/language pathologist (SLP), and developmental specialist. The team members worked together to schedule times to complete their assessments with Lily’s child care center staff and grandmother. They gathered information about Lily’s functional skills during daily routines through interviews with Lily’s grandmother and a short interview over the phone with her parents. Two standardized assessments [i.e., the Preschool Language Scale 4 and Bayley Scales of Infant Development-III (BSID-III, cognitive subscale)] also were completed. The team had a difficult time collecting assessment information because it was hard to engage Lily in the activities. Lily attended to the activities she chose, frequently repeating the activity over and over (e.g., repeatedly putting the puzzle pieces in and out). Even during preferred activities, such as playing with an iPad or shape boxes, Lily did not typically look at the adult or imitate adult actions The child care staff reported seeing similar behavior from Lily in their program. They reported that Lily most often played by herself without initiating interactions with her peers and without imitating peers’ play. The child care staff also reported she rarely used words to communicate what she needed or to interact with the other children. The assessment team will synthesize the information gathered across these settings and from the people who know Lily best and will share it at the multidisciplinary team meeting with the parents.

*After reading the section above, please rate the extent to which the following best practice approaches were illustrated.*

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| **The Assessment Process**  *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

| DEC Recommended Practice | No | Partly | Yes |
| --- | --- | --- | --- |
| A2. Practitioners work as a team with the family and other professionals to gather assessment information. |  |  |  |
| A3. Practitioners use assessment materials and strategies that are appropriate for the child’s age and level of development and accommodate the child’s sensory, physical, communication, cultural, social, and emotional characteristics. |  |  |  |
| A4. Practitioners conduct assessments that include all areas of development and behavior to learn about the child’s strengths, needs, preferences, and interests. |  |  |  |
| A6. Practitioners use a variety of methods, including observation and interviews, to gather assessment information from multiple sources including the child’s family and other significant individuals in the child’s life. |  |  |  |
| A7. Practitioners obtain information about the child’s skills in daily activities, routines, and environments such as home, center, and community. |  |  |  |
| A8. Practitioners use clinical reasoning in addition to assessment results to identify the child’s present levels of functioning and to determine the child’s eligibility and plan for instruction. |  |  |  |
| Agreed Upon Practice for Providing Early Intervention Services in Natural Environments | No | Partly | Yes |
| 10. Evaluate and assess the functional needs and strengths of the child. |  |  |  |
| 11. Throughout the assessment process, observe and ask the family about their teaching and learning strategies with their child. |  |  |  |

**Reflection questions:**

What would you suggest to improve this team’s practices?

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Are there practices here you would like to incorporate in your practices?

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**Joining with the Family to Review the Results of the Initial Assessment.** The service coordinator briefly talked with Lily’s mother over the phone to schedule the meeting to discuss the results of the assessments. Amber shared that the providers completed standardized assessments with Lily and observed her at the child care center and at her grandmother’s home. She asked Mrs. Herman if she had any questions about the process; Mrs. Herman indicated that she did not have questions. Together they coordinated a time for the meeting; it was scheduled for the next time the team had an opening, which was the following week.

At the meeting, the team greeted the family and then the service coordinator began the meeting by describing the assessments and observations that were completed. The psychologist described the results of the standardized assessment, the BSID-III, including the cognitive and language domains. She explained that this assessment is designed to evaluate how Lily is doing compared to other children her age and that it provides one source of information on her strengths and areas that are less well‑developed. Her strengths on this assessment were in the area of her learning or cognitive skills. For example, areas of strength for Lily were her problem solving skills (e.g., she tried a number of different strategies to place puzzle pieces into a form board) and matching skills (e.g., Lily matched pictures to pictures). The psychologist reported that overall, Lily is doing well in the area of cognitive skills. Lily’s score of 92 places her within the average range, which includes scores from 85 to 115.

The speech/language pathologist (SLP) reported that the main area of concern seen in the assessment results matched what the parents had described: how Lily has limited functional use of language when interacting with others. She indicated that the results of the standardized assessments and the informal observations at the child care center and grandmother’s home found that Lily is demonstrating significant communication delays, with scores in the low 70s (Lily’s overall score on Receptive Language Skills was 72 and on Expressive Language Skills, Lily scored 74 overall). These skills are significantly below the average range (i.e., 85-115). These assessments confirmed the parents’ observations that although Lily knew and could express several words, she typically did not use them to communicate with others. Based on her delays in language development, Lily would be eligible for early intervention services in our program.

In addition, the psychologist indicated, “Lily is also demonstrating delays in the ways she socializes which interfered with how she interacted with adults and children during our observations. The behaviors we saw were consistent with children with autism. In addition, your completion of the M-CHAT indicates behaviors associated with autism. We would suggest that you make an appointment with your pediatrician to confirm our suspected diagnosis.” The team then asked the family if they had any questions.

The family was stunned and did not immediately respond. Mrs. Herman began to cry. Mr. Herman asked, “Don’t most 2-year-olds act like Lily?” He did not see any problem with her behavior. The parents said they were only concerned about her language. It didn’t seem like Lily could have autism: “Wouldn’t our pediatrician have suggested this was a problem?” Mr. Herman said that he wanted to get a second opinion. The family expressed that they needed time to talk together about the news they heard. They wanted to go back and discuss the findings with their physician, with whom they had a good relationship, and they would follow up with the service coordinator later (maybe) by calling her to let her know the next steps they wanted to take. The services coordinator indicated that she would call the Hermans the following week.

*After reading the section above, please rate the extent that the following best practice approaches were illustrated.*

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| Joining with the Family to Review the Results of the Initial Assessment *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed to a limited extent, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| DEC Recommended Practice | No | Partly | Yes |
| A11. Practitioners report assessment results so that they are understandable and useful to families. |  |  |  |
| F1. Practitioners build trusting and respectful partnerships with the family through interactions that are sensitive and responsive to cultural, linguistic, and socio-economic diversity. |  |  |  |
| F2. Practitioners provide the family with up-to-date, comprehensive, and unbiased information in a way that the family can understand and use to make informed choices and decisions. |  |  |  |
| Agreed Upon Practice for Providing Early Intervention Services in Natural Environments | No | Partly | Yes |
| 10. Give equal weight to the family’s observations and reports about their child’s behaviors, learning, and development. |  |  |  |
| 11. In order to make the eligibility decision, review and summarize findings, sharing perspectives among the team, which includes the family. |  |  |  |

**Reflection questions:**

What would you suggest to improve this team’s practices?

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Are there practices here you would like to incorporate in your practices?

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## Part 2. Determining the Child Outcomes Summary (COS) rating at program entry

This section is focused on the IFSP meeting and specifically the COS rating process. The multidisciplinary team meeting section below is a recap of Part 1 of the scenario. You can skip this section and start at the provider pre-meeting if you have read Part 1 of the scenario.

**Multidisciplinary Team (MDT) Meeting:** The Hermans contacted the early intervention program because their pediatrician expressed concern regarding their daughter Lily’s communication skills. Lily is 26 months old and is only child. The service coordinator met with the family to provide them with information about the program and the assessment process that would be used to determine if Lily was eligible for services. The Hermans were interested in having Lily evaluated. They had been worried about Lily’s language ever since their pediatrician voiced his concern. Otherwise, they did not have any concerns about their daughter’s development. The team completed their assessments and met with the family to review the findings. The providers first discussed Lily’s strengths and then talked about their concerns regarding her functional language skills. They shared that her behavior was consistent with a child with autism, which was upsetting to the family. Mr. Herman said that they wanted to get a second opinion. The meeting ended abruptly at this point. The service coordinator indicated that she would call the Herman’s the following week.

The Hermans met with their pediatrician in consultation with the psychologist in his clinic and the diagnosis of autism was confirmed and discussed with the family. Following that appointment, the Herman’s decided that early intervention services would be the best thing for Lily. They called their service coordinator who indicated since Lily qualified for services based on the assessments completed earlier, the next step would be to schedule a time for the parents to meet with the team to review Lily’s current levels of functioning, develop an IFSP, as a team determine the type of services and supports that would best support Lily and her family, and complete the Child Outcome Summary ratings.

**Provider pre-meeting: Planning for the COS**. The developmental specialist and SLP met to review the assessment data that had been gathered. They had data from the original multidisciplinary team assessment observations of Lily from the child care center and her grandmother’s home, as well as information from an interview that was completed with Lily’s grandmother. The following is a summary of these data:

The team had gathered information about Lily’s functional skills during daily routines through interviews with Lily’s grandmother and a short interview over the phone with her parents. The team split up, with some completing observations at Lily’s grandmother’s home and others at the child care center. Two standardized assessments, the Preschool Language Scale 4 and Bayley Scales of Infant Development-III (BSID-III), were also completed. The team had a difficult time collecting assessment information because it was hard to engage Lily in the activities. Lily attended to the activities she chose, often repeating these activities over and over. Even during preferred activities, such as playing with an iPad or shape boxes, Lily did not typically look at the adult or imitate adult actions. The child care staff reported seeing similar behavior from Lily in their program. They reported that Lily most often played by herself without initiating interactions with her peers and without imitating peers’ play.

The SLP and developmental specialist discussed Lily’s skills and behavior based on these evaluation data. They discussed Lily’s strengths and areas that they were concerned about, such as her lack of social interaction across settings.

*After reading the section above, please rate the extent to which the following best practice COS approaches were illustrated.*

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| 1. Planning for the COS (based on the COS-TC Toolkit checklist)   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| **Quality Practice** | **No** | **Partly** | **Yes** |
| 1. Providers review COS background information, including the meaning of the three outcomes, the rating criteria, the decision tree, the descriptor statements, and the COS process *(as needed)*. |  |  |  |
| 1. Providers **review age-expected growth and development** for the age of the child *(as needed).* |  |  |  |
| 1. Providers ensure that **multiple sources of information** about the child’s functioning are available for review *(e.g., parent report, child care provider, observation, evaluation, progress reports, and specialists, and others who know the child)*. |  |  |  |
| 1. Providers confirm there is information about the child’s functioning for each of the **three child outcomes.** |  |  |  |
| 1. Providers confirm that there is information about the child’s **current** functioning **across settings and situations**. |  |  |  |
| 1. Providers consider the child’s functioning in terms of **AE-IF-F** with reference to **age-anchoring** tools and resources. *(AE age-expected, IF-immediate foundational, F-foundational)* |  |  |  |
| 1. Providers review plans for sharing information about the COS and how to engage the family in the COS decision-making process. |  |  |  |

**Background-Explaining the COS Process.** The service coordinator called the family to discuss the purpose of the upcoming meeting: to develop an Individualized Family Service Plan (IFSP) to support Lily and her family. She indicated that, “We will also have to come up with a rating of Lily’s functional skills to decide the extent to which Lily displays behaviors and skills expected for her age related to each of the three functional outcomes. This entry data rating is a requirement for our federal reporting.” The family expressed an understanding of the information about the child outcomes that was shared earlier.

*After reading the section above, please rate the extent to which the following best practice COS approaches were illustrated.*

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| 1. Explaining the COS Process to Families   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ to indicates that the practice is observed some of the time or some, but not all, of the practice is observed,, and ‘Yes’ indicates that the practice is fully observed most or all of the time.* |

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| **Quality Practice** | **No** | **Partly** | **Yes** |
| 1. Providers **explain to the family why** outcomes data are collected and **how** they are used. |  |  |  |
| 1. Providers **describe the three child outcomes** that are measured. |  |  |  |
| 1. Providers **describe how** the outcome data are collected. |  |  |  |
| 1. Providers **check for family understanding** before moving on. |  |  |  |

**Child Outcomes Summary (COS) – Understanding Child Functioning and Building Consensus for a High‑Quality Rating.** After introductions and a review of the purpose of the IFSP meeting, the developmental specialist and SLP engaged the family in a conversation. Together they discussed how Lily interacted with familiar and unfamiliar adults, her understanding of social rules, such as “sharing,” to what extent she understood routines and transitions, and how she played and socialized with other children (e.g., did she sit next to a child and exchange toys or imitate the child’s actions?). The providers were interested in whether her parents saw any differences in Lily’s interactions with others at home versus at child care. They explained that these are the types of skills that are related to the positive social relationships outcome. Lily’s parents described how these behaviors were often different at child care and at home, specifically Lily’s interactions with adults. At home she was more likely to hand her parents a toy she needed help with (e.g., turning on the iPad), but child care staff rarely saw this type of request. Across settings, Lily primarily imitated words, but she did not typically use words to request what she wanted (e.g., use a sign or say, “More” to make a request). The SLP indicated that we would expect two year olds to use short phrases to communicate and use language in social conversations. The SLP added she had seen, both at the grandparents’ home and child care that Lily also didn’t make much eye contact or engage in social games (e.g., “five little monkeys”). The providers reaffirmed what the parents had observed, as Lily displayed a higher level of social skills at home or at her Grandmother’s home than at child care. At the conclusion of this discussion, the developmental specialist suggested that, based on the observations and information presented, Lily was demonstrating many skills like those of a younger child in the area of positive social relationships and demonstrated fewer skills at age level. The team reached consensus that, in this outcome area, Lily demonstrated some age-expected functioning, with more skills that come in just before age-expected functioning (i.e., immediate foundational functioning).

The parents and providers agreed that this description best defined Lily’s functional skills in this area.

The team then discussed the second outcome, use of knowledge and skills, following a similar process. For third outcome, taking appropriate action to meet needs, the developmental specialist lead the discussion. She reviewed the results of Lily’s gross and fine motor screening assessment, which was completed at the child care center. She provided many examples of the skills Lily was able to perform, e.g., stringing beads, throwing a ball, and standing on one foot with support. She indicated on the Child Outcomes rating for Outcome 3, she would rate Lily at a level 7. She asked the parents if they had any input about that rating. They said they agreed with the test results. Following this discussion, the team began to develop the IFSP outcomes. They used the descriptive information from the discussion to identify Lily’s strengths and needs as well as other concerns the family raised to determine the outcomes for the plan.

*After reading the section above, please rate the extent that the following best practice COS approaches were illustrated.*

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| 1. Understanding Child Functioning   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.*  *O1 refers to COS Outcome 1; O3 refers to COS outcome 3.* |

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| **Quality Practice** | **O1**  **No** | **O1**  **Partly** | **O1**  **Yes** | **O3**  **No** | **O3**  **Partly** | **O3**  **Yes** |
| 1. Team members discuss the full **breadth of each outcome** (i.e., across the range of functioning pertinent to each outcome). |  |  |  |  |  |  |
| 1. Providers invitethe **family to share information** about their child’s functioning for each outcome area. |  |  |  |  |  |  |
| 1. Team members discuss the child’s **current functioning in** each outcome area. |  |  |  |  |  |  |
| 1. Team members discuss **information from multiple sources** (e.g., family input, other observations, assessments, progress monitoring, child care providers, specialists, and neighbors) for each outcome. |  |  |  |  |  |  |
| 1. Team members discussthe child’s functioning **across settings and situations**. |  |  |  |  |  |  |
| 1. Team members discuss the child’s functioning for each outcome in sufficient **depth** to describe how the child uses skills in meaningful ways. |  |  |  |  |  |  |
| 1. Team members focus onthe child’s **functional use of skills** versus discrete skills. |  |  |  |  |  |  |
| 1. Team members discuss **skills the child has and has not yet mastered**. |  |  |  |  |  |  |
| 1. Team members discusshow the child’s **current use of skills** **relates to age-expected development** (AE-IF-F). |  |  |  |  |  |  |

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| 1. Building Consensus for a High Quality COS Rating   *Place a checkmark in the appropriate column to indicate the extent to which there is evidence that each quality practice is observed. ‘No’ indicates that the practice is not observed, ‘Partly’ indicates that the practice is observed some of the time or some, but not all, of the practice is observed, and ‘Yes’ indicates that the practice is fully observed most or all of the time.*  *O1 refers to COS Outcome 1; O3 refers to COS outcome 3.* |

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| **Quality Practice** | **O1**  **No** | **O1**  **Partly** | **O1**  **Yes** | **O3**  **No** | **O3**  **Partly** | **O3**  **Yes** |
| 1. Team members discuss **key decisions** about the child’s functioning shown on the **decision tree** using all they know about the child’s mix of skills. |  |  |  |  |  |  |
| 1. Team members discuss the **rating for each outcome in descriptive terms**, not simply as a number. |  |  |  |  |  |  |
| 1. Team members **reach consensus** for each outcome rating. |  |  |  |  |  |  |
| 1. The COS **ratings are consistent with rating criteria** for all the information shared and discussed. |  |  |  |  |  |  |