



May 2015 | In This Issue:

**THE HIGH STAKES WORK OF
CHILD PROTECTION**

DIGGIN' DATA

STUMP THE STATE

**OUTCOMES: MAKING A
MEASURABLE DIFFERENCE**

7 KEY PRINCIPLES

PROGRAM HIGHLIGHT

JOB OPENING



THE HIGH STAKES WORK OF CHILD PROTECTION

It's unlikely that anyone working in the field of early intervention would disagree that child protection staff have one of the hardest jobs in the world. They work with the most challenging families and often times are engaged in extremely high stakes work. They are many times tasked with making life or death decisions. They are asked to do a lot with limited resources (I have yet to visit a community that could be described as having enough caseworkers and foster parents). They also are in a position to receive criticism from all angles. Other service providers may be critical of their decisions and perceived 'lack of responsiveness', and, as you might imagine, parents can be extremely angry. Failures often make headlines and successes rarely do. The stress of the work is reflected in high turnover, which has averaged 34.6 percent per year since 2004.

The past 18 months of working in the Anchorage Office of Children's Services have provided me with an even greater insight into the depth and breadth of this demanding work. One of the biggest insights relates to the personal safety of OCS staff. There is a

reason this building has armed security guards. Real threats to staff working here are not uncommon. One of the more serious occurred last month when a father who shot a foster parent made threats regarding his child's caseworker. During the time when the father was 'at large' staff were escorted out of the building by security.

During this same week at the OCS Manager's Summit I had an opportunity to hear from regional managers and other leadership about the successes and challenges of their work. As I sat in a group working on their strategic plan, goal after goal was rated as 5/5 in difficulty and 5/5 in importance. This is critical and difficult work. At the same time the care and concern about children and families was clearly apparent in the group's dialogue.

During one of the sessions, State Infant Learning staff facilitated discussions about how we might work together on behalf of children and families. The following questions were discussed:

1. How can ILP and OCS work together to engage biological and foster families in services without 'forcing' participation?
2. What can ILP do to support our shared efforts to problem solve with families?

Some of the ideas generated from this discussion included the following:

- Invite ILP staff to Team Decision Making meetings (TDM's)
- Better educate foster parents about their responsibilities and the special needs of foster children.
- Develop a more engaging referral process and have caseworkers share ILP brochures and information to better explain ILP services.
- Promote regular ongoing communication between local OCS and ILP providers.

As I have listened to both OCS and ILP staff, I am struck by some common threads. "They don't respond... we need more information... we just want them to meet us halfway?" In your efforts to build collaborative relationships with local and regional OCS staff, think about what you can do to get to know them, simplify requests, and support the children and families we serve together. It's possible that we have an incomplete picture of the depth of complexity inherent in their work... and maybe it's even feasible to meet a bit more than halfway.

Laurie Thomas, M.Ed
State EI/ILP Manager

[Read Next Article](#) | [Back to top](#)

Did you know that Early Intervention programs across the nation are challenged to explore their data for **clues**...



Clues that tell us (as a country) what makes a difference for children in early intervention. To do this we have been asked by OSEP to create a plan that will improve all but especially one major outcome for the children we serve. This plan was submitted to OSEP on April 1, 2015.

I've been looking at what other states chose as their "**State-identified Measurable Result**" (SiMR)

statement... and much like ours, many states will focus on social-emotional development. The national Part C system intends to demonstrate the impact of early intervention by the collective impact of these SiMRs.

Our SiMR goal: "**Children with social emotional needs are identified early and receive evidence-based services that strengthen their primary relationships and positively impact their further developmental trajectory**". Our task in the coming 5 years is to increase our awareness and understanding of how what we do impacts the social emotional development of children in our programs and to implement strategies that may turn our data curve.

Our SiMR statement: **The percentage of Alaska Part C infants and toddlers who show greater than expected social-emotional growth will substantially increase from 65% to 71% by Federal Fiscal Year 2018.**

Our thanks to those of you who spent many hours discussing our existing data, evidence-based practice, early childhood outcomes, our mission and vision and most of all, where we want to go and how to get there. A special thank you goes out to our leadership team for their extra time: Jean Kincaid, Gail Trujillo, Kristen Bradshaw, Amanda Sanford, Susan Kessler, Amy Tovoli and Christie Reinhart.

A link will be available soon to the full report. You can see your own agency progress and comparison to the statewide data under Reports in the ILP database (click on Outcomes Summary).

[Read Next Article](#) | [Back to top](#)

STUMP the STATE

Your Questions and Answers

QUESTION: What defines the multidisciplinary team for Eligibility for Part C services? The IFSP says must include the parent and at least 2 individuals from separate disciplines or professions and one of these individuals must be the service coordinator. When can medical records or records from the hospital (in case of an infant referral) be used? Do the records need to have anything specific in them to be considered the second discipline?



Here are two possible scenarios:

Scenario 1. An infant is referred from the NICU. The discharge summary contains his or her medical information and recommendations. Can the review of the medical records be used as the second person and summarized in the report?

ANSWER: While any information included in the referral can be used as collateral information, a referral from a hospital alone does not meet the second discipline requirement. However, if a pediatrician, OT, PT, or SLP completed an assessment while the child was in the NICU then this could be considered a 2nd discipline (as long as they met AK's definition of qualified). If the discharge notes from the hospital include assessment information about the child's development, you could also record some of this information. If such information is available it would support the EI evaluation and assessment.

Scenario 2. A local pediatrician refers a child due to concerns about a speech delay and medical records state these concerns. Can a review of these records be used as second person and summarized in the report when the speech therapist confers there is only a speech delay and all other areas are developing typically.

ANSWER: Yes, using an outside provider is acceptable in all cases as per 34CFR 303.321(3)(i) . The only requirement is that they meet the federal and state definition of 'qualified'.

Federal Regulations for records to establish eligibility

The regulations (303.321(a)(3)(i)) permit that medical and other records can be used to establish eligibility. If eligibility can be determined through a review of records, a multidisciplinary evaluation is not needed. (303.3321(1)(a)(i)) However, a multidisciplinary (2 or more disciplines or professionals or 1 person representing 2 disciplines (303.24)) assessment must be conducted to determine the unique needs of the child and family assessment in accordance with 303.321(c). (303.321(3)(i)).

Please note there is nothing in the regulations that states the service coordinator is one of

the 2 disciplines or professionals as part of the multidisciplinary team.

If a review of records cannot establish eligibility

1. a timely, comprehensive, multidisciplinary evaluation of the child must be conducted in accordance with 303.321(b);
2. a multidisciplinary assessment of the child must be conducted in accordance with 303.321 (c)(1); and
3. a family directed assessment of the resources, priorities, and concerns of the family and identification of supports and services necessary to enhance the family's capacity to meet the developmental needs of the child in accordance with 303.321(c) (2). (303.321(a)(i))

Questions for this column are considered and responded to through a review of statute, regulation and policy and other supporting documents and vetted by the State team through a consensus process.

Please submit questions for "Stump the State" to:

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[Read Next Article](#) | [Back to top](#)

OUTCOMES: Making a Measurable Difference

Outcomes 101 - Why do we complete outcomes on each child at entry, annually and at exit? Where did the outcomes originate? *(This information was gathered from The Early Childhood Technical Assistance Center or ECTA website.)*

What are child and family outcomes?

An outcome is a benefit experienced as a result of services and supports provided for a child or family. The fact that a service has been provided does not mean that a positive outcome has been achieved. Likewise, an outcome is not the same as satisfaction with the services received. The impact that services and supports have on the functioning of children and families constitutes the



outcome. Consider the example of a child with autism who receives therapy services to increase communication skills. Receiving the services is not an outcome, but, if the child learns words he can use to convey his needs to others, then he has achieved an outcome. Similarly, a family may receive information about their child's disability. Although this information is a service provided to the family, it is not an outcome. However, if the information enables them to assist in their child's learning and development more effectively, then the family has achieved an outcome.

Why are states measuring outcomes for programs serving young children with disabilities?

In this age of accountability, policymakers are asking questions about the outcomes achieved through participation in programs supported by public funds. Judging the effectiveness of any program requires looking at results, not simply at the process of providing services. The Office of Special Education Programs (OSEP) in the U.S. Department of Education now requires states to report outcomes data for children and families served through Part C and Part B Preschool of the Individuals with Disabilities Education Act (IDEA) as part of their Annual Performance Report (APR). Many states have begun to use data on child and family outcomes in many different ways to improve their programs

Where did these outcome statements come from?

The Office of Special Education Programs (OSEP) funded the Early Childhood Outcomes (ECO) Center to build consensus around a set of child and family outcomes. Between fall 2003 and spring 2005, ECO convened numerous stakeholder groups to gather input on what the outcomes should be and to review and comment on initial drafts of the outcomes. A draft set of outcomes was posted on the ECO website in December 2004 and January 2005. Based on the input received, ECO recommended a set of child and family outcomes to OSEP in February 2005. The child outcomes required by OSEP are similar to those recommended by the stakeholders. However, the OSEP-required family data are somewhat different from the ECO-recommendations.

Kim Mix, M.Ed

[Read Next Article](#) | [Back to top](#)

7 KEY PRINCIPLES

Looks Like/Doesn't Look Like



1. IFSP outcomes must be functional and based on children's families' needs and priorities.

Key Concepts	<ul style="list-style-type: none"> • 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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This principle DOES look like this:	This principle DOES NOT look like this:
Writing IFSP outcomes based on the families' concerns, resources, and priorities	Writing IFSP outcomes based on test results
Listening to families and believing (in) what they say regarding their priorities/needs	Reinterpreting what families say in order to better match the service provider's (providers') ideas
Writing functional outcomes that result in functional support and intervention aimed at advancing children's engagement, independence, and social relationships	Writing IFSP outcomes focused on remediating developmental deficits.
Writing integrated outcomes that focus on the child participating in community and family activities	Writing discipline specific outcomes without full consideration of the whole child within the context of the family
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	Having outcomes that focus on deficits and problems to be fixed
Describing what the child or family will be able to do in the context of their typical routines and activities	Listing the services to be provided as an outcome (Johnny will get PT in order to walk)
Writing outcomes and using measures that	Writing outcomes to match funding source

make sense to families; using supportive documentation to meet funder requirements	requirements, using medical language and measures (percentages, trials) that are difficult for families to understand and measure
Identifying how families will know a functional outcome is achieved by writing measurable criteria that anyone could use to review progress	Measuring a child's progress by "therapist checklist/observation" or re-administration of initial evaluation measures

Workgroup on Principles and Practices in Natural Environments

[Read Next Article](#) | [Back to top](#)

PROGRAM HIGHLIGHT

SeaView Community Services Infant Learning Program serves the Eastern Kenai Peninsula. Our population of 5,634 is strung out along 74 miles of scenic highway from Lowell Point, through Seward, Primrose, Moose Pass, Cooper Landing and Hope. We are in Coastal Alaska, so our weather is often rainy and blustery, but the sun comes out to warm us once in a while.



Seward Providence Hospital ER, Chugachmiut North Star Clinic, Seward Health Clinic, Glacier Family Medical Clinic provide medical care. A Public Health Nurse visits twice a month, as does WIC, but the office will close after December 2015, so further services are a question. Providence Seward Mt. Haven Rehab provides OT, PT, SLP services to the community.

Infant Learning has been with SeaView Community Services since July of 1985. There are two of us employed at the Infant Learning Program in Seward, Alaska. Heather Cinereski keeps the office running smoothly, produces our monthly newsletter, helps out with Play and Chat, Baby Welcome Wagon and manages ASQ. PJ Hatfield-Bauer is ILP manager, developmental specialist, early childhood educator and family service coordinator. We are under the umbrella of SeaView Community Services as a part of Family Services in Disability Services. ILP contracts for OT, PT and SLP evaluations with Providence Seward Mountain Haven Rehabilitation clinic.

PJ provides direct services to families. We try to visit each family at least twice a month, but some families receive visits every week, depending on their needs. Some families prefer to meet us in the community, rather than at home.

Our biggest challenge at this time is raising the community consciousness about the value of Early Childhood issues and Early Intervention. Building partnerships with local medical providers has been slow. Our common work with OCS to serve families in their system is always a learning process. Having few resources in Seward, is another challenge that causes us to send families long distances by road to connect with medical and other services in Anchorage or Soldotna/Kenai, which can be a real barrier to their accessing those services. Because of our tourist economy, many families are living below the poverty line, or fall in the gulf between Denali Kid Care and what insurance will provide. 47% of children in this area qualify for free and reduced cost lunches at school.

We are proud of our community outreach and collaboration with Parents as Teachers, the Seward Library, Qutekcak Native Tribe, Kenai Peninsula Borough School District and Seward Area Quilters. Encouraging community awareness about early childhood issues is important to bringing the services of ILP to every family in our area that has a child who needs early intervention. If the community is aware of what we offer, they will know where to turn when the need arises.

Play & Chat meets weekly at the Seward Community Library. Up to 22 adults and 28 children enjoy the hour and a half of play in the large, warm dry space. We do sensory activities, parent support and education, and provide tablets parents can use for ASQs and signing up for Imagination Library. We have guest speakers from time to time from the Safe Kids Program, Book talks, nutrition and lactation consultants and ASL educators. Toys and activities are chosen to enhance community building across generations, so the room has materials and equipment stimulating for the whole child and family. In nice weather, we convene at the park down the street that borders Resurrection Bay to add water and bubble play. We end with fresh fruit and veggie snacks and sometimes whole grain chips, to introduce new foods and teach about basic nutrition.

Baby Welcome Wagon introduces ILP families with new as they transition back into the community with a home visit. It is a fine opportunity to explain the importance and necessity of early childhood development and intervention. A gift bag includes a beautiful handmade quilt from Seward Area Quilters, a print from local artist Dot Bardarson, information about early childhood development, local resources for parents, and special parenting information for



Dads, a choke testing tube and other useful swag.

PJ Hatfield-Bauer

[Read Next Article](#) | [Back to top](#)

JOB OPENING - Bristol Bay

Bristol Bay Area Health Corporation is seeking a licensed Physical Therapist, Occupational Therapist, Audiologist, or Speech Therapist.



The successful candidate must have a minimum of one year experience working with young children, knowledge of unique and special needs of communities in the BBAHC and ILP service area, parent-child relationships, and creative learning programs for children with developmental delays.

This position requires an understanding of the principles of growth and development over the life span (e.g., pediatric/adult/geriatric) and possess the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his/her age-specific needs, and to provide the care needed as described in the assigned unit's policies and procedures. The employee will complete state-mandated Part C credentialing during regularly scheduled work hours within the first 180 calendar days on the job.

Salary Range: \$82,451.20-\$127,628.80

For more information contact: BBAHC's Human Resources Department 1 (800) 478-5201 ext. 6325

[Back to top](#)

"A house is not a home unless it contains food and fire for the mind as well as the body." - Benjamin Franklin

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