Case Study
Standard 2: Partnering with Families

Case Study	Discussion and Resources
In this story, Frank, his family, and early intervention (cross-disciplinary) team navigate challenges and demonstrate components of Standard 2 Partnering with Families: • Candidates use their knowledge of family-centered practices and family systems theory to develop and maintain reciprocal partnerships with families. They apply family capacity-building practices as they support families to make informed decisions and advocate for their young children. They engage families in opportunities that build on their existing strengths, reflect current goals, and foster family competence and confidence to support their children's development and learning. **Resources to support adult learning:** • [ECPC Curriculum Modules: Professional Standards](#) • [Resources You Can Use for Pre- and In-service Professional Development (DEC Website)](#) • [Supporting Explanations for Early Component](#)	*The specific components of Partnering with Families are listed as bulleted items below. Highlight in the story when professionals and caregivers navigate challenges and demonstrate these components. Reflect on your own and compare your findings with others in small groups.* **Specific components include:** • Applying their knowledge of family-centered practices, family systems theory, and the changing needs and priorities in families' lives to develop trusting, respectful, affirming, and culturally responsive partnerships with all families that allow for the mutual exchange of knowledge and information. • Communicating clear, comprehensive, and objective information about resources and supports that help families to make informed decisions and advocate for access, participation, and equity in natural and inclusive environments. • Applying knowledge of biological and environmental factors that may support or constrain children's early development and learning as they plan and implement early intervention and instruction. • Engaging with families in identifying their strengths, priorities, and concerns; support families to achieve the goals they have for their family and their young child's development and learning; and promote families' competence and confidence during assessment, individualized planning, intervention, instruction, and transition processes.

Case Study	Discussion and Resources
Frank, His Family and Important Adults	

Frank, His Family and Important Adults

Francisco (Frank) is a 20-month-old boy that was born prematurely at 30-weeks gestation. He had a low birth weight at 2 lbs. 6 oz. and was diagnosed with cerebral palsy and microtia of the ear. Due to his early arrival, Frank's lungs had not developed fully, and he was diagnosed with respiratory distress syndrome (RDS), apnea, and retinopathy of prematurity (ROP). He spent twelve weeks in the Neonatal Intensive Care Unit (NICU). Due to these conditions, he used a ventilator until he was two months of age to help maintain sufficient oxygen levels in his blood.

Since the departure from the NICU, Frank's journey has been challenging with multiple hospitalizations and illnesses. He has had pneumonia twice. His mother has been his primary caregiver during this time. Now at 20-months, Frank's health needs have stabilized, and he has made many improvements thanks to his Early Intervention team, and his mother who dedicated most days to caring for and supporting him.

His mother, Isabella (Izzy), has decided it is time to return to the workforce and their extended family has decided to babysit Frank. She plans for Frank to spend two days per week at his grandparent's house and three days per week at his aunt's house. They all live nearby in a small rural community outside of the city. Izzy is one of five children, and they are close. On Sundays, the family usually attends church and then eats dinner together. Izzy is the oldest child in the family; Frank was the first grandchild born. The family members identify as Latino.

Frank's grandparents, Bella and Papi immigrated from Mexico and have five children of their own. They speak English and Spanish in the home.

Izzy is the oldest at 25. Mimi has been a stay-at-home caregiver while Papi worked as a history teacher at the local high school. He retired about five years ago and now drives a bus for a local school district three days per week.

Discussion and Resources

As is highlighted in the standards, candidates need to apply the knowledge of biological and environmental factors that may support or constrain development. In this case, it is important to know how to define Frank's conditions, their impact on infant development and learning so that we can plan and implement intervention and instruction that meets his needs.

This standard focuses on the *family*. Specifically, it addresses a candidate's ability to understand and apply family-centered practice (i.e., culturally competent practice in natural settings that involves and actively engages the family in decision-making and the provision of services/therapy). The resources shared here will be more focused on providing families with information to build understanding of their child's conditions.

Characteristics and Potential Causes (etiologies) Learn more by exploring the content of each link below:
- Cerebral palsy – Cerebral Palsy Family Network
- Prematurity – March of Dimes
- Microtia of the ear – Ear Community
- Respiratory Distress Syndrome – Nationwide Children's Hospital
- Apnea – Nationwide Children's Hospital
- Retinopathy of Prematurity (ROP) – March of Dimes

EI/ECSE candidates also need to understand how to describe and define family-centered practices, partnering with families, and family systems theory. To learn more about these areas explore these videos and learning modules below:
- Developing Child Harvard – Building Adult Capabilities to Improve Child Outcomes
- Connect Modules – Effective Partnering with Families

Consider Frank's conditions, hospitalizations, and illnesses. How do you think these have impacted the family's life over the past two years?

Frank's father works full-time to provide for his family, his work requires some evening hours. With his work schedule, he does not get to see Frank or the rest of the family very often. He has not been able to participate in IFSP meetings or home visits with providers. Frank's aunt, Luisa, was recently let go from her job due to downsizing. She is 23 years of age and has some experience working as a babysitter and childcare provider. She is fluent in English, but often speaks Spanish in the home.	Consider reading this post to learn more about this impact: • Supporting the needs of children who are medically fragile and their families – National Association for the Education of Young Children Have you had the opportunity to support fathers? Frank's father has had limited participation in Early Intervention services. Consider exploring these resources focused on supporting father involvement: • Article supporting Father involvement in EI • An example of a program Supporting Father Involvement (SFI) • Presentation on father involvement
Navigating Changes in Frank's Caregivers During their next home visit, Izzy shares with Virginia, the primary service provider (PSP) and physical therapist, about the planned shift in daily caregivers and locations. When Virginia leaves the home, she identifies that she needs advice to navigate changes that might need to be made. Virginia sits in her car for a minute and emails her supervisor. She asks if she can add a discussion of Frank and his family to their next group team meeting. On Thursday, Virginia attends their weekly meeting. These meetings include the entire EI team that is employed by the school district. The team includes three speech-language pathologists, a physical therapist (Virginia), two occupational therapists, four service coordinators, two administrative assistants, and their program supervisor. About two years ago, their state implemented changes that asked districts to use the PSP approach to teaming. This was challenging for their team at first because their approach was so different, but Virginia has found that it has led to increased collaboration and a reduction in service redundancy. She has also found that it is an approach that lends itself to helping teams find a common ground across multiple caregivers. Because Izzy has been Frank's primary caregiver, it has been easy for the team of multiple providers to coordinate their services. Now that there will	Are you familiar with the Primary Service Provider (PSP) approach to teaming in EI? If not, learn more about various approaches, including the PSP, through exploring the links below. While you explore, consider – what delivery approach is used to provide services by your team? Service Delivery Approaches: • Multidisciplinary • Description and comparison of service delivery approaches • Transdisciplinary (also called Primary Service Provider) The team in this case study uses the transdisciplinary or PSP approach. It can be helpful to share the **definition** and role of a PSP in EI service delivery with the caregivers. Creating resources to explain the rationale and structure for the PSP approach to families can be helpful. Explore the examples of explanations of the approach: • Early Steps – PSP Approach Handout – Gulf Central Early Steps Program • Academy of Pediatric Physical Therapy – Using a PSP Approach to Teaming • The Early Intervention Teaming Handbook by Shelden and Rush (2022)

be multiple environments and caregivers, with diverse family dynamics.

Each time the team meets, they follow a consistent agenda. This agenda includes updates/announcements from the manager, training and professional development opportunities, review of newly assigned EI children/families that qualified for services, and an opportunity for providers or service coordinators to request support and feedback from the group on specific challenges. Occasionally, they will divide into smaller groups to review documents, provide targeted support to team members, and other collaboration/teaming needs.

During the meeting, it is Virginia's time to share. She provides a description of the changes in Frank's natural environments and primary caregivers. Then, she asks her team for their thoughts. Below is a summary of what was discussed:

- Frank's annual review for his Individualized Family Service Plan (IFSP) is upcoming at 24-months of age; therefore, this may be a good time to re-evaluate and gather assessment information about family resources and the priorities of the other caregivers.
- Through the evaluation process the team can determine new skills he may need due to the shift in his environment. Natural learning opportunities at his grandparent's and aunt's house can be determined.
- The IFSP document will need to be modified to reflect changes in the environment. New child and family outcomes may need to be added as well.
- The team identified that Virginia's role (along with other team members) will be to build capacity from one primary caregiver (Izzy) across multiple caregivers that may have different perspectives and experiences with Frank.

- o [Link to Handbook](#)
- o Link to Chapter 1 – [Introduction to a PSP Approach to Teaming](#)
- Family Infant and Preschool Program resource website
  - o CASEtools - [Checklists for Implementing a Primary-Coach Approach to Teaming](#)
  - o Fidelity in Practice – [Primary Service Provider (FIP-PSP) Checklists](#)
- Virginia EI Professional Development
  - o Primary Service Provider… What Does That Mean? - [Early Intervention Strategies for Success Blog](#)

Due to the collaboration and teaming needed for EI professionals to provide coordinated services, consistent meetings are important. Does your team meet regularly? How is the agenda determined? How is the meeting facilitated?

These presentations from the Early Intervention Training Network in Illinois can be helpful in learning to facilitate meeting successfully:

- [Defining Facilitation](#)
- [Roles of a Facilitator](#)
- [Facilitating Teaming](#)
- [Facilitation Tips](#)
- [Overcoming Facilitation Barriers](#)

Are there other items or issues you might recommend the team considers and discusses?

- This [professional development document](#) from the Early Childhood Technical Assistance Center documents how changes can be made on the IFSP document (p. 84)

How familiar are you with the steps of the IFSP process? And the components of the IFSP document? Did you know the IFSP is a living document that can be modified at any time?

- [Learn more about the IFSP components](#)
- [IFSP is a living document](#)

Next Steps to Support Frank and His Family Virginia was thankful her team had lots of suggestions for how to move forward with supporting Frank and his family. She is a little overwhelmed about where to start so she asks for Frank's team of providers to convene after the large group meeting. Frank's team includes Virginia (physical therapist), an occupational therapist, a speech-language pathologist, and a developmental specialist. His family also has occasional support from a hearing specialist, due to the microtia and hearing loss. She was not present at the large group meeting as she works across several times and cannot always be present. During this meeting, they first determined that they would schedule Frank's re-evaluation as soon as possible. They will ask his grandparents and aunt to attend the evaluation. During this process, they will conduct assessments focused on the family members and their experiences in the different environments. Then, they will schedule an IFSP meeting and invite all team members. During this meeting, they will discuss with the family changes to services that may need to be made and determine, if appropriate, additional child and family outcomes. The current plan included visits to Frank's home one time per week with the physical therapist for an hour, two times per month with the occupational therapist, one time per month with the speech-language pathologist, one time per month with the developmental specialist and every other month visits with the hearing specialist. The providers often conducted home visits with one another. The assigned service coordinator scheduled the evaluation and assessment with providers and Frank's family. His grandmother attended in person and his aunt participated virtually via web conference. Virginia and her team member Susan (speech language pathologist) conducted the re-evaluation and assessment gathering rich information on Frank's experiences with his caregivers across environments.	Consider the evaluation and assessment conducted by Frank's team. What tools might they use to evaluate him? What tools might they need to include to conduct assessments related to his everyday experiences with other caregivers such as his grandparents and aunt? What tools does your team use? To understand the interactions with Frank and his extended family members that will be caring for him, his team may consider using several tools. This assessment is an example of the application of family systems theory as it focuses on the environment, family characteristics, and their impact on his development. First, the team may consider completing an Ecomap with the caregivers to determine informal (friends, extended family) and formal (doctors, service coordinators, providers) supports along with the strength of those supports. The Ecomap is an important part of a Family Directed Assessment. Explore these resources below to learn more about the eco-map process: • [What is an Ecomap?](#) • [Ecomap Development Checklist](#) • [Lost? Use an Ecomap!](#) Next, to dig deeper into daily family routines, the team may use another tool such as the Routines-based Interview (RBI), Satisfaction with Home Routines Evaluation (SHoRE), or the Measure of Engagement, Independence, and Social Relationships (MEISR). It is possible that his grandparents and aunt may not have had experiences with caring for Frank within the context of these daily routines, yet; however, these assessment tools can help the team to determine the experiences they have had so far. Explore the links below to learn more about these tools. • [RBI Checklist with Ecomap](#) • [RBI at review and annual update](#) • [SHoRE](#) • [MEISR (old version)](#) • [Published MEISR](#)

After the evaluation and assessment, the team scheduled the annual review and IFSP meeting. Luckily, all team members were available to attend.

At this meeting, the team first reviewed the results of the evaluation and assessment. Virginia took the lead and shared that Frank has made great progress on his current outcomes but still qualified for all the same services he was currently receiving. Izzy has also met her outcomes of identifying a support group and engaging in reflection/self-care at least two times per month.

With the change of environments and provider, the team discussed how to arrange services. Jointly, with the family, they determined that Virginia would visit Frank's home one time per month, Bella and Papi's home one time per month and Luisa's home two times per month. Frank has made progress in the last two years and the team has found that they collaborate well and are all on the same page, generally, when it comes to supporting Frank. Therefore, they determine Virginia's frequency of services will stay the same (1x per week) except she will alternate homes between Frank's, Bella and Papi's, and Luisa's homes to make sure she can support all caregivers.

Changes in service frequency

The team determined they would decrease occupational therapy to one time per month and increased the developmental therapy services two times per month. Frank was nearing the time where transition would need to be discussed; therefore, it was important the developmental therapist stepped in more frequently to prepare the family for that shift. Providers would consult with the PSP (Virginia) and engage in role-release by supporting the caregivers as they use strategies to support Frank's speech/language, self-care, and other developmental needs.

Identifying resources

The team had used the Ecomap to gather information on family resources. The Ecomap showed that the entire family has a dedicated support system in their Catholic church community. They also identified that the family was close knit and relied heavily on one another. Further, the Ecomap identified that Frank received a great deal of

- [Video of using the MEISR](#)

The team members may also want to conduct authentic, functional assessment through which they observe the family members with Frank during daily routines.
- Universal Online Part C EI Curriculum Learning Modules – [Authentic Assessment in EI](#)
- Podcast – Ongoing [Functional Assessment](#)

Does your team have a process you use to determine, jointly with the family, who is best to provide services or how frequently the services occur? And how is the PSP determined?

Interestingly we do not yet know entirely "how much" services are enough in EI. More research is needed in this area! Why is this? The Early Intervention Strategies for Success explores some of the reasons why.
- [Service Frequency – How Often is Enough?](#)

Some research ([McManus et al., 2019](#)) has demonstrated that more services were associated with more child gains.

It can be helpful; however, to utilize tools as a team to determine, in a consistent manner, *how often* services will occur. Here are some resources that may be explored:
- [Worksheet for Selecting the Most Likely Primary Service Provider](#)
- ["Dosage" for Early Intervention Services](#)

What resources may be helpful and support all caregivers? It seems as if their Catholic faith is important to the family. Currently, it doesn't seem as if they are utilizing the church to support Frank. What recreational activities might be helpful for Frank's development that align with his needs as a child with cerebral palsy? What activities may exist where he can engage with same-age peers?

How might you and your team approach making sure all team members are on the same page to build capacity across multiple caregivers?

One important strategy to support well-coordinated, consistent services is to involve families in the planning

services outside of EI. He had been attending outpatient sessions with a private physical therapist and occupational therapist. He was lacking in interactions with peers and other recreational activities.

Building the capacity of multiple caregivers
A challenge Virginia was unsure of how to approach was making sure that all family members received the same information and support from the team. She knew that it was important to focus on building the competence and capacity of all caregivers to support Frank's needs. His aunt Luisa was young and had not experienced caregiving for someone like Frank before. Bella and Papi had five children, so it's likely they had some already established expectations about caregiving in general.

During the IFSP meeting, the team determined they would continue to support Frank and his family towards five of his seven existing outcomes. Izzy had met her two priorities (e.g., support group, and self-care) and following the assessment, his grandparents and aunts seemed to have different areas they wanted to improve. Bella wanted to be able to take Frank to the store with her. Luisa wanted to learn how to transport him safely from place to place. The team developed three additional outcomes emerged. These focused on obtaining a vehicle all family members could use to transport Frank from place to place, learning to support him and engage him in public spaces (including the store), and identifying two social outings he could participate in to engage with same-age peers.

process. By including Bella and Luisa in the IFSP meeting, the team did just that! Here is a video that focuses on involving families to encourage and build capacity.

Another strategy to build capacity is for providers and service coordinators to utilize a similar structure and framework during visits. There are several different evidence-based frameworks that have been developed. Each of these focuses on building a relationship/partnership with families and coaching them to embedding strategies within daily activities and routines.

Explore a few frameworks and resources below:
- Family Guided Routines Based Intervention
- Getting Ready Approach
- Coaching in Early Intervention

- Is there a plan to coordinate all the services that Frank receives?
- Is there coordination across the private and EI providers?

Virginia and the other providers may need to consider how to coordinate and engage all providers, family members, and other individuals supporting Frank.

- What type of communication may be helpful with this coordination?
- How does your team share information with other providers?

Additional Discussion Questions:

1. Consider the languages spoken in each home. It is likely that Frank is exposed to individuals using two different languages to communicate with him daily. How might this impact his development? What might the team need to consider related to teaching him to communicate?

2. What additional professional might be important to support visits with Bella, so she feels fully included and understood?

3. Knowing that Frank's family is Mexican, what cultural and language aspects may need to be considered to support them well?

4. Knowing that Frank's family is Catholic, what could the service coordinator look for in the local community that may support him or his caregivers?