Arizona Early Intervention Program (AzEIP)

Fidelity Checklist

This document was developed through a collaborative TA activity between NECTAC, MPRRC and AzEIP (Molly Bright, AZEIP, Karie Taylor, AzEIP, Kristy Thornton, NAU/IHD, Anne Lucas, NECTAC/WRRC, Wendy Whipple, MPRRC, Carol Massanari, MPRRC and Kathi Gillaspy, NECTAC/ECO)

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DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

Table of Contents

Background

In 2011, Arizona completed a review of their integrated monitoring activities, which included both compliance and performance items. During this review, Arizona realized there were several early intervention programs that successfully satisfied the requirements of all IDEA Part C Compliance Indicators – all of which are heavily connected to timelines and the capturing and documentation of data in the IFSP. However, there were discrepancies between the state office's expectation of program performance in using evidence-based practices and the early intervention program's perception of their level of comprehension and application of these practices. It was also noted during the review of monitoring activities that the process of determining comprehension and implementation of evidence-based practices tended to be less structured and more subjective.

As a result, the State had two very contrasting sets of data that did not provide an accurate or holistic picture of early intervention services in Arizona. The status of each early intervention program's ability to implement early intervention services in accordance with both federal and state policy, the Mission and Key Principles of Early Intervention and/or the Team Based Early Intervention Services Model (TBEIS) was not clear to the State.

The state decided to create a self-assessment tool to support early intervention programs in looking at compliance requirements and the fidelity of their implementation on the Mission and Key Principles of Early Intervention and the Team Based Early Intervention Services Model practices. The resulting Fidelity Checklist was designed so that Early Intervention Program Teams within a region and/or individual team members could perform self-assessments on a specific focus areas (e.g. Family/Caregiver Engagement), for a specific practice (e.g. Initial Contact/Discussion of Early Intervention), or of all focus areas and practices.

Arizona realizes that ensuring conformity to the Team Based Early Intervention Services Model is an ongoing process that requires ongoing assessment, training, technical assistance and monitoring. This Checklist is one resource available to individuals, teams, programs and regions to improve their understanding and adherence to evidence-based practices.

Purpose and Use

The purpose of this tool is to provide early intervention programs a self-assessment on global practices that are used from referral through transition. The tool is designed for individuals and teams within programs to review their practices, and for programs to identify where they are in implementing practices as a whole. This tool is organized around activities in the Individualized Family Service Plan (IFSP) process, focusing on teaming and coaching practices. Other tools and checklists that have been developed by national experts are available for use to help teams and practitioners further explore and improve their practices.

Description and Use of the Rating Scale

This document uses a rating scale of 1, 3 or 5 for teams and/or individuals to rate themselves on the implementation of best practices in early intervention. Each number on the rating scale is defined below:

1 – Starting Point: A rating of 1 means that teams or individuals are consistently implementing basic and expected early intervention practices. These include practices that are required by federal regulation (e.g., procedural safeguards) as well as basic family-centered, routines-based practices.

3 – Progressing: A rating of 3 means that teams or individuals are consistently implementing early intervention practices that begin to exceed the basic standard outlined in 1- Starting Point. The practices in 3 – Progressing build upon and enhance the practices in 1 – Starting Point and create more opportunity for the family and all team members to be active participants in early intervention.

5 – Innovating: A rating of 5 means that teams or individuals are consistently implementing early intervention practices that are recognized best practices for providing services to infants and toddlers and their families. Innovation includes practices that encourage reflection, critical thinking and connection and those that create equal partnership between team members and families.

Only ratings of 1, 3 and 5 may be used – there are no ratings of 2 or 4 or half ratings. One rating should be selected based on the level in which all the practices described are consistently implemented.

This Fidelity Checklist may be used by individuals, teams and/or programs. For individual use, individuals should first read all of the descriptors, and then select the number of the rating that best represents their typical practice. A space has been provided at the top of the page for each practice for the rating to be recorded. For team use, it is suggested that each individual on a team complete ratings separately prior to a team meeting, then meet as a team to discuss each person's rating for each practice and come to a consensus rating for the team. A Notes and Plans section is provided on each page for teams and/or individuals to write comments about the rating selected and to note plans for improving or changing practice. There is also an Action Planning Form in the Appendix A of the Fidelity Checklist that may be used to develop specific plans for improvement in one or more areas of the practices included in the checklist.

Program administrators and/or supervisors may want to use the ratings determined in either individual or team review to identify and plan for technical assistance. Appendix B of the Fidelity Checklist contains a list of resources for technical assistance associated with each of the areas of the checklist that may be useful in this planning.

Resources

McWilliam, R. A. (2012). *FINESSE IIa: Families in natural environments scale of service evaluation*. Retrieved from http://www.siskin.org/downloads/FINESSEIIarevised.pdf

Rush, D.D. & Shelden, M.L. (2008). Coaching Quick Reference Guide. *BriefCASE,* 1(1), 1-2. Available at http://www.fipp.org/Collateral/briefcase/briefcase_vol1_no1.pdf

Rush, D.D. & Shelden, M.L. (2009). Checklists for Implementing a Primary Coach Approach to Teaming. *CASEtools, 5*(1), 1-8. Available at http://www.fipp.org/Collateral/casetools/casetool_vol5_no1.pdf

Rush, D.D. & Shelden, M.L. (2012). Worksheet for Selecting the Most Likely Primary Service Provider. *CASEtools, 6*(3), 1-9. Available at http://www.fipp.org/case/casetools/CASEtool_vol6_no3.pdf

Workgroup on Principles and Practices in Natural Environments, OSEP TA Community of Practice: Part C Settings. (2008, February). *Agreed upon practices for providing early intervention services in natural environments*. Retrieved from http://www.ectacenter.org/~pdfs/topics/families/AgreedUponPractices_FinalDraft2_01_08.pdf

Missouri First Steps IFSP quality indicator rating scale. (2012). Retrieved from http://dese.mo.gov/se/fs/documents/se-fs-qirsmanualfinalwithndstatement.pdf

FAMILY/CAREGIVER ENGAGEMENT

Initial Contact/Discussion of Early Intervention [1]

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator describes the Early Intervention Mission and Key Principles, and based on what the family has described about their family priorities, provides examples of how the mission and principles would be reflected in AzEIP's support with the family.
	The Service Coordinator describes the early intervention process, the steps and what to expect next, family rights, and early intervention funding.	
The Service Coordinator describes the AzEIP service delivery structure, and available services, as identified under IDEA, Part C. The Service Coordinator listens to the family's concerns about their child.		

Notes and Plans:

[1] Since procedural safeguards need to be explained and provided to families through the IFSP process, this icon is used as a reminder at each step when procedural safeguards need to be provided.

Procedural Safeguards 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator uses various methods (e.g., open-ended questions, discussion) to check for the family's understanding of procedural safeguards.
	The Service Coordinator explains the purpose of procedural safeguards to the family at each point using jargon-free, clear language to ensure understanding and answers questions from the family about procedural safeguards accurately.	
The Service Coordinator provides procedural safeguards to the family at all appropriate times throughout the IFSP process and uses alternative methods of communication (e.g., notification in native language, translators, ASL) as necessary.		

Notes and Plans:

Screening 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator comes to agreement with the family on the results of the screening and determines what the next steps should be.
	The Service Coordinator asks engaging questions that invite the family to share their thoughts and observations about their child's development during screening.	
The Service Coordinator reviews records, if available, to determine if the child has an established condition or 50% delay in one area of development; or obtains parental consent for screening to determine if the child is suspected of having a developmental delay. The Service Coordinator informs the family they can request an evaluation at any time during the screening process, regardless of screening results. The Service Coordinator selects appropriate instruments, conducts screening, and talks with the family about what the screening is showing.		

Notes and Plans:

Evaluation Planning 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator invites the parent to determine what role they would like to have in the evaluation process. The Service Coordinator gathers information related to cultural and linguistic characteristics of the child and family, and shares information from screening and initial discussion with the family with the multidisciplinary team. The multidisciplinary team develops a plan for gathering information from multiple sources (e.g., tools, observations, reports from those who know the child). They select appropriate methods (e.g., translators) and tools.
	The Service Coordinator uses screening and family information to identify evaluation team members including any team members the family would like to include in the evaluation.	
The Service Coordinator explains to the family the purpose of and process that will be used for the evaluation.		

Notes and Plans:

Evaluation and Eligibility 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The multidisciplinary team uses appropriate reflective questions with the family to determine next steps. The team ensures that the family understands the evaluation information, what it means for the child and family, and what the next steps will be.
	The multidisciplinary team gathers information from other sources such as family members/caregivers, medical providers, social workers, educators and others to understand the full scope of the child's development.	
The multidisciplinary team uses evaluation instrument(s) appropriately to identify developmental status in each developmental area and incorporates the use of Informed Clinical Opinion in determining the child's eligibility.		

Notes and Plans:

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator facilitates a conversation with the family and other team members about everyday routines and activities, and the family's priorities (information shared by the family in the Child and Family Assessment Guide). Team members use appropriate reflective questions, and, as available/appropriate, observation to capture information about caregiver/child (and other participants – siblings, peers in child care, etc.) engagement in routines, including successful and less-successful strategies, and parent-defined measures of success. Through discussion, team members gain a clear understanding of the child's development and interests within the context of routines and relationships, the family and/or caregiver's interests, resources and engagement, the strategies that they have found successful or not, the routines and activities that they want to focus on, and what success would look like within the priority routine/activity. The Service Coordinator and team member(s) meet with the family and explain the child indicator measurement process, and based on the information gathered through the child and family assessment process complete the child indicator summary with the family.

Child and Family Assessment and Indicator Measurement 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
	The Service Coordinator facilitates a conversation with the family and other team members about everyday routines and activities, and the family's priorities (information shared by the family in the Child and Family Assessment Guide). Team members use appropriate reflective questions, and, as available/appropriate, observation to identify who is involved in the routines and activities, and the roles they have. The Service Coordinator and team member(s) share basic information about child indicators and rating decisions with the family.	
The Service Coordinator and team member(s) explains that family assessment is optional, describes use of the Child and Family Assessment Guide for Families, and encourages sharing only information parents feel comfortable sharing. The team obtains consent for the child assessment and through the assessment process, identifies the child's skills that seem to be emerging and how the child is functioning. The Service Coordinator and team compile information from multiple sources to determine child and family strengths and needs to complete the child indicators summary.		

Notes and Plans:

IFSP DEVELOPMENT

IFSP Child Outcomes

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The IFSP team develops individualized child outcomes using information from the child and family assessment that support: (1) the child's successful participation in home, child care and community; and (2) the confidence and competence of the caregiver(s) and others involved in the routines and activities around which the outcome is written.
	The IFSP team develops individualized child outcomes that support the development of the child's positive social-emotional skills, acquisition and use of knowledge and skills and use of appropriate behaviors to meet needs, emphasizing the child's engagement, independence and social relationships.	
The IFSP team uses the family's priorities within the routines and activities the child and family are interested in, as discussed during the assessment process, and the child's strengths and needs to develop child outcomes. Child outcomes are written to be achieved within 3 to 6 months.		

Notes and Plans:

IFSP Family Outcomes

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The IFSP team develops family outcomes that reflect the family's interest and engagement in a breadth of community and family activities and resources that promote the family's overall well-being.
	The IFSP team develops family outcomes that reflect what the family wants and needs related to building their confidence and competence in parenting a child with a disability, (such as learning about the child's disability and connecting with other families), knowing and understanding their rights, and being able to communicate their child's needs to others.	
The IFSP team develops family outcomes that reflect what the family wants and needs related to interacting with their child, promoting their child's development, and accessing needed information and resources.		

Notes and Plans:

Team Lead and Service Decisions 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The IFSP team selects the Team Lead and makes decisions about services and supports by considering the family's and/or caregiver's confidence and competence related to supporting the child's participation in routines and activities (outcomes).
	The IFSP selects the Team Lead and makes team decisions about services and supports based on the family's priorities and participation-based outcomes, practitioners' relationship/rapport with the family, parent recommendations, child's interests, activity settings, natural learning environments, and the expertise needed to support the outcome.	
The IFSP team selects the Team Lead from the core team, psychologist, social worker, vision or hearing specialist and makes decisions about services and supports based on family dynamics and individual parent or caregiver characteristics, child's diagnosis, condition and needs, environmental factors (safety, distance), geographic region served by practitioner, billability, and personnel availability.		

Notes and Plans:

IFSP IMPLEMENTATION

Team Lead Coaching Characteristics During Visits– Joint Planning **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead ends the visit with: (1) a joint plan that includes who is going to do what by when, determines if a joint visit is needed, and specifies what the family and/or caregiver will try to accomplish; and (2) a joint plan for the next visit.
	The Team Lead facilitates a review of the previous joint plan of action and what the family and/or caregiver has tried or accomplished since the last visit.	
The Team Lead facilitates the conversation with the family about what the family and/or caregiver tried or accomplished since the previous visit.		

Notes and Plans:

Team Lead Coaching Characteristics During Visits– Observation **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead ensures the family understands the purpose of the behaviors and activities within the context of every day routines and activities through discussion, modeling, additional observations, etc.
	The Team Lead and family and/or caregiver determine the process of observation, such as the Team Lead modeling behaviors and activities that have been discussed and may assist with the child's participation in an activity or routine.	
The Team Lead observes the child and the caregiver/child interaction within the context of every day routines and activities.		

Notes and Plans:

Team Lead Coaching Characteristics During Visits– Action/Practice **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead encourages the parent or caregiver to try new ideas and activities that were discussed or planned and that relate to the parent's or caregiver's priorities for the child within routines or activity settings.
	The Team Lead interacts with the child to model a specific behavior or activity or to assess the child in the context of an everyday activity while parent watches.	
The Team Lead discusses and tailors the level of support to reflect individual family needs, preferences, and learning styles.		

Notes and Plans:

Team Lead Coaching Characteristics During Visits – Reflection **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead encourages the family to continually identify strategies that will improve their knowledge and skills related to promoting the child's participation in every day routines and activities and improve their overall family well-being.
	The Team Lead asks reflective questions that support the parent or caregiver in analyzing what did and did not work. With the family, the Team Lead evaluates and adjusts strategies that support achieving IFSP outcomes within and across the family's routines and activities that are part of the family's everyday life.	
The Team Lead asks open-ended questions to identify any significant family events or activities, how well the planned routines and activities have been going, and if there are any new issues and concerns the family wants to talk about.		

Notes and Plans:

Team Lead Coaching Characteristics During Visits – Feedback **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead engages the family in self-assessment and provides supportive feedback of the family's and/or caregiver's demonstration of their knowledge and skills.
	The Team Lead provides information to enhance the family and/or caregiver's knowledge and skills.	
The Team Lead provides affirmation related to what the family and/or caregiver says or does.		

Notes and Plans:

Joint Visits

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Team Lead debriefs the joint visit with the family and/or other care providers, as well as other team members, to evaluate the usefulness of the joint visit and to determine next steps.
	Team members provide coaching to the Team Lead and family about functional child participation in everyday routines, or meeting family-level needs.	
Team members ensure that the roles of the Team Lead and other team members, including the family, are defined for the joint visit based on the current needs and issues identified by the Team Lead and the family.		

Notes and Plans:

Family Resource Engagement

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator encourages and facilitates the family's independent identification, acquisition, and evaluation of community resources based on interests and needs.
	The Service Coordinator assists the family with identification of resources and supports based on identified family priorities and concerns. The Service Coordinator supports and encourages family decisions by facilitating referrals and providing needed assistance, adaptations, or support for the family and the child to participate in desired community activities.	
The Service Coordinator reviews and updates concerns, priorities and resources in the context of every day routines and activities on an ongoing basis as needed. Additional resources, appropriate community activities, and informal supports that will assist the outcomes and activities to be achieved are identified.		

Notes and Plans:

Measuring Progress and Discussing Progress with Families 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		On an ongoing basis, the Team Lead and other team members evaluate with the family whether or not progress is being made in achieving outcomes and revise outcomes as appropriate. The Team Lead and other team members expand or create strategies within activities or routines to continue progress toward achieving outcomes and address any new family concerns or interests. On an ongoing basis, the Team Lead and other team members review with the family the child's progress in the three global outcome areas.
	The Team Lead and other team members use reflective questions on a regular basis with the family to review and share information about the child's progress including functional skills and behaviors across various settings and interests.	
The Service Coordinator plans and convenes an IFSP meeting with the family, at least every 6 months and annually, and at any other time the family/provider team wants to make significant changes to the IFSP.		

Notes and Plans:

Transition Planning 

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The Service Coordinator supports the family's decisions related to what community option, if any, the family wants to access for their child's transition and facilitates the implementation of transition plan steps and services to ensure a smooth transition for the entire family.
	The Service Coordinator shares information with the family about all available options for children at age three, and assists the family in exploring these options.	
The Service Coordinator has ongoing discussions with the family about transition, provides notification to the Arizona Department of Education (ADE) and the school (PEA) for the child potentially eligible for Part B, convenes a transition conference, and develops and implements a transition plan which includes the outcomes and activities to prepare the child and family for success after early intervention.		

Notes and Plans:

TEAM ENGAGEMENT

Team Membership and Interaction During Team Meetings **Date: _____** **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The team meeting facilitator promotes the use of coaching interactions within the team to ensure good decision-making about strategies that will assist the Team Lead in supporting the needs of the child and family. Team members support and question one another related to using evidence-based practices, and maximize the expertise of individual practitioners and as a collective team.
	The team meeting facilitator facilitates the meeting using meeting guidelines to ensure that all team members participate and share information about family priorities and concerns, child's needs and what is or is not working. All team members are engaged in discussions and work as a team at meetings.	
The team selects a team meeting facilitator who is the same person for each team meeting, arranges logistics for all meetings, and ensures documentation of discussions. All core team members (OT, PT, SLP, and DSI) are available to act as Team Lead and to attend, participate in and share information during team meetings.		

Notes and Plans:

Family Role in Team Meeting

Date: _____ **Rating: _____**
Date: _____ **Rating: _____**

1 – Starting Point	3 - Progressing	5 - Innovating
		The team meeting facilitator and other team members support the family to engage in the team discussion by using reflective questions and assisting the family in sharing information related to what has been tried, what's worked, and progress that has been made.
	The Team Lead ensures that the family understands the purpose of the team meeting and their role by preparing them to participate in the team meeting in a way that is helpful and meaningful. This includes identifying questions, what has been tried, what worked and didn't work so that discussions with team members are focused and maximized.	
The Team Lead invites the family to participate in team meetings, including quarterly reviews, in person or via telephone. The family is provided flexibility about what roles they assume in the team meeting according to their interests and availability.		

Notes and Plans:

Appendix A

AZEIP Local Implementation Plan

AZEIP Local Implementation Plan

Based on the results of the AZEIP Fidelity Checklist self-assessment, develop a plan for making changes in practice(s) and ensuring sustainability. Describe the specific action steps that will be taken and identify the particular experiences and opportunities that will be used to make the needed changes.

AZEIP Individual/Team/Program Name: Click here to enter text.
Date: Click here to enter text.
Fidelity Checklist Focus Area: Choose an item.

New practice(s) you want to implement: Click here to enter text.	
Describe: Click here to enter text.	
What are you doing now? What's working well? What's not working well? What are the barriers?	
Click here to enter text.	
Who will be involved and what will they be doing that reflects recommended practices?	
Click here to enter text.	
Describe Your Action Steps (proposed solutions, next steps). If your program/team is stuck, identify what outside help is needed.	Timelines
Click here to enter text.	Click here to enter text.
How will you know that you are successful? (Describe criteria or benchmarks of success)	
Click here to enter text.	

Appendix B

Technical Assistance Resources