

Guidance · Resources · Procedures

Guidance For Collaboration Between Community Partners & Early ACCESS

DEC Recommended Practices call on all professionals who work with young children and their families to engage in "teaming and collaboration practices that promote and sustain collaborative adult partnerships, relationships, and ongoing interactions to ensure that programs and services achieve desired child and family outcomes and goals" (DEC, p. 15). This guidance is designed to promote coordination and collaboration among Early ACCESS providers and their community partners (e.g. Early Head Start, child care including family child care, home visitation programs, child welfare agency, etc.) by clarifying roles and responsibilities so appropriate expectations are understood, opportunities for connections are increased, and service duplication and gaps are addressed (see self-assessment).

The ultimate goal is to increase the effectiveness and efficiency of services for children and families receiving services from Early ACCESS and additional programs. As with everything in the IFSP process, partnership with community organizations should be done through engagement with parents and caregivers, including the consent to exchange information about the child and family.

What follows is general guidance for Early ACCESS providers and their community partners who have children receiving Early ACCESS services or have children potentially eligible for Early ACCESS services. The guidance is organized around four key phases in the provision of Early ACCESS services:

- 1. Screening, Referral, and Enrollment
- 2. IFSP Development
- 3. <u>Service Delivery (IFSP implementation/monitoring)</u>
- 4. Transition



Screening/Referral/Enrollment

EARLY ACCESS	COMMUNITY PARTNER
1. Understand the purpose of community partner programs and enough information about what the programming entails to inform families if a referral is needed.	Understand the purpose of Early ACCESS and enough information about what services entail to inform families if a referral is needed. See Mission & Key Principles
	See Iowa Family Support Network - Early ACCESS <u>website</u>
2. Identify and form relationships with community partners (beyond medical providers) in your service area who are doing routine screening for developmental, behavioral, and sensory delays or concerns. These partners serve as referral sources.	2. If your agency is doing routine screening for developmental, behavioral, and sensory delays or concerns, inform local Early ACCESS providers so they are aware and understand your procedures for sharing results. Refer families to Early ACCESS as necessary.
3. Use screening data provided by community partners as much as possible and support them to make improvements in their screening procedures when needed. Cooperate with community partners if additional data collection is needed.	3. Inform the family of the screening results and get their permission to make the referral to Early ACCESS. Provide all evidence you have collected when families are referred and make sure you have parental permission to share data in advance. Cooperate with Early ACCESS if additional data collection is needed.
4. On an annual basis, develop written agreements with community partners that describe the data needed to make an eligibility determination so community partners can help identify and determine potentially eligible children.	4. Work with Early ACCESS to develop written agreements that include what data you are willing to provide and how that data can be shared with Early ACCESS. If possible, make needed adjustments to your screening procedures and tools to facilitate the identification and eligibility of children.



IFSP Development

EARLY ACCESS

COMMUNITY PARTNER

- 1. Include any adult directly and regularly interacting with the child (i.e. involved with daily routines and activities) in the development of the IFSP (outcomes, strategies, etc.). Identifying and involving those adults should be done with the full knowledge and consent of parents and other caregivers. If not able to attend physically, the service coordinator should gather relevant information from these adults.
- 1. When a child in your program is enrolled in Early ACCESS, communicate with the Early ACCESS service coordinator about how the representatives from your program can be involved in the IFSP development, taking into consideration the desires of parents or other caregivers. Make an effort to participate actively in the IFSP team as possible and needed. Involvement should include sharing relevant information about the child and family based on your ongoing involvement with them. Ensure the IFPS team understands what services you are providing to the family and child.
- 2. As part of the IFSP development process (not necessarily as part of the IFSP itself), and using a collaborative process, establish clear and mutually agreed upon roles, procedures and strategies for EA early interventionists, caregivers and community partners to perform as part of the IFSP implementation. The goal is a single plan for implementation that describes what is done and who does it so all work related to the IFSP is coordinated and not duplicative of other services. (Include this as part of the written agreement, if desired. Here are samples of written agreements.)
- 2. Participate in a collaborative process with Early ACCESS to establish all roles, procedures, and strategies related to the IFSP outcomes and meeting those outcomes. Know what supports are needed to perform those roles, follow procedures, or implement the strategies. Ensure that the IFSP team understands how the roles, procedures, and strategies support your family/child plan. These issues should be addressed and resolved as part of the IFSP development process.

Service Delivery (IFSP implementation/monitoring)

EARLY ACCESS

COMMUNITY PARTNER

- 1. Equip and support community partners and other caregivers to perform the desired, coordinated work. Participate in training and meetings offered by community partners as necessary to perform the coordinated work. Create and use mutually agreed upon checkin processes to evaluate roles, procedures, and strategy implementation to support IFSP team members and community partners. Monitor child and family progress and use the information to continuously improve the processes.
- 1. Participate in training and meetings as necessary to perform the coordinated work. Create and use mutually agreed upon checkin processes to evaluate roles, procedures, and strategy implementation to support IFSP team members and community partners. Monitor child and family progress and use the information to continuously improve the processes.
- 2. Establish at least monthly communication with community partners to share progress monitoring data, make adjustments in implementation plans, and coordinate activities as needed. It is both parties' responsibility to make sure communication occurs, and communication is, by definition, two-way (maybe multilateral if more than two partners involved.)
- 2. Establish at least monthly communication with the Early ACCESS service coordinator to share progress monitoring data, make adjustments in implementation plans, and coordinate activities as needed. It is both parties' responsibility to make sure communication occurs, and communication is, by definition, two-way (maybe multilateral if more than two partners involved.)

All parties need to be willing to share data relevant to the child's IFSP outcomes, current status and progress toward reaching those outcomes. If transfer of protected information is involved, consent from families to share information among partners and Early ACCESS is required. (Include this as part of the written agreement, if desired. Here are samples of written agreements.)

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- 3. Establish in writing how communication between Early ACCESS and community partners is initiated and reciprocated, and how disputes among parties are resolved.
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Transition

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1. Provide families options for services once the child turns three, including early childhood special education (Part B) services if needed, and support the family in choosing their next steps.	1. Help to ensure families are aware of service options once the child turns three.
2. Identify the needed supports for all children (regardless of whether they will continue with Part B or not) to best support them during their transition to their new setting.	2. Understand the needed supports for all children after they turn three, and offer to provide them if appropriate and the community partner is able to.
3. Communicate with the new service providers; share data after receiving parent consent and provide necessary information regarding support for the child to be successful in the new setting. Understand what supports and services are available in the new setting/program. Work with the partner to prepare the best possible environment to support success.	3. Gather family and child information from Early ACCESS service coordinator and share any additional information partner program has so there is a joint understanding of what will support the child to be successful in the new setting/program. Work with Early ACCESS to prepare the best possible environment to support success.
4. Provide support for the family, the child, and the community partner to be prepared for the transition to the new setting, including equipping parents to be advocates for their child. Work with family, child, and community partners to help the family understand the new setting/program through written materials, conversations, and visits when possible. Include policies, procedures, and opportunities for family engagement in the new setting. Support the child's transition to a new setting/program through activities such as visits, talking about changes, sharing photos or items between home and the program, and sharing routines from home and those of the new program.	4. Provide support for the family and the child to be prepared for the transition to the new setting, including equipping parents to be advocates for their child. Work with family, child, and Early ACCESS to help family understand the new setting/program through written materials, conversations, and visits when possible. Include policies, procedures, and opportunities for family engagement in the new setting. Support the child's transition to a new setting/program through activities such as visits, talking about changes, sharing photos or items between home and the program, and sharing routines from home and those of the new program.

