Quick Guide to FIT Program Practices
For Contracted Service Providers

Developed November 2012
This manual provides a very brief overview of many of the basic concepts/requirements for the Family Infant Toddler (FIT) Program, and is not intended as a substitute for specific training, FIT regulations or the FIT service definitions and standards. For a more thorough look at FIT rules, please visit the FIT Program website at www.fitprogram.org

Special thanks to the New Mexico Interagency Coordinating Council (ICC) for their work on this project.
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Welcome to our agency. We are an early intervention provider for the New Mexico Family Infant Toddler (FIT) Program.

As a contracted service provider of this agency, this manual provides you with a brief overview of the New Mexico Part C Early Intervention philosophy, principles, terminology, and processes. As noted earlier, this manual touches on many of the basic concepts/requirements for the FIT Program, **and is not intended as a substitute for training, FIT regulations and the FIT service definitions and standards**. For a more thorough look at FIT rules, please visit the FIT Program website at [www.fitprogram.org](http://www.fitprogram.org)

We are pleased that you will be working with us in providing quality support and services to the families of children with identified disabilities or those at-risk for developmental delay in New Mexico. We want you to be knowledgeable about the framework under which Part C services are provided and hope that you will embrace the FIT Philosophy in order to best serve infants/toddlers and their families. This understanding will assist you in working in a collaborative partnership with families and with other program employees.

After you have an opportunity to review this manual, let’s plan on discussing some of the concepts. Don’t hesitate, at any point, to let us know if you have questions regarding any of the materials in this manual.

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**The following letter from a parent is the best introduction to this manual:**

*As a parent of a child who has gone through FIT services, I would like to take a moment to thank you.*

First, thank you for your dedication in service to our youngest children. Your work in their lives not only assures that they can get the best start possible but it also encourages the families. Whether you are working with a family who is facing a lifelong disability in their child or with a family who just need a little help getting their child down that road to success, your time in their home and with them will forever change the families outlook and future as you all work together for the benefit of the child.

Secondly, I would like to thank you for taking the time both to read through this manual and also to use it to refer back to as you work as a contractor in the FIT system. As a parent, it can often be overwhelming and intimidating to have so many people in and out of your home. Consistency between all these people became very important not only to my child but to the whole family. Many families will have a child in FIT for up to 3 years and others may have more than one child go through FIT. Knowing what to expect and how the system works is very comforting. We live in an every changing world and it is not always possible to have the same group of people working with your child and family. As those assisting your family may change over the years, it is nice to know that you are all working from the same manual and following the same guidelines.

*Thanks again for the difference you are making in the lives of families all over our state.*

**A grateful parent**
Family Infant Toddler (FIT) Program

The FIT Program is a statewide program that provides early intervention services to infants & toddlers (under the age of three) who have, or are at-risk for, a developmental delay and their families in New Mexico. Early intervention provides activities and strategies for families to use to promote their child’s development throughout the day. **Early intervention services may begin at any time between birth and age three; however, when early intervention is needed, the earlier it is provided, the better the outcome for the child and family.**

Early intervention’s supports and services include evaluations of a child’s strengths and needs; individualized learning experiences; special therapies, such as physical, occupational, and/or speech and language therapy; family supports, such as home visits; family service coordination; and transition supports to facilitate a smooth change from early intervention to preschool programs. These services may be provided in homes, childcare centers, Early Head Start programs, or other early childhood settings.

In New Mexico, Part C early intervention services are provided under the Department of Health Family Infant Toddler (FIT) Program. The FIT Program is a state and federally-funded entitlement program for families whose child is under the age of three and has, or is at-risk for, a developmental delay or disability.

Early intervention can make a lifetime of difference!
From Entry to Exit in the FIT Program

Below, a flow chart illustrates the major events that occur in the FIT Program. Each event has associated timelines and specific requirements, but is discussed in only general terms here.

**Child Identification**
There is a concern about the development of a child, who is under the age of 3 and living in New Mexico.

**Referral and Intake**
Referral is made to a FIT Provider by calling a provider in the community where the family lives. The FIT Provider arranges for a developmental evaluation with the child's family within 45 days from the date of referral.

**Comprehensive Multidisciplinary Evaluation (CME)**
The developmental evaluation occurs at the family's home or a community location where the child is most comfortable. An evaluation report is written summarizing findings and making recommendations regarding the child's eligibility.

**Eligibility Determination**
- Child is found not eligible for FIT Program services
  - Child will be referred to the ASK Project that will administer and track development every three months using the Ages & Stages Questionnaire (ASQ) screening tool. The child will be followed until the child turns three years of age.
  - Child's family is provided with information on growth and development.
  - Referrals to other community resources, if appropriate, are made
  - Child may be re-evaluated at a later date.

- Child is found eligible for FIT Program services

**Individualized Family Service Plan (IFSP)**
At a setting and time convenient for the family, an initial IFSP will be developed. The child’s caregiver(s) will work in coordination with a team of professionals and will determine individualized outcomes for the child and family and the services necessary to meet those outcomes. Services are delivered according to the IFSP. Ongoing assessments are done, and the IFSP is reviewed every 6 months to determine progress toward outcomes.

**Early Child Outcome (ECO) determination**
In addition to developing individualized outcomes for the IFSP, ratings will be determined for three common outcomes for all children. These ratings will be compared to ratings conducted at the child’s exit to determine progress.

**Transition**
All children must transition at age 3. Transition planning will occur to ensure a smooth and effective transition of the child and family from the FIT Program to other resources in the community, such as the public school’s preschool special education services, Head Start, or community care and education programs. Transition planning is a multistep process, but will be finalized at an annual IFSP or transition conference meeting which will occur at least 90 days but not more than 9 months prior to the child’s third birthday, where representatives from both the current EI Provider and the transitioning agencies are present.
Qualifying a Child for Early Intervention Services

Once a child is referred for FIT early intervention services, an intake is completed and a Comprehensive Multidisciplinary Evaluation (CME) is scheduled. The CME involves professionals trained in different areas, such as a developmental specialist and a therapist. These professionals use assessment tools to look at the child’s abilities and needs. This information is used to determine eligibility for the FIT Program, as well as for recommending outcomes and strategies. At least two professionals from two different fields of expertise will conduct an evaluation. The evaluation must involve assessment activities in the following areas of development:

- **Adaptive or self-help skills** – such as bathing, feeding, dressing, toileting
- **Cognitive skills** – such as thinking, learning, reasoning, and problem-solving
- **Communication skills** – such as understanding and using words or gestures
- **Physical development** – such as vision, hearing, movement, and health
- **Social/emotional development** – such as feelings, getting along with others, and relationships.

Children may be determined eligible according to the following four eligibility requirements:

- **Developmental Delay:**
  - *25% or more delay in one area of development using FIT Approved Tool*
  - *If FIT approved tool does not indicate a 25% delay, a domain specific tool may be used to establish eligibility if the score is 1.5 or more standard deviations below the mean*
  - *If developmental level cannot be gained through the use of tools, informed clinical opinion of "significant atypical development"*

- **Established Condition:**
  A condition that has a high probability of causing a developmental delay, such as vision or hearing loss, Down Syndrome, cerebral palsy, etc.

- **Medical/biological Risk:**
  Medical or biological factors, such as low birth weight or prematurity that places the child at risk for a developmental delay.

- **Environmental Risk:**
  Environmental conditions that could affect the child’s development.

Once a child is determined eligible for the program, a Family Service Coordinator is assigned to complete an Individualized Family Service Plan (IFSP) and follow the family throughout their duration in Early Intervention.
The IFSP

The Individualized Family Service Plan (IFSP) is a service plan written specifically for a child and their family. The plan will focus on changes the family wants to see for their child and family as a result of participation in the early intervention program. These changes are referred to as “outcomes.”

The plan will include details of the early intervention services in which the child and family will participate – including how, when, where, and how often services will be delivered. The plan is a written document that can be changed and modified as the child and family’s needs change. Early intervention professionals (i.e., you) will work as a team to develop the IFSP. This plan is unique to each child and family and includes the following:

- What things the child is doing well upon which parents would like to build and strengthen.
- What parents would like to see changed for their child and family as a result of early intervention.
- What will need to happen to help make these changes occur (This will be a description of the people who will interact with the child and family, and the activities that will be worked into their daily routines to help make these changes happen).
- What kinds of early intervention services will be provided to help parents and other people in the child’s life make the identified changes.

Because of the importance of starting services early for infants and toddlers who are eligible for the FIT Program, the IFSP must be completed within 45 days of referral and any services listed on the IFSP must initially be delivered within 30 days of the IFSP start date.

The ECO Measurement

Early Child Outcome (ECO) information is required by the IDEA (Individuals with Disabilities Education Act of 2004). This outcome information is different from the individual outcomes developed for the IFSP in that these outcomes were developed at a federal level and are measured for all children. This information is needed to make improvements in statewide services and to justify money spent on early intervention.

Developmental assessment information about each child served is needed to determine if progress has been made. The information includes three early childhood outcomes: (1) Children have positive social relationships, (2) Children acquire and use knowledge and skills (like early communication skills), and (3) Children take appropriate action to meet their needs.

Assessment information is used to compare the child with typically developing children of the same age, and ECO ratings are assigned. ECO data is collected for all children at entrance, annually, and at exit to determine the level of progress made in each area.
FIT Services

FIT services support families in meeting their child's developmental and health-related needs. Service providers offer ideas on how parents can best help promote their child's development and how to use their suggestions for intervention in their everyday routines. There are opportunities for children to learn and develop throughout the day, both when the service providers are present with the family and when they are not. Services that may be received in the FIT Program are:

- **Family Service Coordination (FSC):**
  Family Service Coordinators work with a family throughout their time in early intervention. Family Service Coordinators coordinate and assist in the development and review of the Individualized Family Service Plan (IFSP). Family Service Coordinators make sure the family/child receives the services that are on the IFSP and help access support services, such as parent groups, child care, health, or family support services, etc. Every family receives Family Service Coordination. Like an air traffic controller, Family Service Coordinators are in constant communication with the family and other service providers.

- **Occupational Therapy:**
  Occupational Therapists help families and caregivers enable children to gain skills needed for play and daily living activities, design and provide adaptive and assistive devices, as well as, address the sensory motor and fine motor needs of the child.

- **Physical Therapy:**
  Physical Therapists help families and caregivers enhance the child’s movement abilities (including crawling, standing, walking, and balance) through therapeutic activities, and appropriate positioning with adaptive and assistive devices that can be incorporated in the child’s typical day.

- **Speech and Language Therapy:**
  Speech and Language Pathologists help families and caregivers enhance the child’s understanding of language and develop communication skills, which may include speech, signs, and/or gestures.

- **Developmental Instruction:**
  Developmental Specialists design and facilitate developmentally appropriate activities that families and caregivers may include in the child’s typical day and within all developmental areas.

- **Social Work:**
  Social Workers coordinate community resources and services to enable the child and family to receive maximum benefits from early intervention services.
Any time a service you are providing is listed on the IFSP, you must initially deliver that service within 30 days of the start date on the IFSP.

- **Family Therapy, Counseling, and Training:** Social Workers, Counselors, and other qualified personnel assist the family in understanding their child’s behavior and improve child and family interaction and other parenting skills.

- **Vision Services:** A vision specialist provides evaluation and assessment of vision, visual and mobility training, as well as referral to medical and other necessary professional services.

- **Audiology:** An audiologist or hearing specialist assesses a child’s hearing and other auditory services (including hearing aids or specific training regarding amplification needs).

- **Adaptive Equipment & Assistive Technology:** Devices or services are used to increase, maintain, or improve the functional capabilities of a child to improve independence in daily activities.

- **Medical Services for Diagnostic & Evaluation Purposes:** Licensed Physicians determine a child’s developmental status and other information related to the need for early intervention.

- **Health Services:** These services enable a child to benefit from the provision of other early intervention services (e.g., clean intermittent catheterization, tracheotomy care, tube feeding).

- **Nursing Services:** A Nurse assesses health status and provides nursing care to restore or improve functioning, promotes optimal health and development, and administers medications, treatments, and regimens prescribed by a physician.

- **Nutrition Services:** Nutritionists develop and monitor appropriate plans to address the nutritional needs of eligible children, particularly around feeding skills and feeding problems.

- **Psychological Services:** Psychologists provide psychological counseling for children and parents or family counseling and/or psychology assessment.

- **Transportation Services:** Supports the family with the cost of travel and other related costs that are necessary to enable the child and family to receive early intervention services.
The Hoopla on 30 Day Initial Service Delivery

The Office of Special Education (OSEP) requires that all services listed on an IFSP are delivered in a timely manner. In New Mexico, “timely manner” has been defined as within 30 days of the “start date” of the service on the IFSP. Therefore, all services listed on the IFSP must be initially delivered before 30 days have elapsed since the IFSP start date (usually the day the IFSP meeting with the family was held). Initial service delivery is monitored and reported at both a state and federal level.

Once the IFSP meeting has been conducted and you have been asked to provide services to the child and family, contact the family immediately to schedule the first appointment for service delivery. Do not wait until day 29 to contact a family.

If you are unable to contact the family, notify your FSC right away for assistance.

Even with the best attempts to deliver timely services, certain events may prevent this from occurring. There are several reasons that the FIT program accepts as reasons for not meeting the 30 days. These include the following documented reasons:

- **Family Choice**: Family chooses to delay service delivery.
- **Family Medical**: Family is unable to meet with the service provider due to child’s or parent’s illness.
- **Family Schedule**: The family’s schedule is preventing them from keeping their scheduled appointments.
- **Family Unavailable**: Family is out of town, or otherwise unavailable during the 30 day time period, making it impossible to deliver the service. A series of “Family No Shows” might be listed in this category.
- **Family Other**: There may be other reasons the family is unable to receive timely service delivery. These should be discussed with your supervisor.
- **Other-Agency not Service Coordinator**: This reason can be used if another agency created the IFSP, but never delivered the service prior to transferring it to the agency with whom you are contracting.
- **Other-Weather**: We live and work in New Mexico. If weather makes it too risky to deliver a service, this reason can be used.

While these are acceptable reasons for not meeting the 30 day service delivery timeline, the information related to the reason must be clearly documented in the family’s record.

Document all your attempts at service delivery. Also, if you start scheduling with the family immediately after being assigned the service placement, usually missed appointments can be rescheduled to assure the service is delivered within 30 days.

**Subsequent service additions to the IFSP:**
Whenever a new service is added to the IFSP (e.g., the family’s annual IFSP, the 6-month IFSP review, or any other time an ongoing assessment determines the need for a new service), the 30 day time line
Key Points related to 30 day initial service delivery

When assigned the service delivery for a child and family:
- Services are determined only via the IFSP process. Whether it is an initial IFSP, an annual IFSP, or an IFSP review, the family must be informed in advance and sign their agreement before any services can be provided.
- Once the weekly, bi-weekly, or monthly service is agreed upon and your supervisor assigns you to provide the service, schedule the appointment with the family to deliver the service immediately.
- Document all attempts to schedule and/or meet with the family to provide the service.
- If you are unsuccessful in contacting the family or delivering the service, work with the Family Service Coordinator for assistance.
- Deliver that initial service within 30 days.

30 day initial service delivery has always been the most challenging issue for contractors working with the FIT Program. Please forgive us for being excessive on this topic, but it is very important.
Transition

Early intervention in the FIT Program is available until a child turns three years of age. The process of exiting the FIT Program and entering into the public, private, or other school setting (i.e., Part B) is called Transition.

- Supporting families in understanding the transition process begins at the child’s initial IFSP meeting with the initiation of a transition plan. When the child turns 24 months, the Family Service Coordinator will talk with the family about options for their child after he or she leaves the FIT Program. A transition plan will describe what needs to happen to make the transition smooth and successful. Some options for transition when the child leaves the FIT Program are:
  - Head Start
  - Special education services (through the local public school district)
  - Private childcare or preschool setting
  - Remaining at home with parents or grandparents
  - Other community supports

Three to nine months prior to the child’s third birthday, the transition plan will be finalized at a conference with the family and receiving transitioning agencies. The parents and the team (i.e., you) will meet with representatives from the preschool or other programs to develop a detailed transition plan.

Please Remember: This manual will provide you with only an awareness of key events occurring in the FIT Program. There are lots and lots of required activities and timelines surrounding transition planning that the service coordinator will share with you. Please work with the service coordinator to understand your role in transition planning.
By this point in the manual, you must realize that providing early intervention services in the FIT Program may be somewhat different than providing services in more traditional programs, as illustrated below.

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<thead>
<tr>
<th>Traditional</th>
<th>FIT Program Early Intervention</th>
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<tbody>
<tr>
<td>• Treatment Models</td>
<td>• Promotion Models</td>
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<td>• Expertise Models</td>
<td>• Capacity Building Models</td>
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<td>• Deficit-based Models</td>
<td>• Strength-based Models</td>
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<td>• Service-based Models</td>
<td>• Resource-based Models</td>
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<td>• Professionally-centered Models</td>
<td>• Family-Centered Models</td>
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Technical Assistance Community of Practice: Mission and Key Principles for Providing Early Intervention Service in Natural Environments.

Likely the most important understanding you can obtain when working within the FIT system is related to working with children and families in their “natural environments.” Natural environments certainly encompass some of the earlier references made in this manual. Services are provided collaboratively with the family and not just with the child. Strategies are developed that blend with the family’s everyday routines.

Natural Environments, however, involve more than just “settings.”

An Office of Special Education Programs (OSEP) Community of Practice developed seven “Key Principles.”

The NM FIT Program has added the 8th key principle related to reflective practice.

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
2. All families, with the necessary supports and resources, can enhance their children’s learning and development.
3. The primary role of a service provider in early intervention is to work with and support family members and caregivers in children’s lives.
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.
5. IFSP outcomes must be functional and based on children’s and families’ needs and family-identified priorities.
6. The family’s priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.
8. Support for families in developing strategies to understand, interpret and nurture their child’s development is best achieved through the use of reflective practices.
Below are descriptions of what these key principles might “look like” in practice. There are also descriptions of what the specific principle “doesn’t look like” because too often those practices are still being used.

1. Infants and toddlers learn best through every day experiences and interactions with familiar people in familiar contexts.

Key Concepts

- 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

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<tr>
<th>This principle DOES look like this</th>
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<tr>
<td>• Using toys and materials found in the home or community setting</td>
<td>• Using toys, materials and other equipment the professional brings to the visit</td>
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<tr>
<td>• Helping the family understand how their toys and materials can be used or adapted</td>
<td>• Implying that the professional's toys, materials, or equipment are the “magic” necessary for child progress</td>
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<tr>
<td>• Identifying activities the child and family like to do which build on their strengths and interests</td>
<td>• Designing activities for a child that focus on skill deficits or are not functional or enjoyable</td>
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<tr>
<td>• Observing the child in multiple natural settings, using family input on child's behavior in various routines, and using formal and informal developmental measures to understand the child's strengths and developmental functioning</td>
<td>• Using only standardized measurements to understand the child's strengths, needs, and developmental levels</td>
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<tr>
<td>• Helping caregivers engage the child in enjoyable learning opportunities that allow for frequent practice and mastery of emerging skills in natural settings</td>
<td>• Teaching specific skills in a specific order in a specific way through “massed trials and repetition” in a contrived setting</td>
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<td>• Focusing intervention on caregivers’ ability to promote the child’s participation in naturally occurring, developmentally appropriate activities with peers and family members</td>
<td>• Conducting sessions or activities that isolate the child from his/her peers, family members, or naturally occurring activities</td>
</tr>
<tr>
<td>• Assuming principles of child learning, development, and family functioning apply to all children regardless of disability label</td>
<td>• Assuming that certain children, such as those with autism, cannot learn from their families through naturally occurring learning opportunities</td>
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2. All families, with the necessary supports and resources, can enhance their child’s learning and development

**Key Concepts**

- 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

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<td>• Assuming all families have strengths and competences; appreciating the unique learning preferences of each adult and matching teaching, coaching, and problem-solving styles accordingly</td>
<td>• Basing expectations for families on characteristics, such as race, ethnicity, education, income, or categorizing families as those who are likely to work with early intervention and those who won’t</td>
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<td>• Suspending judgment, building rapport, gathering information from the family about their needs and interests</td>
<td>• Making assumptions about family needs, interests, and ability to support their child because of life circumstances</td>
</tr>
<tr>
<td>• Building on family supports and resources; supporting them to marshal both informal and formal supports that match their needs and reduce stressors</td>
<td>• Assuming certain families need certain kinds of services, based on their life circumstances or their child’s disability</td>
</tr>
<tr>
<td>• Identifying with families how all significant people support the child’s learning and development in care routines and activities meaningful and preferable to them</td>
<td>• Expecting all families to have the same care routines, child rearing practices, and play preferences</td>
</tr>
<tr>
<td>• Matching outcomes and intervention strategies to the families’ priorities, needs and interests, building on routines and activities they want and need to do; collaboratively determining the supports, resources, and services they want to receive</td>
<td>• Viewing families as apathetic or exiting them from services because they miss appointments or don’t carry through on prescribed interventions, rather than refocusing interventions on family priorities</td>
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<tr>
<td>• Matching the kind of help or assistance with what the family desires; building on family strengths, skills, and interests to address their needs</td>
<td>• Taking over and doing “everything” for the family, or conversely, telling the family what to do and doing nothing to assist them</td>
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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

**Key Concepts**

- 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

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<tr>
<td>• Using professional behaviors that build trust and rapport and establish a working “partnership” with families</td>
<td>• Being “nice” to families and becoming their friends</td>
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<tr>
<td>• Valuing and understanding the provider’s role as a collaborative coach working to support family members as they help their child; incorporating principles of adult learning styles</td>
<td>• Focusing only on the child and assuming the family’s role is to be a passive observer of what the provider is doing “to” the child</td>
</tr>
<tr>
<td>• Providing information, materials, and emotional support to enhance families’ natural role as the people who foster their child’s learning and development</td>
<td>• Training families to be “mini” therapists or interventionists</td>
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<td>• Pointing out children’s natural learning activities and discovering together the “incidental teaching” opportunities that families do naturally between the providers’ visits</td>
<td>• Giving families activity sheets or curriculum work pages to do between visits and checking to see these were done</td>
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<tr>
<td>• Involving families in discussions about what they want to do and enjoy doing; identifying the family routines and activities that will support the desired outcomes; continually acknowledging the many things the family is doing to support their child</td>
<td>• Showing strategies or activities to families that the provider has planned and then asking families to fit these into their routines</td>
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<tr>
<td>• Allowing the family to determine success based on how they feel about the learning opportunities and activities the child/family has chosen</td>
<td>• Basing success on the child’s ability to perform the professionally determined activities and parent’s compliance with prescribed services and activities</td>
</tr>
<tr>
<td>• Celebrating family competence and success; supporting families only as much as they need and want</td>
<td>• Taking over or overwhelming family confidence and competence by stressing “expert” services</td>
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4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect family members learning styles and cultural beliefs and practices

| Key Concepts |  
|---|---|
| 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) |  

| This principle DOES look like this |  
|---|---|
| Evaluation/assessments address each family’s initial priorities, and accommodate reasonable preferences for time, place, and the role the family will play |  
| Preparing the family to participate in the IFSP meeting, reinforcing their role as a team member who participates in choosing and developing the outcomes, strategies, activities and services and supports. |  
| Collaboratively tailoring services to fit each family; providing services and supports in flexible ways that are responsive to each family’s cultural, ethnic, racial, language, socioeconomic characteristics, and preferences |  
| Collaboratively deciding and adjusting the frequency and intensity of services and supports that will best meet the needs of the child and family |  
| Treating each family member as a unique adult learner with valuable insights, interests, and skills |  
| Acknowledging that the IFSP can be changed as often as needed to reflect the changing needs, priorities and lifestyle of the child and family |  

| This principle DOES NOT look like this |  
|---|---|
| Providing the same “one size fits all” evaluation and assessment process for each family/child regardless of the initial concerns |  
| Directing the IFSP process in a rote professional-driven manner and presenting the family with prescribed outcomes and a list of available services |  
| Expecting families to “fit” the services; giving families a list of available services to choose from and providing these services and supports in the same manner for every family |  
| Providing all the services, frequency, and activities the family says they want on the IFSP |  
| Treating the family as having one learning style that does not change |  
| Expecting the IFSP document outcomes, strategies, and services not to change for a year |
• Recognizing one’s own culturally and professional-driven childrearing values, beliefs, and practices; seeking to understand, rather than judge, families with differing values and practices

• Learning about and valuing the many expectations, commitments, recreational activities, and pressures in a family’s life; using IFSP practices that enhance the families’ abilities to do what they need to do and want to do for all family members

• Acting solely on one’s personally held childrearing beliefs and values and not fully acknowledging the importance of families’ cultural perspectives

• Assuming that the eligible child and receiving all possible services is and should be the major focus of a family’s life
5. IFSP Outcomes must be functional and based on children’s and families’ needs and priorities

| Key Concepts |  |
|--------------|  |
| ➢ 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 |  |

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<tr>
<th>This principle DOES look like this</th>
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<tbody>
<tr>
<td>• Writing IFSP outcomes based on the families’ concerns, resources, and priorities</td>
<td>• Writing IFSP outcomes based on test results</td>
</tr>
<tr>
<td>• Listening to families and believing (in) what they say regarding their priorities/need.</td>
<td>• Reinterpreting what families say in order to better match the service provider’s ideas</td>
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<tr>
<td>• Writing functional outcomes that result in functional support and intervention aimed at advancing children’s engagement, independence, and social relationships</td>
<td>• Writing IFSP outcomes focused on remediating developmental deficits</td>
</tr>
<tr>
<td>• Writing integrated outcomes that focus on the child participating in community and family activities</td>
<td>• Writing discipline specific outcomes without full consideration of the whole child within the context of the family</td>
</tr>
<tr>
<td>• Having outcomes that build on a child’s natural motivations to learn and do; match family priorities; strengthen naturally occurring routines; enhance learning opportunities and enjoyment</td>
<td>• Having outcomes that focus on deficits and problems to be fixed</td>
</tr>
<tr>
<td>• Describing what the child or family will be able to do in the context of their typical routines and activities</td>
<td>• Listing the services to be provided as an outcome (Johnny will get PT in order to walk)</td>
</tr>
<tr>
<td>• Writing outcomes and using measures that make sense to families; using supportive documentation to meet funder requirements</td>
<td>• Writing outcomes to match funding source requirements, using medical language and measures (percentages, trials) that are difficult for families to understand and measure</td>
</tr>
<tr>
<td>• Identifying how families will know a functional outcome is achieved by writing measurable criteria that anyone could use to review progress</td>
<td>• Measuring a child’s progress by “therapist checklist/observation” or re-administration of initial evaluation measures</td>
</tr>
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</table>
6. The family’s priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support

**Key Concepts**
- 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

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<td>• Talking to the family about how children learn through play and practice in all their normally occurring activities</td>
<td>• Giving the family the message that the more service providers that are involved, the more gains their child will make</td>
</tr>
<tr>
<td>• Keeping abreast of changing circumstances, priorities, and needs, and bringing in both formal and informal services and supports as necessary</td>
<td>• Limiting the services and supports that a child and family receive</td>
</tr>
<tr>
<td>• Planning and recording consultation and periodic visits with other team members; understanding when to ask for additional support and consultation from team members</td>
<td>• Providing all the services and supports through only one provider who operates in isolation from other team members</td>
</tr>
<tr>
<td>• Having a primary provider, with necessary support from the team, maintain a focus on what is necessary to achieve functional outcomes</td>
<td>• Having separate providers seeing the family at separate times and addressing narrowly defined, separate outcomes or issues</td>
</tr>
<tr>
<td>• Coaching or supporting the family to carry out the strategies and activities developed with the team members with the appropriate expertise; directly engaging team members when needed</td>
<td>• Providing services outside one’s scope of expertise or beyond one’s license or certification</td>
</tr>
<tr>
<td>• Developing a team based on the child and family outcomes and priorities, which can include people important to the family, and people from community supports and services, as well as early intervention providers from different disciplines</td>
<td>• Defining the team from only the professional disciplines that match the child’s deficits</td>
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<tr>
<td>• Working as a team, sharing information from first contacts through the IFSP meeting when</td>
<td>• Having a disjointed IFSP process, with different people in early contacts, different</td>
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More on how this is implemented in the FIT Program in the next section on “Transdisciplinary Team Approach”
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations

Key Concepts
- 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

This principle DOES look like this
- Updating knowledge, skills, and strategies by keeping abreast of research
- Refining practices based on introspection to continually clarify principles and values
- Basing practice decisions for each child and family on continuous assessment data and validating program practice through continual evaluation
- Keeping abreast of relevant regulations and laws and using evidence-based practice to amend regulations and laws

This principle DOES NOT look like this
- Thinking that the same skills and strategies one has always used will always be effective
- Using practices without considering the values and beliefs they reflect
- Using practices that “feel good” or “sound good” or are promoted as the latest “cure-all”
- Using practices that are contrary to relevant policies, regulations, or laws


Workgroup Members:
8. Support for families in developing strategies to understand, interpret and nurture their child’s development is best achieved through the use of reflective practices.

**Key Concepts**

- Early intervention providers take the time to pause and explore their reactions and feelings regarding their work with children and families.
- Reflection occurs at individual, family, team, supervisory, programmatic and interagency levels.
- Reflective supervision supports individuals to focus on their experience, taking another’s perspective, and exploring their reactions to the work leading to increased self-awareness and improved practice.
- Reflective practices promote a parallel process whereby early intervention providers reflect on their relationships and interactions with parents/caregivers who in turn reflect on their relationship and interactions with their child.

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<tr>
<td>• Regularly scheduled supportive opportunities are provided for staff to reflect and discuss their role in their work with families.</td>
<td>• Supervision is provided only on an “as needed” basis, or in response to a “crisis” situation.</td>
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<tr>
<td>• Reflective practice within an agency promotes program development and leadership practices that create a relationship based service system with chains of thoughtful and reflective dialogue that run throughout the organization.</td>
<td>• Reflective practice is seen as specific to the work of the early intervention provider, and separate from the larger agency and/or management.</td>
</tr>
<tr>
<td>• Early intervention personnel understand that the relationships they build with parents, children and colleagues are the foundation for service delivery.</td>
<td>• Services are driven solely by regulations and discipline-specific professional knowledge and practices.</td>
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<td>• There is an understanding that relationships between supervisors and early intervention providers directly influence how early intervention providers relate to families and in turn, how families relate to their children.</td>
<td>• Early intervention provider relationships with families are viewed as being unrelated to how the family interacts with the child and in isolation of the larger relationships within the agency.</td>
</tr>
<tr>
<td>• Reflecting on internal experiences can lead to a better understanding of the work and the role that our feelings and experiences play in interactions with others.</td>
<td>• Feelings that are experienced when working with others are minimized or ignored.</td>
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<tr>
<td>• Individuals who are not trained mental health professionals can receive sufficient training to become highly effective reflective supervisors.</td>
<td>• Only licensed mental health professionals can provide reflective supervision.</td>
</tr>
<tr>
<td>• Reflective supervision promotes personal and professional growth.</td>
<td>• Professional development can only be attained by attending training and reading professional articles.</td>
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Transdisciplinary Team Approach

Remember that one of the Key Principles of Early Intervention is “The family’s priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support.” The FIT Program actively supports this principle and expects all FIT Providers to approach service delivery from this framework.

This may require a shift in thinking for many therapists who are accustomed to routinely providing discipline specific services directly with the child and family. Instead, this approach involves consulting within a team to determine a primary provider who will assist the family and team to maintain a focus on what is necessary to achieve functional outcomes and likely reduce the number of direct service providers in family’s home.

The Transdisciplinary Team Approach may look very different with each provider agency and even with each family; however, the definition below most clearly articulates the process.

Members of a transdisciplinary team cross professional discipline boundaries to achieve service integration by consulting... one another. They do not abandon their discipline, but blend specific skills with other team members to focus on achieve integrated outcomes (Pletcher & Younggren-in press)

Key Elements of the Transdisciplinary Team Approach

- **“Lead” person** identified and listed on the IFSP who will work most frequently with the family: The team lead is selected based upon what the family knows now, what else they would like to know, the primary needs of the child and outcomes on the IFSP. There is no presupposing of who on the team will be the lead.

- **Consultation** between members of the IFSP team, in order to promote:
  - Alignment of strategies
  - A coordinated approach
  - Collaboration between team members

- **Co-visits** between members of the IFSP team: The team determines how best the outcomes on the IFSP can be met and this can include a mix of direct services, co-visits and/or consultation, as appropriate.

Again, the Transdisciplinary Team Approach will look different for each child and each provider agency, but the key elements will always be the same. This information will prepare contracted staff that service provision in the FIT Program will not be “traditional.” Instead, it is based on recognized current and emerging evidence based practices and scientific research.
Final Thoughts...

It is our hope that this manual will quickly guide service contractors through the FIT Program and related philosophies and general requirements. Remember, this manual just touches on the primary activities and practices you will encounter in the FIT Program, and more specific information can be found by reviewing FIT rules and by discussing with agency staff. Welcome to the world of Early Intervention, and we hope you will enjoy your stay.

In the attached appendices are number of forms that may be helpful in understanding many of the items in this manual.