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Wendy Whipple, Program Specialist
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KEY PRINCIPLES OF EARLY INTERVENTION AND EFFECTIVE PRACTICES: A CROSSWALK WITH PEDIATRIC MEDICINE LITERATURE

Many states have been evaluating their early intervention practices and undergoing system change to incorporate effective practices related to providing services within the natural environment, as well as implementing a primary service provider approach based on the family and child's needs. This document provides a crosswalk that illustrates effective early intervention practices and relevant statements from disciplines providing early intervention services.

This document highlights how pediatric medicine literature supports the early intervention key principles and reflects how pediatric services align with high quality early intervention practices. It is intended to promote dialogue within the early childhood community, including pediatricians, about the key principles and provision of high quality early intervention services, which each profession provides within their profession's scope of practice.

The starting point for this document was the "*AGREED UPON PRACTICES FOR PROVIDING EARLY INTERVENTION SERVICES IN NATURAL ENVIRONMENTS*" document, which includes practices that support the key principles of providing early intervention services in natural environments. The document, developed by the Workgroup on Principles and Practices in Natural Environments, reflects practices validated through research, model demonstration, and outreach projects implemented by workgroup members. The document includes the consensus opinions of the workgroup members, who avoided endorsing any specific model or approach.

The national workgroup included Susan Addision, Betsy Ayankoya, Mary Beth Bruder, Carl Dunst, Larry Edelman, Andy Gomm, Barbara Hanft, Cori Hill, Joicey Hurth, Grace Kelley, Anne Lucas, Robin McWilliam, Stephanie Moss, Lynda Pletcher, Dathan Rush, M'Lisa Shelden, Mary Steenberg, Judy Swett, Nora Thompson, Julianne Woods, and Naomi Younggren.

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- Workgroup on Principles and Practices in Natural Environments (2007). *Agreed upon practices for providing early intervention services in natural environments*. OSEP TA Community of Practice—Part C Settings.
  Agreed upon Practices for Providing Early Intervention Services in Natural Environments
- Workgroup on Principles and Practices in Natural Environments (February 2008). *Seven key principles: Looks like/doesn't look like*. OSEP TA Community of Practice—Part C Settings.
  Seven Key Principles: Looks Like/Doesn't Look like

The principles identified in this document were cross-walked with statements from pediatric medicine literature that supports the early intervention key principles. In some instances, the literature may use different terms to refer to the principles and practices. This document reflects statements found in pediatric medicine literature, but it does not attribute meaning to those statements. References used in developing this publication are included at the end of this document.

Early Intervention Key Principles	Supporting Statements from Pediatric Medicine Literature
1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts • Learning activities and opportunities must be functional, based on child and family interest and enjoyment • Learning is relationship-based • Learning should provide opportunities to practice and build upon previously mastered skills • Learning occurs through participation in a variety of enjoyable activities	• Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
2. All families, with the necessary supports and resources, can enhance their children's learning and development • All means ALL (income levels, racial and cultural backgrounds, educational levels, skill levels, living with varied levels of stress and resources) • The consistent adults in a child's life have the greatest influence on learning and development-not EI providers • All families have strengths and capabilities that can be used to help their child • All families are resourceful, but all families do not have equal access to resources • Supports (informal and formal) need to build on strengths and reduce stressors so families are able to engage with their children in mutually enjoyable interactions and activities	• Strong connections within a loving, supportive family, along with opportunities to interact with other children and grow in independence in an environment with appropriate structure, are important assets in a child's life.
3. The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child's life • EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child's development • Families are equal partners in the relationship with service providers • Mutual trust, respect, honesty and open communication characterize the family-provider relationship	• Families and providers work together as partners at all levels of decision making. • The concerns of both parents and child health professionals should be included in determining whether surveillance suggests that the child may be at risk of developmental problems. • A medical home provides patient- and family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life. • Providing sufficient information, encouraging partnership, being sensitive to values and customs, spending enough time, and listening to the family's concerns are core elements of a medical home.

Early Intervention Key Principles	Supporting Statements from Pediatric Medicine Literature
4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs • Families are active participants in all aspects of services • Families are the ultimate decision makers in the amount, type of assistance and the support they receive • Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly • The adults in a child's life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals • Each family's culture, spiritual beliefs and activities, values and traditions will be different from the service provider's (even if from a seemingly similar culture); service providers should seek to understand, not judge • Family "ways" are more important than provider comfort and beliefs (short of abuse/neglect)	• Patients and families participate in quality improvement activities at the practice level. • Families are respected and listened to and receive appropriate information necessary to share in decision making on behalf of their child.
5. IFSP outcomes must be functional and based on children's and families' needs and priorities • Functional outcomes improve participation in meaningful activities • Functional outcomes build on natural motivations to learn and do; fit what's important to families; strengthen naturally occurring routines; enhance natural learning opportunities • The family understands that strategies are worth working on because they lead to practical improvements in child & family life • Functional outcomes keep the team focused on what's meaningful to the family in their day to day activities	• Parents and child health professionals have valuable observation skills, and they share the goal of ensuring optimal health and developmental outcomes for the child. In the optimal situation, the child health professional elicits parental observations, experiences, and concerns and recognizes that parental concerns mandate serious attention. • Emphasize care that puts the patient first, emphasizes open communication, and supports the patient and his or her caregivers. • Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. • Management plans should be based on a comprehensive need assessment conducted with the family. • A medical home means that your pediatric primary care provider knows your child's health history, listens to your concerns and needs (as well as your child's), treats your child with compassion, has an understanding of his/her strengths, develops a care plan with you and your child when needed, and respects and honors your culture and traditions.
6. The family's priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support	• The medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty, ancillary and related community services.

Early Intervention Key Principles	Supporting Statements from Pediatric Medicine Literature
• The team can include friends, relatives, and community support people, as well as specialized service providers • Good teaming practices are used • One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family's life • The primary provider brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won't overwhelm or confuse family members	• Establishing an effective and efficient partnership with early childhood professionals is an important ingredient of successful care coordination for children within the medical home.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations • Practices must be based on and consistent with explicit principles • Providers should be able to provide a rationale for practice decisions • Research is on-going and informs evolving practices • Practice decisions must be data-based and ongoing evaluation is essential • Practices must fit with relevant laws and regulations • As research and practice evolve, laws and regulations must be amended accordingly	• Decisions regarding appropriate therapies and their scope and intensity should be determined in consultation with the child's family, therapists, and educators (including early intervention or school-based programs) and should be based on knowledge of the scientific evidence for their use. • Evidence-based medicine and clinical decision-support tools guide decision making.

SOURCES

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