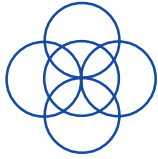


Birth to 6 EVENTS



A BULLETIN FOR THOSE WHO WANT TO LEARN MORE ABOUT SERVING YOUNG CHILDREN WITH SPECIAL NEEDS AND THEIR FAMILIES

Issue 55—Winter 2007

Implementing Family-Centered Practices with Fiscal Responsibility



Family-Centered Practices:

- Do your programs, supports, or services...
 - ...focus on the strengths of the child and family?
 - ...support relationship building and community membership?
 - ...foster mutual trust and respect between families and program staff and/or administration?
 - ...promote family choice and control?
 - ...offer families good information and access to information?
 - ...include families in policy decisions and program planning?

(from the Rhode Island Coalition for Family Support and Involvement)

I must admit, I was a bit overwhelmed when I first considered dedicating an issue of EVENTS to the interface between early intervention and early childhood special education program philosophy and design. This issue of EVENTS focuses specifically on Birth to 3 programming. A lot of information was available on service delivery model characteristics, as well as the importance of delivering family-prioritized services within natural environments. Much less was available, however, on sound fiscal decision-making in light of these principles. Wisconsin's considerable county-to-county variation in population, staffing models, and available resources also contributes to the challenge of addressing these issues.

Over the course of several months, I had the honor of speaking with several county Birth to 3 Program staff making family-wise and fiscally-wise decisions, as well as state Birth to 3 and RESource staff. This issue of EVENTS discusses their insights, as well as the persistent questions raised by these issues. Although this newsletter is not a "magic bullet" to address every county's fiscal concerns, my hope is that it will provide food for thought and reflection, as well as tools to help programs consider how to best serve children and families while more fully utilizing available financial resources.

*Thanks for joining in the discussion.
Arianna Keil, editor*

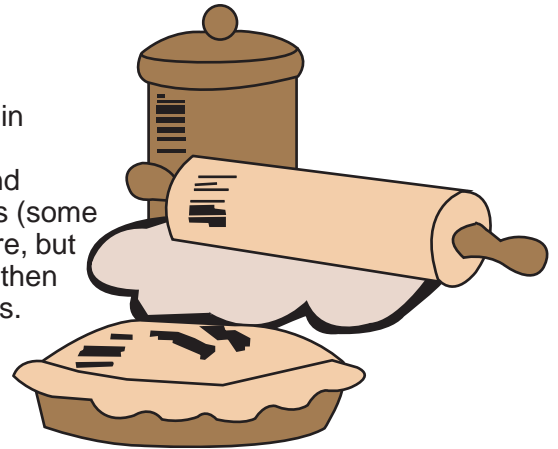
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FISCAL-FAMILY BALANCE

Family-Centered Early Intervention Pie

Take a helping of state and federal budget, mix in county funding. Add 2 cups EI program expectations, along with ½ cup team meetings. Stir in 1 c each: child and family strengths, mutual respect, and community partnerships. Add evaluation team members, eligibility interpretation, and frequency and intensity of delivered services according to your supplies (some people find the primary provider approach to service delivery helpful here, but make sure to account for the necessary role release). Sift in TCM, and then gradually sprinkle in enhanced rate for therapies in natural environments. Pour into contracted services or county employees pan. Bake in your county's oven until golden-brown. Serve to children with special needs and their families.



Aligning Family-Centered Practice and Fiscal Responsibility in Early Intervention

Wouldn't it be nice if providing family-centered early intervention (EI) in a fiscally responsible manner was as easy as baking a pie? The issues surrounding family-centered service provision with limited budgets are multiple and complex. What follows is a discussion of some of these challenges, as well as influential factors. Key elements in supporting family-centered service provision by EI programs are also outlined. This article is not intended to be an all-inclusive summary of these issues, but rather an overview of some of the most relevant pieces.

Staff from county Birth to 3 programs throughout the State have contributed to this article by sharing some of their creative approaches to the family-fiscal puzzle. Even if your program is not experiencing any challenges in this area, you may learn new strategies to make your good work even better.

Challenges

Broadly, the challenges in balancing family-centered practice and fiscal responsibility fall into 3 main categories: system considerations, reimbursement considerations, and family considerations. Many programs across the state face static or decreasing budgets with increasing numbers of children and

families served. Some areas of the State struggle not only with limited fiscal resources, but limited professional resources as well. Although a relative scarcity of providers in a region can enhance cross-discipline and cross-organization delivery of services, some fear loss of expertise.

The influence of health care financing presents another potential challenge to a family-centered service delivery. Much of the reimbursement provided to EI programs comes from health care financing, such as payment for therapy services. At times Birth to 3 programs and health care financing can work hand-in-hand to offer high-quality, sensitive care to children and families, such as Medicaid (MA) enhanced rate for service delivery in natural environments.

At other times, focusing on the child-caregiver relationship as the primary way to support the child's development, the family's capacities and strengths, and the promotion of parent-professional partnerships seems at odds with health care financing structures. For example, time outside of direct service provision (such as consultation among team members or team meeting time) is generally not reimbursed. Other factors that are influential include

lack of MA reimbursement for educators' time apart from service coordination, as well as whether the provider agency or the county Birth to 3 program is responsible for insurance deductible payments. These considerations may encourage programs to provide more traditional therapies through multiple providers, rather than being more family-centered and utilizing an approach that emphasizes one or two professionals establishing a strong relationship with the family with input from other disciplines as indicated.

Family considerations also play a role in fiscal decision-making. Some programs also experience challenges in accommodating the needs of working families. EI providers may find it hard to carve out time to communicate directly with families and to support child care providers in including children in typical interactions and routines in child care settings. EI providers may also wonder if written information they leave detailing their visit with a child in a child care center is read and understood by the family, and if the time and effort required to communicate directly with the family is efficient and effective.

Some families experiencing difficult circumstances can require a

INFLUENTIAL FACTORS

significant amount of staff resources. Families in transient circumstances often present particular challenges to EI programs. Programs must often spend considerable time and money attempting to contact and interact with families experiencing such difficulties.

Influential Factors

Many factors, both in and out of our control, influence the challenges of service delivery and program implementation. Service delivery is often significantly affected by messages from the federal government, state government, and MA; these messages are often evolving and sometimes contradictory. Fortunately, HFS-90 provides guidance by emphasizing the central nature of family-centered services in EI. Recent research supports service delivery that stays true to the outcomes outlined in a child's IFSP.

Birth to 3 programs work to meet each family where they are, and respect and respond to unique family strengths and needs. Service delivery frequently requires professionals to cross educational, economic, and cultural divides to provide services and supports to families. "We must trust that we can coach those different from ourselves, and help to build that trust with parents through conversations," states Southern

RESource Representative Meredith Green. "[We should] focus on what little piece we can do to make a difference...[we] must take a holistic view of families, including nutrition and mental health, in order to best serve children and families."

County structure also affects the service delivery and fiscal balance. Each county administration's understanding of the benefits and value of EI programming is highly influential. Contracting with therapists or rehabilitation agencies as compared with a Birth to 3 program having its own providers is influential as well. Many county EI programs contract with rehabilitation agencies, CESAs, or

"[Our program] contracts with a provider that understands and supports our work and philosophy. In our contract we have an all inclusive rate that includes participation in monthly staffing as well as attendance at the various components of service to the child and family. Our provider does not balk when the therapists they employ spend some time that is not billable. We have a lot of interaction and communication within our team that makes us a stronger program and results in better services."

Peggy Buchda, Birth to 3 Coordinator, Clark County

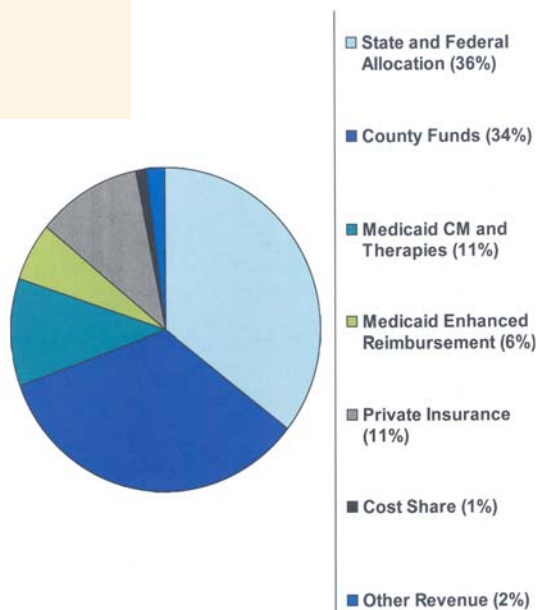
"Our contract for therapy services allows us to house our therapists in our Birth to 3 office, which has been very beneficial in having almost daily contact between all Birth to 3 staff. The therapists are contracted by a total number of hours, rather than by the hour. For example, we have a full time speech therapist [(ST)] and part-time ST, OT, COTA and PT. They work a regular schedule for the program and do not have duties outside the program during those times. This allows for flexibility in what they do for the program and a feeling of overall ownership in the program. This also allows for weekly staff meetings to discuss upcoming referrals, plan for more involved children and consultation with all Birth to 3 staff."

Bridgitte Bodette, Birth to 3 Service Coordinator, Sauk County

other provider agencies to deliver the supports and services required by HSF-90. Ideally, provider contracts are written to reflect the family-centered Birth to 3 philosophy as well as fiscally-sound elements.

Birth to 3 Program 2004 Total Expenditures

- Total Revenue: \$36,548,801
- Total Annual Child Count: 11,514
- Average Cost Per Child for 2004: \$3,174.29
- (Note: Percentages total >100% due to rounding)



INFLUENTIAL FACTORS

Although most counties hire their own service coordinators, less than half hire their own special instructors or educators. An even smaller percentage of programs (estimated at slightly greater than 20%) have their own occupational, physical, and/or speech and language therapists (Wisconsin DHFS Birth to 3 Program Provider Rate Survey, 2006). Programs with their own staff frequently have greater influence in training

“I feel so lucky that we do employ our SLP [Speech and Language Pathologist]. ...Because she is employed by the county, we can use her time and talents in a variety of ways in addition to seeing the children for direct services. She can truly be a part of our team and 100% invested in our program rather than being pulled in other directions for unrelated work duties. She can be more flexible and accommodating to families because her entire work week is with us. She is available to participate in child find events, screenings and to be a consultant on other cases.

[In making the change from contracting to direct employment of the SLP], we basically crunched the numbers and were able to demonstrate [to the county] that it was more cost effective to employ our own therapist. Our program had grown to the point that it could keep a full time SLP busy. We considered the amount that we were paying out to contracted providers in addition to the revenue they were collecting from those that did have insurance. In reviewing this it was very important to count both the lost revenue and the cost.”

Peggy Buchda, Birth to 3
Coordinator,
Clark County

In late 2004 and early 2005, the **Birth to 3 Program Workgroup** was convened at the request of Secretary Helene Nelson, Department of Health and Family Services. A variety of early intervention partners were represented on the Workgroup, including parents. The majority of the members were from county Birth to 3 programs. The group was charged with making recommendations in critical areas related to early intervention services for infants and toddlers. Their recommendations are italicized; supporting narrative text from the full report follows some recommendations.

Recommendations around developing contracts:

The Birth to 3 Workgroup recommends...

...counties develop contracts that require a certain percentage of third party reimbursement or contracts that share risk with provider agencies to assure vigorous third party billing.

...samples of these [successful contract] documents be shared with all counties perhaps as a part of a fiscal management workshop where counties could learn from each other's successes.

“Several counties have developed position descriptions that hold the various early intervention team members accountable not only to families, but also to the county's management requirements. Several counties have also developed strong contracts with their providers which make it clear that their billing practices, service delivery practices and other documentation intended to assure quality and cost-effectiveness are embedded into the agency's practices.”

...sample contract and quality management tools be provided to counties to ensure strong contract management practices to mitigate potential conflict of interest.

“A number of counties raised concerns that contracted agencies that provide intervention services are also involved in providing evaluation and assessment of children for both eligibility, as well as service recommendations. This conflict of interest may lead to more children being served than necessary, as well as some eligible children receiving more services and supports than necessary to meet their developmental needs. This can be addressed through sum certain or risk sharing contracts.”

... DHFS gather and publish rates paid by counties and Medicaid to various providers so that counties are aware of prevailing rates and can assure that they are negotiating a competitive rate for services. Determining and sharing the cost of service per child may serve a similar and valuable purpose.

KEY FACTORS

and promoting family-centered mission and guiding principles, as well as supporting effective practices. This is not always feasible in the smaller, less resource-rich areas of the state.

Another consideration faced by many programs is joint visits with families with more than one therapist in attendance. Billing structures can work against these practices. “These are critical at the beginning [of a relationship with a child and family],” states Karen Williams, Northern RESource Representative. “Joint meetings really demonstrate a team effort in connecting with families. However, only one person can be reimbursed for their time [after the initial evaluation], so joint visits can get to be expensive.”

Key Factors Supporting Family-Centered Service Provision

Many elements are important in creating an environment in which teams can effectively provide family-centered services and supports. Setting appropriate expectations for parents, professionals, and community partners about the Birth to 3 program’s philosophy, guiding principles, and services is important. All of these partners need to be made aware of how the program works with families to facilitate children’s development.

Some programs find that establishing a primary provider can help provide family-centered service delivery in a fiscally-sound manner. Recent research supports the idea that families generally prefer to work with one or two providers as compared with numerous professionals. This can present challenges as time connected to co-treatments is not fully reimbursed, and offsite consultation between professionals is generally not reimbursed. Furthermore, most

providers have not had support in developing skills to coach other providers and families.

“Understanding the training of each discipline may be a necessary part of developing trust among the team,” notes Early Intervention Consultant and RESource Representative Karen Wollenburg. “Determining when language development can effectively be supported by an educator and when speech therapy is required is an important program discussion that requires supervision in implementation... We must go back to the individual family service plan for each child to make this determination.”

“We must keep asking if we are compromising quality [by using the primary provider approach],” comments Western RESource Representative Kathy Boisvert. “It’s really about trust issues among team members. We must intentionally teach each other. We do good work by giving it [(our skills)] away to families and to colleagues.”

We also have had the good fortune of hiring staff that have a strong desire to work in natural environments and have embraced the Birth to 3 philosophy. Even though our Birth to 3 numbers continue to increase, our team has been able to be flexible and positive in providing services. We continue to serve more families with almost the same amount of providers by being flexible, positive, [and] supportive to each other and focusing on our Birth to 3 guidelines. This is not to say that we do not struggle, but we all struggle together and that helps us all get through the really crazy, busy times. Treats at our weekly meetings also seem to help.”

Bridgitte Bodette, Birth to 3 Service Coordinator, Sauk County

Recommendations around workforce recruitment and retention:

The Birth to 3 Workgroup recommends...

...a regional or multi-county collaboration be considered to increase access to needed professionals.

Consistent team meetings, with team training time, are essential in supporting EI providers and teams in doing their best work. This means everyone involved with families in the program meeting together, rather than county hired staff meeting separately from contracted staff. “Some [county Birth to 3] programs put team training time to discuss the importance of family-centered services into their contracts [with provider agencies],” notes Melissa Velez, Southeastern RESource Representative. “Perhaps the [contracted] agency then keeps the enhanced reimbursement for services in natural environments. It’s a give-and-take.”

“We have managed to retain staff, and that saves more money than most people realize. If you figure that it is \$500 just to run a short ad[vertisement] in the paper for one weekend, and it takes tons of time and effort to recruit and train [new staff], it is much more cost effective to maintain quality, proven staff members. We do this not by a great salary (which I wish we could change) but by other motivators (benefits, extra vacation time, a positive work environment, [and] flexible hours).”

Wendi Schreiter, Birth to 3 Program Director, Outagamie County

CREATIVE APPROACHES

Creative Approaches

Given all of these variables, there clearly is not one right answer to address how to deliver family-centered services in a fiscally sound manner. Many counties have done creative problem-solving and achieved a sustainable balance. We'll walk through some of these starting at evaluation for eligibility.

Determining Eligibility

Many counties critically examine their evaluation process to control resource use at the beginning of the process. These counties have determined through experience to strategically identify the most appropriate and necessary team members. In addition to the service coordinator, an evaluation team often consists of an educator or social worker to look globally at the child. Other team members including therapists are involved on an as-needed basis.

Eligibility interpretation can provide another opportunity to examine which children are served within a program. The new *Wisconsin Birth to 3 Program Eligibility Guidelines* (<http://www.waisman.wisc.edu/birthto3/EligibilityGuidelines.pdf>) help to establish consistency across programs, and also include an updated list of diagnosed conditions for which children

qualify for the Birth to 3 Program without documentation of developmental delays. The Guidelines also offer direction in the less clear, or "grey," eligibility areas. Some programs have strict eligibility interpretations, whereas others consider serving children with borderline eligibility criteria. These decisions not only have fiscal implications, but family implications as well.

"We have to ask ourselves if Birth to 3 really is the best option for a child that just missed eligibility requirements," states Northeastern REsource representative Rene' Forsythe. "We say children must have significant developmental delays to receive services. If they truly do not, do we somehow unnecessarily label a child and cause lower expectations? Perhaps these families could be better served by directing them to supports and services within the community." Forsythe notes that these considerations are influenced by federal requirements to reach certain percentages of children.

"We have worked pretty hard in our county to make sure that we are meeting the needs of the families we serve, while at the same time actually doing what Birth to 3 should be doing (saving money in the long run). We have developed some creative strategies that still meet the parameters set by the state, but are likely considered to be 'thinking out of the box'."

Wendi Schreiter, Birth to 3 Program Director, Outagamie County

Recommendations around eligibility determination

The Birth to 3 Workgroup recommends...

...training of program managers and administrators to ensure understanding of the eligibility criteria so that they can monitor consistent eligibility interpretations within the county.

... identification of tools for lower cost screening and tracking, as well as training on such approaches to provide cost savings to counties.

"One concern of Workgroup members was that children who are initially not found to meet the eligibility criteria often require repeated rescreening and tracking. Some counties indicated that these costs could consume any savings from limiting eligibility. These are typically costs that are not reimbursed because the parental fee system cannot charge for these required administrative functions. Often Medicaid and private insurance is not available either."

...the State provide clarification to counties related to the ability of the service coordinator to be one of the minimum of two professionals that comprise the early intervention evaluation team. The Workgroup also recommends that training and technical assistance should be offered to Service Coordinators so that they could assess a child's development in all areas.

"For most teams, the service coordinator could be one member of this team, rather than in addition to at least two other team members. The cost savings of one less professional for a majority of evaluation and assessment teams would be significant. "

CREATIVE APPROACHES

Service Provision

When a child is determined eligible for EI, he or she qualifies for the Birth to 3 program, rather than specific services. The EI team then chooses who delivers the services, as well as service frequency and intensity. We know that more is not always better, and the capacities of the family, extended family, and community supports available to the child and family all should be factored in when making these decisions. Increasingly, some programs are focusing on quality of all available supports and capacities rather than quantity of services delivered only through Birth to 3 programs. This can be complicated when direct service provision is most readily reimbursed.

Some counties try to limit service provision to one or two team members, with consultation from others. Recent research supports that families respond better when services are delivered within one main relationship. Karen Wollenburg discusses the distinction between relationship-based intervention and the

“We focus on looking at services from a family perspective and the staff have learned to be flexible in the services they are providing by supporting what others are doing in the home. For example, if a family is having a difficult time keeping appointments, we may identify one provider that has connected with the family and build on that success by letting that provider be the lead in providing services. The other providers may back out into more of a consultative and supportive role for the lead provider and family.”

Bridgitte Bodette, Birth to 3 Service Coordinator, Sauk County

primary provider approach: “There is a difference between talking about a primary relationship person and a primary provider. In the former, the implication is that the person is there to support the primary relationship of the child and caregiver and to orchestrate the services to individually promote the family’s ability to best support their child’s development. This is an aspect of relationship-based intervention.”

“[In contrast, the] term primary provider often is thought of as relating to the child’s main area of disability,” she continues. “For example, a child with cerebral palsy would have a physical therapist as a primary provider. Clarifying exactly what is meant and having actual practice examples is necessary when a team uses what have become ‘jargon’ terms to

“Another product of this team work is the willingness and ability for all team members to carry over work on skills others are targeting during their own sessions. For example, if the physical therapist knows the speech and language pathologist is working on action words, she will include opportunities to work on action words in her session. In some cases a team member can have more of a consultation role, providing [periodic services,] ideas and support rather than seeing the child on a regular basis. This does not happen all the time for us, it really depends on the child and family and the specific needs, but we are able to look for opportunities to have fewer people in the home on a regular basis. This strengthens the relationship with the family for those who are going into the home and also conserves some resources.”

Peggy Buchda, Birth to 3 Coordinator, Clark County

discuss their approach to the work.” Wisconsin Personnel Development Project Director, Linda Tuchman-Ginsberg, states “The goal is for all providers, including primary providers, to focus on helping children reach their outcomes in the context of a family relationship.”

Team members practicing the primary provider approach must be willing to undergo “role release,” or teach others to use some of their profession-specific skills. “Spend specific and ongoing staff time working through ‘role release’ and supporting other team members to become more adept at specific skills of varied disciplines,” recommends Wollenburg.

“Our program believes that one visitor is the lead when working with a family and child. That person develops a relationship with the family and all that happens goes through the family and this person. For example, the main visitor is an occupational therapist (OT) and she visits the family regularly. When a question arises (from the parent or main visitor) regarding any issue, the main visitor can contact another team member. If it is a question regarding attention, she may contact the educator. When this educator visits, she visits the family and the OT. The OT helps the family ask the questions and helps the educator consider what is important to the family. A main visitor can change based on the needs of the child and family.

This primary provider approach builds a strong team. All members learn to rely on, trust and challenge one another. They teach each other new skills and strategies; they all become better and better home visitors. In many ways they become very skilled generalists and escape the title-related boundaries.”

Michelle Davies, Coordinator, Portage Project Birth to 3 Program

CREATIVE APPROACHES

“The boundary issues around role release and what is appropriate service for a specific child and family has to be an active part of everyday team conversations. For some, this may require a rethinking of professional models of identity.”

Supporting parents or caregivers in integrating therapy into daily routines and interactions can increase the impact of the EI visit and perhaps save resources as well. Although many EI professionals do not receive preservice training on working with

families, many programs encourage the primary therapeutic relationship to be between the professional and the parent, rather than the professional and the child. Children supported to do intervention activities in daily routines will likely progress faster than those practicing one time weekly with the therapist. Working directly with parents is often the best investment of time and resources for the child, as well as for the Birth to 3 program.

Some Birth to 3 programs also consider blended plans for

Recommendations on intervention approaches

The Birth to 3 Workgroup recommends ...

... parent support approaches for intervention should be promoted with professional organizations and through continuing professional education of early intervention providers. Higher education must also shift its focus to prepare professionals to work with families of infants and toddlers.

“The value of transferring knowledge to parents and other caregivers as a foundation for the child’s development must be promoted to the various professional associations. Often therapists are focused on treating the child’s delays rather than fostering the family’s skills and participation.”

...DHFS continues to try to influence preservice curricula to address key elements of the Birth to 3 Program such as natural environments, family-directed and activity-based interventions, promoting the parents’ primary role in their child’s development, and a professional’s role as a consultant versus a direct service provider.

“One county had a creative solution by providing transdisciplinary training for their professional team members. This way the professional located closest to the family is often able to provide the greatest amount of direct service for the child.”



“We believe that children learn within the context of their important relationships and within their regular routines. We try to remember that children don’t learn best in hour sessions with strangers. We strive to find a way to support the family to do the ‘therapy’ through out their day. When families integrate the strategies into their routines, ‘therapy’ happens all the time, not just in scheduled chunks.”

Michelle Davies, Coordinator,
Portage Project Birth to 3
Program

“We are pretty creative with our utilization of community resources. We have a part time social worker that specializes in that area, and she can usually find a solution to any barriers that are present.”

Wendi Schreiter, Birth to 3
Program Director,
Outagamie County

CREATIVE APPROACHES

families, where Birth to 3 services are coupled with other community and medical services and supports. In these cases, each participant must be clear about their role and responsibilities, and families must be aware of each agency's role, their options, and associated expenses. Under these circumstances, the service coordinator's role is crucial.

Another consideration is graduating from programming prior to age three in the case when a child has met his or her outcomes and is functioning at age level. This may be a consideration if a child is steadily becoming age appropriate, and his or her family is comfortable facilitating the child's development without continued professional involvement. Ideally, this expectation has been communicated to the family from the beginning of the relationship. At issue is helping the parent and the provider "let go" when the child is at an appropriate developmental age level and knowing what formal and informal supports are in the community for the family as the EI professional transitions out of their lives.

Counties with success in these areas report ongoing investigation of their practices. They regularly ask: Why are we doing this? Is it better for families? Is it habit? Is there another approach that might look different, but provide services and supports of comparable quality? They prepare the family to see leaving the program as a good and successful step.

They frequently examine the ages of children served (ideally the entire age spectrum is represented, rather than an over representation of older children), as well as the percentage of children served within their county. Counties serving greater

Recommendations around exit policies

The Birth to 3 Workgroup recommends ...

...the State develop policies and procedures defining the circumstances under which services can be discontinued for children with normal development.

"...Some children progress to the point where their development reaches normal levels. Many families whose child reaches this successful milestone are pleased that their child no longer requires intervention. There are other families that are concerned that their child will regress if services are no longer provided, even when services are gradually faded. Counties have indicated that without a state-level policy and procedure for children to exit services under these circumstances, they must continue to provide costly interventions."

than 3% of their population may want to look at their eligibility process.

Billing and Expenditures

Equally as important as eligibility and service provision considerations are billing issues. Nearly all counties (93%) receive targeted case management (TCM) reimbursement (Wisconsin DHFS Birth to 3 Program Provider Rate Survey, 2006). County programs or provider agencies are also receiving enhanced reimbursement for therapies provided in natural environments. If provider agencies receive this additional money, some counties negotiate team meeting time and/or modified travel expenses in contracts to reflect this.

Different interpretations of therapy codes are an additional

consideration. Covered services vary widely among private insurance plans, so coding a particular service in different ways might result in different levels of reimbursement. For example,

"The [Portage Project's] program was originally set up to charge counties a set yearly fee for services. CESA [5] bills the counties an equal amount monthly for these services. The fees are set by figuring a daily rate for our program services. This daily rate factors in all staff salaries, travel and fringe, support staff time, some material and equipment, all incidentals related to the program per CESA. The number of days each county buys is based on the slots (or HV's needed to fulfill the IFSP requirements. In a typical day my staff will see 4-5 children. This number can vary based on the individual needs of families (length of visit etc). The county contract days can change as the caseload does, but over the years we have a good idea.

[In addition], each county bills MA and insurance (not CESA [5]) through their own agency. That way CESA [5] handles no other money. This keeps the money trail simple and clean.

[Finally,] CESA [5] pays all employees on a teacher salary scale. That allows all employees to be paid in an equitable manner (for example, a PT in our program with a Bachelor's degree and 5 years experience is paid the same a teacher with the same education and experience). I see this as a great strength because it values all team members. It fits philosophically with a primary provider approach."

Michelle Davies, Coordinator, Portage Project Birth to 3 Program

CONCLUSION

some health insurance plans will cover occupational therapy services billed under self-help codes, but not under sensory integration codes. Follow-through with the billing department to determine outcomes of coding can also provide useful information.

Conclusion

The balance between family-centered practice and fiscal responsibility in EI programming is not easy. If your program is struggling, consider speaking with your RESource representative, Human Services Area Coordinator (HUSAC) staff, or other counties experiencing success. Consider joining one of the existing support groups for supervisors, or start your own so that the wealth of experience around these issues can be shared regularly. If your program is doing well, please consider sharing what you have learned and what works well. Stay tuned for opportunities for continued discussion from your region's RESource representative, the Birth to 3 listserve, and the Waisman Center Birth to 3 Training and Technical Assistance site. www.waisman.wisc.edu/birthto3/EVENTS.html

References:

Birth to 3 Program Workgroup Recommendations to Wisconsin Department of Health and Family Services Secretary Nelson, 2005.

Wisconsin Department of Health and Family Services Birth to 3 Program, Provider Rate Survey, Draft, 2006.

Recommendations around MA synchronization

The Birth to 3 Workgroup recommends...

...Medicaid documentation be synchronized with the Birth to 3 Program requirements. The Workgroup recommends that there be continued efforts to improve coordination of early intervention services for children with Medicaid HMOs; reduce the separate documentation required for Medicaid reimbursement and the early intervention program; increase accountability of providers to counties in order to receive the Natural Environments payments, and move to accounting for this reimbursement on a per child, per county basis; and provide further training to counties programmatic and fiscal staff in order to maximize revenues available under the State Medicaid Program.

Circles of Life

April 26 -27

Madison Marriott West, Middleton

For details: <http://www.wfv.org/circle/>



Circles of Life

Wisconsin's Annual Family & Provider Conference



AT on a Shoestring (sponsored by Wisconsin Assistive Technology Initiative)

February 6

CESA #9 Office, Tomahawk

For details: www.cesa9.k12.wi.us/registration

Contact: Marcia Obukowicz at marcioa@newnorth.net or 715-453-2141

FEDERAL PROGRAM REVIEW

Wisconsin Birth to 3 Undergoes Federal Program Review by OSEP

Much like individual county Birth to 3 program reviews, the State Birth to 3 Program recently underwent a federal review conducted by representatives from the Office of Special Education Programs (OSEP). OSEP representatives spent several days in early November meeting with staff from the State Birth to 3 Program, RESource and Wisconsin Personnel Development Project (WPDP). Discussion focused on program implementation and monitoring and included extensive data review. Wisconsin was the 50th state in the OSEP review cycle.

Beth Wroblewski, Manager Children's Section Services in the Wisconsin Department of Health and Family Services, and Julia Herwig, B-3 RESource Director, presented the review findings at fall 2006 regional meetings. OSEP staff was generally positive about Wisconsin's Birth to 3 programming, finding it compared favorably with other broad eligibility states' early intervention systems.

Several of the concerns raised by OSEP were highlighted by Wroblewski. They included:

1. Data system: Concern was expressed over the adequacy of the HSRS system to accurately reflect program subtleties. Efforts are underway to design a new system for data management, potentially also including child outcomes data within the main reporting form. Wroblewski anticipated HSRS would gradually be faded out over the next 10 years, with the Birth to 3 Program's transition occurring earlier within the 10 year period.
2. Service timeliness: All services listed on the IFSP must begin within 30 days of IFSP writing to be considered timely. Wroblewski discussed the possibility of distinguishing between early intervention services and supports (such as therapies or support referral), and other services (such as assessment by a neurologist) when writing an IFSP.

3. Transition: The importance of documenting essential transition elements was emphasized, included writing transition steps in the IFSP, holding a transition planning conference, and referral to the local educational agency (LEA).
4. Documenting program problem resolution: Corrections of county-specific problems are to occur within one year, with documentation to include problem resolution dates.
5. Rates of parent-filed disputes and mediation: Wisconsin's Birth to 3 Program has traditionally had low rates of parent-filed disputes. OSEP staff wanted to ensure such rates were low due to overall parental satisfaction with the program, rather than parents' lack of awareness of their legal rights.

OSEP's formal report has yet to be received by the state. It will be shared with counties upon its arrival.



Preserving Early Childhood Conference 2007: Conversations for Change

A forum to promote collaborative approaches for young children in Wisconsin

March 14-15

The Madison Concourse Hotel, Madison

For details: www.collaboratingpartners.com & www.cesa2.k12.wi.us/

Contact: Susan Donahoe sdonahoe@cesa2.k12.wi.us & Jill Haglund jill.haglund@dpi.state.wi.us

Assistive Technology Across the Lifespan Conference

(sponsored by Wisconsin Assistive Technology Initiative)

March 22-23

Holiday Inn Convention Center, Stevens Point

For details: <http://www.wati.org/Training/Conference/AT-lifespan.htm>

Contact :Mary Chapin at mchapin@cesa6.k12.wi.us or 800-991-5576



SELF-ASSESSMENT

A New Wisconsin Birth to 3 Program Self Assessment Process?

What's That?

A new self assessment process is in the works for Wisconsin's Birth to 3 Programs. It was introduced at fall 2006 regional meetings by REsource Director Julia Herwig. Here are some questions related to the new process that might be on your mind.

A new self assessment process? I didn't know my county was doing that! The new self assessment process is currently in the pilot stage with a handful of programs participating. Pilot counties include Dodge, Forest/Oneida/Vilas, Monroe, Walworth, and Waushara counties.

How does the new process differ from what we have been doing? Basically, the new process offers more opportunity for county self-reflection, as well as greater flexibility in the onsite program review. Counties will submit their self-assessment results to the state on an annual basis. If necessary, data will be clarified through conversations with state staff and REsource. On-site review visits continue to be scheduled every 4 years. The focus of this visit will be determined by self assessment data provided by the counties, as well as data verification needs in

response to the OSEP State Performance Plan. The onsite review will typically be a 1-day visit and will offer an opportunity for counties to highlight their work and seek clarification on any areas of concern.

What does the self assessment process entail? The main portion of the self assessment includes a file review checklist. The checklist is 4 pages in length, and is data-focused. It is to be performed annually on at least 10% of children enrolled in the B-3 Program (or at least 9 files, whichever number is greater). Programs will use this information and additional data to respond to a series of questions. Programs will also have the option of looking deeper into their operations through optional surveys, interviews, and planning processes.

How about family surveys and onsite reviews? For most counties, family surveys and onsite reviews will be conducted in the same year every four years. Exceptions include Milwaukee county for whom onsite reviews and family surveys will be conducted yearly, and Dane, Racine, and Waukesha counties for whom family surveys will be conducted annually.

Which family survey has been selected? The ECO Center Family Outcomes Survey will be used. Baseline data is currently being collected from families enrolled as of September 30, 2006.

Why is this better than what we have been doing? The hope is that annual self-assessment will inform counties of their process and programming on a yearly basis, allowing for earlier self-correction and adjustment. Ultimately, the goal is to improve outcomes for children and their families.

When does the process start for all counties? Annual self-assessments for all counties will begin in 2008. During 2007, counties scheduled for an onsite review will also begin the annual self assessment process.

Where can I find out more? The process is currently being piloted. Response from the pilot process will be studied, and the process will be finalized in March 2007. Folders containing draft information on the process were distributed at fall 2006 regional meetings. Additional questions may be forwarded to Julia Herwig at herwig@waisman.wisc.edu

Wisconsin Head Start Association 5th Annual Training Conference *Believe in the Dream*

February 12-14
Kalahari Resort & Convention Center, Wisconsin Dells
For details: www.whsaonline.org/
Contact: Erica Case at 608-442-6879



Seating for Task Performance

(sponsored by Wisconsin Assistive Technology Initiative)

Karen Kangas, OTR/L, Seating and Positioning Specialist
February 15-16
Comfort Suites, Green Bay
For details: www.cesa7.k12.wi.us
Contact: Darlene Verhaagh at verhaagh@cesa7.k12.wi.us or (920) 617-5626

LONG-TERM CARE REDESIGN

Children's Long-Term Care Redesign

Over the next 5 years, the Wisconsin Department of Health and Family Services (DHFS) plans to implement changes to the ways in which care is provided to some of the state's most vulnerable populations. Family Care Expansion, a program focused on managed care issues for adults over the age of 18 years with physical disabilities, developmental disabilities, and the elderly, is being implemented throughout the state. Its objectives are to decrease waiting lists, coordinate care, allow for early involvement, and result in an overall cost savings of around 15%.

Eight consortiums of counties across the state are involved in Family Care Expansion planning, which currently serves about 25% of this population. By June 2009, the goal is for 68% of this segment of Wisconsin's population to be served.

Similar to the adult system, the children's services system is also being remodeled. Known as Children's Long-Term Care

Redesign, the new system aims to address extensive waiting lists for children with special needs through the application of some managed care principles. As with Family Care Expansion, multi-county regions or consortiums will work on developing shared structures to manage these new programs. Children's Long-Term Care Redesign also intends to provide greater unification of children's services, including developmental systems (such as Birth to 3 and Early Childhood Special Education) and child welfare systems.

Although the need for shorter waiting lists, coordinated care, and cost savings is evident, some concerns have been raised over the redesign of the adult and children's systems. Some have feared that the new system will favor aggregate, group-centered care over community-inclusion care. In addition, the impact will likely be different in counties where children and adults are served together rather than in separate systems. Another variable is

county size. It will likely affect personnel sharing and other staffing issues in the redesigned system.

The impact of this redesign on early intervention programming is not clear. This issue was discussed at the December 6, 2006 meeting of the Birth to 3 Interagency Coordinating Council (ICC). Many ICC members wanted Birth to 3 to be part of the holistic consideration of the system's redesign, despite the fact that not all children served in early intervention have long-term care needs. Members also emphasized the absence of waiting lists in Birth to 3 as compared with other children's programs. ICC members drafted a letter to DHFS Secretary Helene Nelson outlining these issues, and recommending thoughtful consideration of early intervention in Children's Long-Term Care Redesign planning. Copies of the letter will also be sent to regional planning consortiums.



The 41st Annual University of Wisconsin Oshkosh Special Education Conference

Snapshot Perspectives: Images of Success

February 22-23

Oshkosh Convention Center and Park Plaza Hotel, Oshkosh

For details: www.uwosh.edu/cont_ed

A Paraprofessionals Guide to the Universe

(sponsored by Wisconsin Assistive Technology Initiative)

Enter the new galaxy of tools that can support student learning throughout the day. Text readers, word prediction, symbol communication systems, Web supports are just a few of the tools we will explore in this strange new world of technology.

February 21

CESA 9 Office, Tomahawk

For details: www.wati.org

Contact: Marcia Obukowicz at marciao@newnorth.net or 715-453-2141



Social-Emotional Development of Infants and Young Children with Orofacial Clefts

Collett, B.R., & Speltz, M.L., *Infants and Young Children*, 2006, Vol. 19, No. 4, pp. 262-291.

Orofacial clefts (including cleft lip only (CLO), cleft lip and palate (CLP), and cleft palate only (CPO)) are the second most common birth defect in the United States. This article begins with an extensive review of the literature on the social and emotional development of children with orofacial clefts published over the last 30 years. The authors review studies examining parent coping and parent-child relationships, infant and early child development, child emotional and behavioral adjustment, child self-concept, peer relations, and social perception.

The core assumption behind much of this research is that children with orofacial clefts are at

increased risk for compromised developmental and social-emotional outcomes. Some research confirms this assumption, whereas other findings have been variable. The authors discuss methodological challenges found in many previous studies, including small sample size, sample bias, cross-sectional (as compared with longitudinal) design, and reliance upon parent self-report without accompanying observational measures.

To address these concerns, the authors designed and conducted a prospective longitudinal study of infants with CLP, CPO, and sagittal craniosynostosis (premature fusion of skull sutures). The child-infant development project (CIDP) charted the developmental course

of these children at 3 months through 7 years of age, with the goal of developing a predictive model of psychosocial functioning in children with orofacial clefts. Initially 76 children with these diagnoses were recruited and matched demographically with control children; approximately 75% of the original sample was retained throughout the study, resulting in a final sample of 113 children.

CIDP researchers examined cognitive and motor findings, attachment and quality of parent-

The authors highlighted the lack of evidence that children with clefts were any more likely than comparison children without clefts to show problems in behavioral adjustment or academic achievement during the later preschool and early elementary school years.

child relationships, feeding and physical growth, effects of facial appearance, behavioral and social adjustment, and emotional regulation. Overall, the CIDP study found few differences between children with orofacial clefts and demographically-matched control children. The authors highlighted the lack of evidence that children with clefts were any more likely than comparison children without clefts to show problems in behavioral adjustment or academic achievement during the later preschool and early elementary school years.

Some differences between the two groups were noted, however. Study and control children were noted to have different patterns of change in attachment status over time (attachment was fairly stable

among controls over time, whereas children with CLP initially showed high and then decreasing levels of secure attachment, and those with CPO showed nearly the opposite trend). In addition, 5-year old children with orofacial clefts demonstrated less expressed disappointment than control peers.

Although few mean group differences were noted between the study and control groups, CIDP data suggest there is a significant minority of children with clefts who may need assistance in their early academic years. One potential area for future research involves

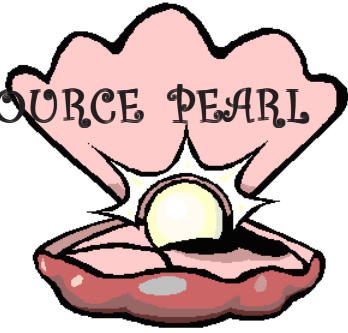
identifying the subset of children at risk for adverse outcomes. For example, maternal-child feeding interactions strongly predicted several outcomes (including early physical growth

and attachment security), and Bayley examination scores predicted later IQ at school entry. "One can easily imagine interventions that would target infants and mothers at the greatest risk," note the authors, "providing additional support and/or specific interventions that would foster positive early relationships and optimize early learning environments."

To view and discuss this article, click "Infants and Young Children" on the ISEI Home Page (www.isei.washington.edu). These articles are in a pdf format exactly as they are published in the journal itself and will be available on the Website until March 31, 2007.

RESOURCE PEARL

RESOURCE PEARL



Tips for your everyday life

Fresh cut flowers are a great way to chase away the winter blues. To help revive wilted fresh cut tulips, place a penny in the vase along with the flowers. The copper from the coin will help to increase the stem's turgor pressure.

-Meredith Green, Southern RESource Representative



Orientation to Mentoring for Early Childhood/Special Education and Care Professionals

(sponsored by CESA 8)

February 26-April 29, **Online Course**

This is a foundation course for the professional educator interested in learning about the mentoring process. This course will support mentors in their important role of working with beginning teachers. Teachers interested in learning more about consulting, collaborating and coaching families and colleagues would also benefit from the course.

For details: <http://www.waisman.wisc.edu/birthto3/OMentor.pdf>

Contact Nancy Pfankuch at npfankuch@wi.rr.com or 920-694-0862

2007 ASW Annual Conference

Kalahari Autism Safari: Journey through the Spectrum

May 10-12

Kalahari Resort & Convention Center, Wisconsin Dells

For details: www.asw4autism.org

Contact: Jane Pribek at asw@asw4autism.org or 920-553-0278



Make & Take - Visual Support Strategies for Students with Autism Spectrum Disorder

(sponsored by Wisconsin Assistive Technology Initiative)

February 26

CESA 9 Office, Tomahawk

For details: www.wati.org

Contact: Marcia Obukowicz at marcio@newnorth.net or 715-453-2141

Birth to 3 Interagency Coordinating Council Meeting

September 2006

Waukesha



Cindy Flauger and ICC Chair Sandra Butts



Resources for Continuing Early Intervention Professional Development

B-3 List Serve: Sign up for this list serve through Yahoo! Groups, and receive timely and relevant emails on upcoming B-6 trainings and program updates. Simply enter "b3etn" on the *Find a Yahoo! Group* page, along with your email address and other information to join this group. <http://groups.yahoo.com/>

WisLine Teleconferences: You may call in from your office on a toll-free number for these conferences held on the second Thursday of every month from 1-2:30 pm. Topics are diverse and range from therapeutic strategies to programmatic updates. Information on these trainings is posted on the DHFS B-3 Wisline site (<http://dhfs.wisconsin.gov/bdds/b3etn/index.htm>) and the Waisman Center B-3 Training and Technical Assistance site (<http://www.waisman.wisc.edu/birthto3/EVENTS.HTML>)

RESource Representatives: Offer direct technical assistance to B-3 administrators and professionals within five regions throughout the state. To learn more about your region's representative, visit: <http://www.waisman.wisc.edu/birthto3/staff.html>.

Waisman Center B-3 Training and Technical Assistance Website: A wealth of information on upcoming trainings, program details, and best practices in the field of EI. The site also contains an educational module designed for new service coordinators, background information on Wisconsin's Birth to 3 Program, and much more. <http://www.waisman.wisc.edu/birthto3/>

Children and Youth with Special Health Care Needs Centers: Five Regional CYSHCN Centers in Wisconsin provide free and confidential assistance to providers and children with special health care needs and their families. http://www.dhfs.state.wi.us/DPH_BFCH/cshcn/CntrsFrstStep.htm

Collaborating Partners: An online community for parents, administrators and staff of early education programs throughout Wisconsin. Information on Child and Family Outcomes is regularly posted on this site. <http://www.collaboratingpartners.com/>

Birth to 6 EVENTS

Wisconsin Personnel Development Project

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For additional information, call 608-890-0144, 1-800-532-3321, or email keil@waisman.wisc.edu

Deadline for submissions to next Birth to 6 EVENTS: April 20, 2007.

WPDP website: www.waisman.wisc.edu/birthto3/