2021 GEORGIAN EARLY CHILDHOOD INTERVENTION: PROGRESS on the PRACTICE STANDARDS

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Prepared for Open Society Georgia Foundation, the Georgian Coalition on Early Childhood Intervention, and the Ministry of Labor, Health, and Social Affairs.

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Executive Summary

Early Childhood Intervention (ECI) is comprised of professional systems and services for young children with developmental delays, disabilities, atypical behaviors, social and emotional difficulties, or young children who are very likely to develop a delay before entering primary school due to malnutrition, chronic illness, or other biological or environmental factors. ECI services are for children birth to three years old but also can be extended to children up through five years of age. Through the provision of ECI services, many early childhood difficulties are reduced or fully overcome. Additionally, ECI services improve family quality of life and supports family preservation.

The Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD) provide foundational support for ECI as a human right for infants and children with or at risk of developing disabilities. As well, the European Disability Strategy 2010-2020 reiterates and supports many of the aforementioned rights including the child's right to inclusive education; access to social protection systems; and encourages "the development of early intervention and needs assessment services" for individuals with disabilities.

ECI services can be conceptualized within five broad processes: (a) outreach and referral; (b) comprehensive assessment and individualized planning; (c) service delivery; (d) monitoring and evaluation; and (e) transition planning. Effective ECI services must be individualized, family-centred, team-based, evidence-informed, outcome-driven, and contextualized. **ECI service delivery occurs in natural environments** such as the family's home or the child's preschool instead of rehabilitation centres or special schools. Within the field of ECI, there has been a move away from service providers directly working with children. Instead, ECI service providers consult with, coach, and mentor the adults who spend the greatest amount of time with a child (e.g., a parent or teacher). Therefore, **the ECI service provider's role is to provide support to the parent or teacher through consultation and coaching**.

In 2011, First Step Georgia and the Association of Neurologists and Neurosurgeons with support from Open Society Foundations (OSF) developed ECI service standards. In June 2020, the Ministry of Labor, Health, and Social Affairs (MoLHSA) adopted the current standards. **The purpose of this report is to document compliance with the current standards.**

This mixed-method study is based on survey and focus group data obtained from ECI directors, specialists, providers, and parents. Audio recordings of ECI visits were also collected and scored and a document review was conducted. Twenty-seven ECI programmes participated in this evaluation. In total, 217 early development specialists; 28 directors; 16 ECI supervisors; and 376 parents/legal guardians submitted survey data.

Existing Strengths

ECI organizations demonstrated high administrative adherence to standards including: internal regulations; confidentiality regulation compliance; record of provider health and conviction certificates; recording of mandatory information (e.g., cases of abuse, parent/guardian complaints); use of MoLHSA-approved assessment tools; use of home visit record form; and evaluation timelines. Programmes also employ personnel with the required education and experience, have job descriptions in place, and almost all providers work 40 hours per week or less. Providers support one another through teaming with group meetings taking place once per

month. Parents/guardians overwhelmingly report ECI sessions as a positive experience and indicate providers are easy to talk to and show them what they can do with their child. Most providers collect feedback from parents/guardians

Opportunities for Improvement

ECI services in Georgia are very good. However, the main area for improvement is moving away from child-focused services. At present, the process of goal development focuses mainly on child developmental domains and the development of domain-specific recommendations to be carried out by the family between provider visits. While providers are friendly and respectful, they primarily use the Child and Family Individual Service Plan (ISP) recommendations as the basis for their visits rather than the parent's/guardian's priorities and concerns. Child goals lack emphasis on necessary functional participation through everyday routine activities with specific criteria.

The mismatch between the existing practice and ECI Coalition philosophy may stem from ISP forms and procedures that emphasize a child-centred, domain-specific approach. Lack of an appropriate family needs assessment that would yield information about family concerns and priorities, family and child daily routines and strengths, and existing family resources contributes to the problem.

Reflective, collaborative supervision is lacking at all levels and urgently needs to be put in place for paraprofessionals with funding from MoLHSA. Supervisors require additional guidance to develop provider confidence, knowledge, skills, and practices by modelling a collaborative communication approach that providers should be using with their cases.

The ECI Coalition requires funding to revise some existing training information and forms and develop online professional development in the areas of collaborative consultation-based visits with families and coaching and supervision.

Moving forward, the ECI Coalition should receive annual funding to carry out a provider needs assessment and develop new professional development that may be delivered online and in-person.

MoLHSA and the ECI Coalition should adopt specific indicators for each standard and collect and summarize the data on these indicators each year. The ECI Coalition should receive support to coach ECI programmes failing to meet specific indicators.

Introduction

All infants and young children need many positive interactions with their primary caregivers, family members, and environment. Repeated, positive experiences in a safe, hygienic environment, along with good nutrition, sufficient sleep, and access to medical care support a child's development. These needs can increase when a child has biological differences or early adverse experiences. Through the provision of early identification of children and families in need of support, many early childhood difficulties are reduced or fully overcome through the provision of Early Childhood Intervention (ECI) services. Children develop improved social relationships, independence, and meaningful engagement in home and community settings including through inclusive early childhood education provision. ECI services improve family quality of life and supports family preservation.

Overview of ECI

Early Childhood Intervention is a cross-sectoral, transdisciplinary, and integrated service. ECI is comprised of professional systems and services for young children with developmental delays, disabilities, atypical behaviors, social and emotional difficulties, or young children who are very likely to develop a delay before entering primary school due to malnutrition, chronic illness, or other biological or environmental factors. ECI services are for children birth to three years old but also can be extended to children up through five years of age.

ECI has systems-level infrastructure components and service-level mechanisms and approaches. Implementation of durable ECI within a country requires simultaneous attendance to infrastructure and service delivery components. There are at least seven infrastructure components central to implementation of an ECI system:

- Governance structures, processes, and tools to enable effective service implementation;
- Appropriate and agreed-upon assessment measures with evidence of reliability and validity for identification, eligibility, program planning, and child-level progress monitoring;
- Methods for assessing program quality and standards for credentialing and service delivery;
- Pre-service and in-service professional development including technical support and performance feedback;
- Accountability mechanisms for monitoring and providing feedback on relevant outcomes;
- Family and community engagement in ECI governance structures and processes (e.g., service on boards, committees, advisory councils, etc.);
- Finance mechanisms and strategies to enable funding of ECI systems, structures, and services across sectors.

These infrastructure components guide and interact with direct service provision, which occurs across sectors, including Health, Education, and Social protection, and across programs. For an ECI system to be effective, systemic outputs must be sustainable, high quality, and equitably distributed among linguistic, cultural, educational, socio-economic, and geographic groups. Additionally, families must be supported and involved in a meaningful way from intake through program exit.

The family's priorities and child's needs inform ECI service decisions. Ideally, ECI services are not centre-based. Instead, service providers deliver ECI services in the child's natural environment such as the child's home, an inclusive kindergarten or crèche, or other settings where children without disabilities can be found.

Effective ECI Services

Effective ECI services must be:

1. **Individualized**: Service providers prioritize the child's strengths, interests, and motivations, delivering ECI services with the context of a child's everyday activities;

2. **Family-centred**: Service providers deliver services that build on the family's strengths, focus on the family's priorities, and are responsive to the family's culture;

3. **Team-based**: Transdisciplinary teams of professionals including the family work collaboratively to solve problems and make decisions;

4. **Evidence-informed**: Strategies utilized by the transdisciplinary team are based on the highest quality evidence available and are implemented in a coordinated and comprehensive manner;

5. **Outcome-driven**: The transdisciplinary team delivers services intended to increase the child's ability to participate in age-appropriate activities and routines;

6. **Contextualized**: Intervention planning and implementation accounts for where and when a skill will be performed in the child's natural environment.

ECI services can be conceptualized within five broad processes: (a) outreach and referral; (b) comprehensive assessment and individualized planning; (c) service delivery; (d) monitoring and evaluation; and (e) transition planning.

Outreach involves identifying children who may benefit from ECI services. Outreach includes raising the awareness of parents, general practitioners, nurses, teachers and others with access to young children so they know when and how to refer children to ECI services and understand the benefits of services and eligibility requirements. Outreach may take the form of a brochure or poster, a radio or television advertisement, and the use of a standardized screening tool. Screening often entails implementation of a low-cost, easy-to-use screening measure with sufficient validity and reliability to identify children who may benefit from ECI services. If a child is identified and referred through the outreach process and scores above a specific cutoff on a screening measure, a more comprehensive assessment and individualized planning process, that includes the family, is initiated to determine if the child is eligible to receive services; to help establish a diagnosis, if applicable; and to inform service planning. If the child is eligible for

services, the child's family work collaboratively with other members of the transdisciplinary team to develop an individualized family service plan (ISP) guided by the family's priorities and the child's needs.

ECI service delivery occurs in natural environments such as the family's home or the child's preschool instead of rehabilitation centres or special schools. Within the field of ECI, there has been a move away from service providers directly working with children. Instead, ECI service providers consult with, coach, and mentor the adults who spend the greatest amount of time with a child (e.g., a parent or teacher). Services support functional skill development are individualized to the child's and family's strengths and needs. The majority of intervention opportunities occur between visits through parent-child or teacher-child interactions. Therefore, the ECI service provider's role is to provide support to the parent or teacher through consultation and coaching. During visits, ECI service providers work with parents or teachers to embed learning opportunities into everyday routines such as playtime and mealtime. Very young children benefit from being in familiar environments with familiar people, toys, and materials. ECI professionals use materials found in these settings and only bring in additional materials when absolutely necessary. The child's family, teachers, and service providers conduct on-going monitoring and evaluation via direct observation and data collection. ECI service providers also use formal data tracking systems to monitor progress toward ISP short-term objectives and longer-term six month or annual goals. Service providers collect quantitative data to evaluate individual child progress as well as the progress of groups of children. Finally, the transdisciplinary team, including the family and teachers, work collaboratively to develop a transition plan to facilitate the child's next service placement setting.

International Support for Early Childhood Intervention (ECI)

Every child has the right to grow up in a family environment, "learning to know, to do, to live together, and to be" (UNESCO, 2000); All children have the right to develop, participate in and be educated in natural environments including home and community settings, including schools (United Nations, 1948; United Nations, 2006) and receive support when a delay or disability is present.

The Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD) provide foundational support for ECI as a human right for infants and children with or at risk of developing disabilities. The CRC specifies the State Parties' obligation to ensure protection and care for each child's well-being (Art. 2) and requires States to give due weight to "the views of the child" (Art. 12) in matters that affect the child. Articles 3 and 6 more directly address ECI service provision in particular. Specifically, these articles delineate each State Parties' obligation (a) to ensure "institutions, services and facilities" that attend to the needs of children deliver high quality supports and services (Art. 3) and (b) to "ensure to the maximum extent possible the survival and development of the child" (Art. 6). Finally, Article 23 directly addresses the right of children with disabilities "to enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community" (Art. 23.1). Furthermore, the Article specifies the right of the child and "those responsible for his or her care" to assistance that is appropriate to his or her needs and, whenever possible, is provided free of charge. Finally, services provided should enable the child's access to community resources such as education and healthcare and should enable the child to achieve "the fullest possible social integration and individual development" (Art. 23.2 & 23.3).

The CRPD echoes many of the same rights specified in the CRC but with a focus on individuals with disabilities. Additionally, the CRPD requires State Parties to “raise awareness” and “foster respect for the rights and dignity of persons with disabilities” (Art. 8) in ways that “nurture receptiveness” to (Art. 8.2.a.i), and “promote positive perceptions” (Art. 8.2.a.ii) of, individuals with disabilities. The CRPD ensures children with disabilities the right to high quality, inclusive education (Art. 24). More specific to ECI, the CRPD describes the right to “early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities” (Art. 25.b) and necessitates that services “begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths” (Art. 26.1.a). As well, the European Disability Strategy 2010-2020 reiterates and supports many of the aforementioned rights including the child’s right to inclusive education; access to social protection systems; and encourages “the development of early intervention and needs assessment services” for individuals with disabilities.

“All families, with the necessary supports and resources, can enhance their children’s learning and development.”

Key Principles of Early Intervention, 2014

Purpose

In 2011, First Step Georgia and the Association of Neurologists and Neurosurgeons with support from Open Society Foundations (OSF) developed ECI service standards. The standards have been revised over time. In June 2020, the Ministry of Labor, Health, and Social Affairs adopted the current standards.

The purpose of this report is to support Open Society Georgia Foundation, the Georgian Coalition on Early Childhood Intervention, and the Ministry of Labor, Health, and Social Affairs (MoLHSA) by documenting compliance with the current standards. Open Society Georgia Foundation engaged a national consultant and international consultant to complete the evaluation and produce the report.

Specifically, this report (a) highlights existing capacity within national and regional ECI service delivery; (b) identifies practice gaps in alignment with standards; and (c) provides recommendations for national supervision and monitoring. The report also examines the compatibility of ECI services with the current established standards to maintain and further improve service quality.

Standards

The current ECI Standards cover ten areas:

1. Information about the service and the beneficiary;
2. Equal access to services, family involvement, and inclusiveness;
3. Confidentiality protection;
4. Protection from violence;
5. Early intervention services, the basic principles and individual approach;
6. Feedback and complaint procedures;
7. Requirements of ECI personnel;
8. The ratio of beneficiaries and service professionals;
9. Termination of services / leaving the services;
10. Team planning and in-service training.

Each area contains a number of indicators that were investigated through this evaluation and presented within this report. Where possible, data are compared across sources.

Evaluation Procedures

Recruitment

Thirty-four organizations approved by MoLHSA were invited to participate along with all 251 early development specialists offering ECI services. ECI specialists have between three to eight children on their caseload, which corresponds to roughly 1500 parents/legal guardians. The ECI specialists were recruited directly. Participating parents and legal guardians were recruited through the ECI organizations that agreed to participate.

Data Sources

Data were generated through surveys, focus groups, audio recordings, and document review. Data were collected between November 2020 and December 2020. A 10-member advisory board was established for the evaluation and represented Tbilisi State University, Batumi State University, an organization of children's rights, parents, and Non-Governmental Organizations. Eight members provided guidance on the survey and focus group questions. Institutional Review Board approval was provided by the Georgian National Center for Disease Control and Public Health.

Surveys

Four separate surveys were developed and disseminated in Georgian through the secure platform Qualtrics following human ethics approval. Those unable to complete the survey on their mobile phone or computer were able to provide their responses through a phone interview.

Director Survey

Directors or program coordinators at all MoLHSA-recognized organizations approved to provide ECI services were invited to complete a 61-question survey. Items were aligned with Georgian ECI practice standards including personnel and documentation requirements, and caseload. Additional areas of inquiry pertained to funding, referral source, and usual practices.

Early Development Specialist Survey

Directors and program coordinators were asked to provide a list of their early development specialists. These ECI providers were invited to complete a 63-question survey. Items were aligned with the Georgian ECI practice standards including education, training, and experience requirements. Providers were also asked questions about their usual practices including the frequency and length of visits and their experience with supervision.

Parent / Legal Guardian Survey

Parents or legal guardians of children receiving ECI services from participating ECI programs were invited to complete a brief, 30-question survey. The survey included questions about ECI services received, including the length and frequency of sessions. It also included questions about the ECI provider; the perceived value of the services received; the parent's or guardian's

confidence helping their child and responding to aspects of family life; and their involvement in services.

Supervisor Survey

Supervisors from participating ECI programs were asked to complete a brief, 25-question survey. The survey focused on the type, frequency, and duration of supervision provided to ECI providers. The survey also asked about supervision practices and procedures followed.

Focus Groups

Focus group were conducted with providers, parents/guardians, and supervisors. Focus group procedures were comparable across these sessions. Each focus group was led by a facilitator with support from an assistant who took notes of the session. Before beginning each session, the participants provided consent to participate and engaged in a brief warm-up activity. The facilitator used a script with key questions and additional probes to guide the session and ensure uniformity. All sessions were completed over Zoom and audio recorded and transcribed.

Provider Focus Group

Five focus groups were held with ECI providers in different regions: Adjara, Guria, Imereti, Kakheti, Mtsketa Mtianeti, Qvemo Qartli, Samegrelo Zemo Svaneti, Samcxe Javakheti, Shida Qartli, and Tbilisi. Group size ranged from four to seven participants. ECI specialists from the high mountain regions of Samegrelo, Guria, Racha-Lechxumi Gvemosvaneti, and Zemo Svaneti were included. Completion time ranged from 1 hour 30 minutes to 1 hour 45 minutes. Providers participating in focus groups were asked 16 questions to inform an understanding of compliance with working in a natural environment, fostering parenting skills, including parents in ISP development, informing parents/guardians on child and family goals, supporting transitions, the home visit record form, and supervision frequency and forms.

Parent / Legal Guardian Focus Group

Four focus groups were held with the parents/guardians of children enrolled in ECI services. There were two groups from Tbilisi and two representing regions (Adjara, Imereti, Guria, Kakheti, Mtsketa Mtianeti, Qvemo Qartli, Samcxe Javakheti, Shida Qartli). Group size ranged from two to five participants and lasted approximately one hour. Parents/guardians participating in focus groups were asked 12 questions to understand provider compliance with working in the natural environment, fostering parenting skills, informing parents/guardians on child and family goals, supporting transitions, and use of the home visit record form.

Supervisor Focus Group

Two supervisor focus groups, each with six participants, were held with representation from Adjara, Imereti, Kakheti, Qartli, and Tbilisi. Duration ranged from 1 hour and 30 minutes for the first group and 1 hour for the second group. During focus group sessions, participating supervisors were asked 10 questions to inform an understanding of compliance with supervision frequency and forms, supervision caseload, and the supervision certificate.

Audio Recordings

Providers representing Adjara, Imereti, Guria, Kakheti, Mtsketa Mtianeti, Qvemo Qartli, Qvemo Svaneti, Racha Lechxumi, Samckhe Javakheti, Samcxe Javakheti, Shida Qartli, and Tbilisti were invited to submit ten-minute audio recordings of their practice. They were randomly assigned to collect the first ten minutes of their service visit, the middle ten minutes, or the last ten minutes of their visit. Thirteen randomly selected recordings from each of these three visit periods were selected from different regions and analyzed against a rubric developed for the evaluation.

Document Review

Brochures. Directors and program coordinators were invited to upload their early childhood development program's ECI brochure. Fifteen brochures were received. These were evaluated with a rubric.

Internal Regulations. Directors and program coordinators were invited to upload their internal regulations. Twenty-seven documents were received and reviewed.

Internal Regulations Against Violence. Directors and program coordinators were invited to upload their internal regulations against violence. Twenty documents were received and reviewed.

Job Descriptions. Providers were invited to upload their job description. Twenty-five documents were received and reviewed.

Child and Family Individual Service Plan. Providers were invited to upload a redacted service plan. Ten documents were received. Plan goals were evaluated for emphasizing functional participation during daily activities, including specific and observable goals that are necessary or useful for participation, state acquisition and generalization criteria, the timeframe for achieving the goal, the inclusion of at least one parent/guardian goal, and inclusion of at least six child goals.

Discussion of the Data

Context: Demographics

Of the 34 organizations approved by MoLHSA to participate in this project, 27 (79%) did so. In total, 217 (86%) of 251 early development specialists (hereafter referred to as 'providers') offering ECI services participated. Additionally, 28 directors and 16 ECI supervisors submitted survey data. Finally, 376 parents/legal guardians participated, representing approximately 25% of the roughly 1500 parents/legal guardians receiving ECI services.

Table 1 below summarize demographic data for participating directors and Table 2 summarizes demographic data for participating providers and supervisors. Table 3 provides a breakdown of the percentage of participating providers, supervisors, and directors working in each region and the percentage of participating parents living in each region.

As reported in Table 1, almost all of the participating directors were female. Nearly all were above the age of 30 and just over three quarters held a Master's degree or higher. Over 80% of directors reported working as a director or coordinator for two or more years.

Table 1. Director Demographics

	Percent
Gender	
Female	92%
Age	
21 to 30 years old	9%
31 to 40 years old	56%
41 to 50 years old	18%
51 to 60 years old	15%
More than 60 years old	3%
Schooling	
Less than Bachelor's	3%
Bachelor's	21%
Master's or higher	76%
How long as Director or Coordinator	
1 year or less	18%
2 to 5 years	53%
6 or more years	29%

As described in Table 2, 41% of providers were under the age of 30 years with 51% between 30 and 49 years old. Participating supervisors were older than providers. Forty-four percent of supervisors were over the age of 40; whereas 29% of providers fell into this age category. Supervisors had considerably more experience as ECI providers with all reporting two or more years of experience and the vast majority (81%) reporting six or more years of experience. In contrast, nearly one-quarter of providers had less than one year of experience as an ECI provider and less than 20% of providers six or more years of experience. Although almost all providers and supervisors held a university degree, supervisors reported higher levels of education. Nearly 70% of supervisors held a Master's degree or high as compared to 46% of providers. Supervisors were more likely to have a background as an early interventionist (37%) or psychologist (25%)

than an occupational therapist (19%) or paediatrician (19%). Supervisors provided three types of supervision: internal (53%), external (7%), and both internal and external (40%).

Table 2. Provider & Supervisor Demographics

	Provider	Supervisor
Gender		
Female	96%	100%
Age		
20 to 29 years old	41%	31%
30 to 39 years old	29%	25%
40 to 49 years old	22%	19%
50 to 59 years old	6%	19%
60 years old	1%	6%
Schooling		
Less than Bachelor's degree	4%	--
Bachelor's degree	50%	31%
Master's degree or higher	46%	69%
Years working with children		
1 year or less	6%	
2 to 5 years	45%	12%
6 or more years	49%	88%
Years as ECI service provider		
1 year or less	23%	--
2 to 5 years	53%	19%
6 or more years	17%	81%
ECI Position		
Para-professional	23%	--
Professional	74%	--

Table 3. Participating providers, supervisors, and directors by region.

Region	Provider	Supervisor	Director	Parent/Guardian
Ajara	14%	6%	14%	18%
Guria	3%	6%	8%	5%
Imereti	12%	13%	8%	16%
Kakheti	7%	19%	3%	5%
Kvemo Kartli	5%	--	8%	2%
Mtshkheta-Mtianeti	--	--	--	<1%
Racha-Lechkhumi	--	--	--	<1%
Samegrelo-Svaneti	2%	6%	5%	2%
Samtxkhe-Javakheti	2%	6%	5%	3%
Shida Kartli	4%	--	5%	6%
Tbilisi	25%	50%	43%	42%

Table 3 above provides participant representation by region. The highest representation of providers came from Tbilisi followed by Ajara and Imereti. The percentage of supervisors was also highest for Tbilisi, followed by Kakheti and Imereti. The percentage of participating directors was highest for Tbilisi and Ajara. Tbilisi, Imereti, Ajara, and Imereti had the greatest percentage of participating parents.

Standards, Outcomes, and Indicators

This section lists ECI service area outcomes based primarily on Georgian Standards for ECI. In some areas, widely recognized ECI quality indicators were also included.

Area 1: Information about the service and the beneficiary

Outcome: The service provider is guided by Internal Regulations, which provide information about the services. The legal representative / foster parent of the child (beneficiary) is aware of the service, including their rights and responsibilities and those of the service provider.

Report Indicators:

1. Internal Regulations: The organization or ECI sub-program has internal regulations describing the content of the service, the main goals, implementation process, rights and responsibilities of the service provider and service recipient, feedback and compliance procedures, terms for the termination of services, confidentiality, protection from violence, and the safety of the child, specialist, and the environment.

2. Program Brochure: ECI program has a brochure for potential service recipients. A program brochure that correctly reflects the ECI program's philosophy and accurately describes the services needed for parent/legal guardian informed decision-making to pursue the next step in the service enrollment process outlined in the internal regulations.

3. Job Descriptions: Service providers must have a job description.

4. Child and Family Individual Plan: Review of the Child and Family Individual Plan includes the assessment of (a) the home environment and safety issues; (b) the abilities and skills of the child's parent/legal guardian/foster parent, and their engagement; and (c) the assessment of the child's strengths and needs.

5. Transition Plan: A transition plan is prepared for the child at least six months prior to the child's planned transition to: (a) enter the school or preschool education system and (b) leave the ECI service and enroll in new services offered by another organization.

Findings:

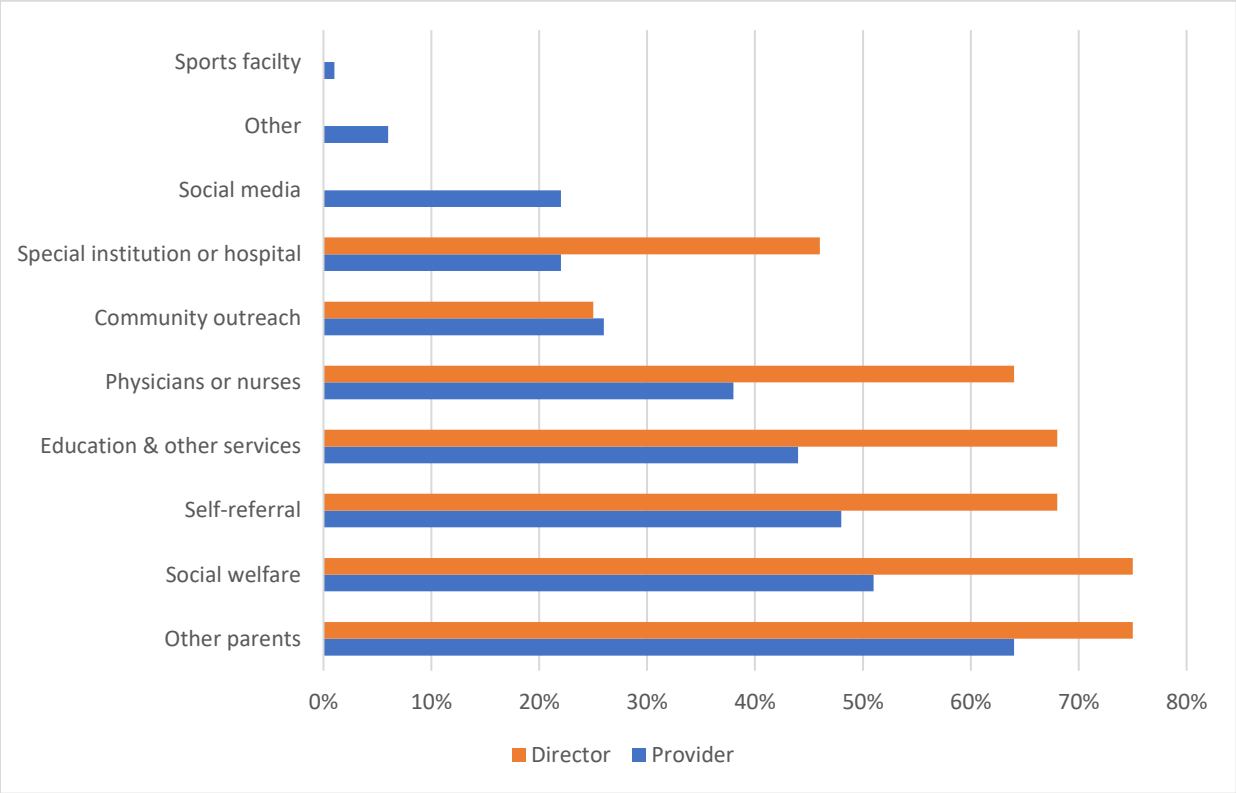
Indicator 1: Internal Regulations Source: Director	• All but one organization (97%) reported having ECI program regulations.
Indicator 2: Program Brochure Source: Director	• 64% of programs reported having a brochure.

Indicator 3: Job Descriptions Source: Provider, Director	• 94% of providers reported their organization had an ECI provider job description and 5% did not know. Professionals were more likely not to know about a job description (6%) compared to paraprofessionals (2%). Only two providers reported there was no job description. • 93% of directors reported their ECI program has a job description for ECI specialists.
Indicator 4: Child and Family Individual Plan Source: Provider	• 47% of providers reported reviewing the Home Security Assessment Summary. • 50% of providers reported reviewing the Positive Parenting Skills form. • 60% reported reviewing the Child Development Evaluation Summary. • 36% reported reviewing Family Outcomes in the individual plan. • 56 % reported reviewing a summary of results achieved. • 18% reported reviewing information on service type in the individual plan. • 21% reported reviewing information on service frequency in the plan.
Indicator 5: Transition Plan Source: Provider, Parent	• 61% of providers reported having between 1 and 10 children who needed a transition plan. • 81% of parents indicated their ECI provider talked with them about their child's transition to preschool, general education, or alternative education.

Brochures from 15 organizations were reviewed. Most brochures presented information about the services a family receives from the ECI program. Brochures included information about the frequency of the ECI program, specialists of the program, and where the ECI services are held. Although almost all fifteen brochures provided information about parent involvement and support for parents during service delivery, 90% of the brochures did not clearly describe parents/guardians as decision-makers.

The most frequent referral source reported by both ECI providers and directors included other parents, social welfare, self-referral and educational and other services (see Figure 1). Directors were more likely to list physicians and nurses or special institutions or hospitals compared to ECI providers. Sixty-four percent of ECI specialists versus 75% of directors reported other parents were the source of information about ECI services for other parents. Social welfare was selected by 51% of specialists versus 75% of directors, and self-referral by parents (48% specialists, 68% directors).

Figure 1. ECI Referral Source.



Area 1: Recommendations

- **Develop and distribute an example brochure and template to all MoLHSA-approved ECI programmes.**
    - Clearly describe ECI services as a support for the family and not only the child with a developmental delay or disability;
    - Emphasize provision of services in natural environments through everyday routine activities by collaborating with and coaching parents/guardians, family members, or other caregivers.
    - State who should be referred and how a referral can be made;
    - Describe the process of eligibility determination and the process of developing an Child and Family Individual Service Plan (ISP);
    - Include a statement of any service costs;
    - Describe the range of services provided by the organization; and
    - Make it available in multiple Georgian languages to increase accessibility.

- **Develop regional ECI referral networks that meet quarterly for two years and bi-annually once referrals have stabilized and pathways developed.**
    - The network should develop a shared understanding of ECI services, especially the family's role;

- Use shared ECI language in written or verbal communication that emphasize the family's role in service decision-making and delivery;
- Strengthen early identification efforts through the use of standardized developmental screening tools;
- Identify barriers to ECI access, especially among lower-income families.
- Create and distribute a directory of community and regional educational and social services to ECI regional network members. Update the directory annually.

- **Develop and deliver virtual training sessions on the link between assessment, Child and Family ISP development, service delivery, and progress monitoring.**

- **Formalize and finance the transition to kindergarten.**
  - Develop a shared understanding of kindergarten skills with parents/guardians, kindergarten teachers, and ECI providers that goes beyond academics; and
  - Recognize kindergarten transition support within the ECI provider's caseload.

Area 2: Equal access to services, family involvement, and inclusiveness

Outcome: The Child and Family ISP is based on assessment of the child's and family's strengths and needs over a maximum of 16 visits following the start of service provision. The evaluation process includes Ministry-approved assessment instruments (i.e., Assessment Evaluation & Programming System [AEPS], Hawaii Early Learning Profile [HELP], and Portage Guide to Early Education [PGEE]) and the service plan is developed with the active participation of the beneficiary's parent/legal guardian/foster parent.

The service provider (i.e., early development specialist) ensures the parent/guardian has access to all relevant educational and social services that are available in the community. The service provider ensures the child is enrolled in an inclusive preschool and/or school based on the needs of the child and family and has a transition plan in place 6 months prior to the transition and supported by a relevant transdisciplinary team of specialists.

The child and family have working objectives (goals) which indicate the persons responsible for their implementation and associated deadlines.

All cases of refusal to provide services to the parent/legal guardian are documented and forwarded to the Social Services Agency along with documentation that outlines the reason for refusal. Potential reasons may include: (a) the child no longer needs services; (b) the parent/legal guardian/foster parent is not involved in the service provision; (c) the service provider's caseload has been reached and no new cases can be added; (d) the beneficiary's residence is in a remote or unsafe location or not accessible by available transportation; or (e) the parent/legal guardian does not create a safe environment for the specialist during visits or has violated his/her rights.

Report Indicators:

1. Approved assessments: Child is assessed with a Ministry approved assessment instrument (AEPS, HELP, PGEE);

2. Service plan development: Child and Family Individual Service Plan developed over a maximum of 16 visits;

3. Access to services: The service provider ensures the beneficiary has access to all relevant educational and social services that are available in the community;

4. Timing of transition plan: Child and family have a transition plan in place 6 months prior to the transition.

Findings:

Indicator 1: Approved assessments	• 76% of service providers reported using one of the Ministry approved tools.

Source: Provider, Director	• 15% of providers reported using the HELP, 58% reported using the AEPS, and 3% reported using the PGEE. 2% reported using other tools (ASQ reported by one specialist). • 14% of directors reported using the HELP, 89% reported using the AEPS, and 7% use the PGEE. Directors also reported using the MEISR, Vineland, Sensory Checklist, LAP, ESDM, and BCP which are not approved by MoLHSA.
Indicator 2: Service plan development Source: Provider	• 99% of specialists complete the assessment of child and family strengths and needs in 16 or fewer visits. • 45% complete the assessment process in 10 or fewer visits. • 56% completed the ISP in one week's time.
Indicator 3: Access to services Source: Provider, Parent	• 68% of providers strongly agreed they know a lot about the community where ECI is provided. • 94% reported they often provide parents/guardians with information about resources, including services. • 90% of providers reported they often shared with parents their right to receive ECI services. • 79% of parents strongly agreed their ECI provider knows a lot about their community. • 33% of parents reported being fully confident they know how to help themselves and their family with knowledge of resources, including services. Another 40% said they mostly know about resources. • 49% of parents reported being fully confident about their family's right to receive services and 37% said they mostly knew their rights.
Indicator 4: Timing of transition plan Source: Provider	• 62% of specialists reported having at least one child in need of a transition plan in the last six months with a range from 0 (24%) to 10 plans per provider. • 81% of parents reported their ECI provider talked with them about their child's transition to preschool, general education, or alternative services in the last six months.

Screening, evaluation, and assessment have different purposes. Screening is used to provide a snapshot of the child's development in order to determine if the child's development appears on schedule compared to same age peers. Screening informs referral for further evaluation to determine if the child may benefit from ECI services. Two standardized, technically sound, parent/guardian tools are available for use in Georgia (i.e., ASQ & ASQ:SE). Early identification is an important aspect of any ECI system.

Evaluation is the process of gathering child and parent/guardian assessment information to create an Individual Child and Family Service Plan. Authentic assessment practices where information

is primarily collected in natural settings with materials and people familiar to the child are recommended.

A functional tool such as the AEPS provides information on mastered and emerging skills and skills that still need to be developed. AEPS results provide a profile of the child's present levels of development across developmental areas (i.e., communication, physical, cognitive).

Assessment of family strengths, needs, concerns, and priorities is an important aspect of the evaluation. Families are the most knowledgeable about their child's functional skills within everyday activities such as mealtime, playtime, toileting, and bath time.

Once the evaluation is complete, the parent/guardian along with one of the evaluation team members reviews the results and develops the child's Child and Family ISP. The plan should list the child's present levels of development across domains by highlighting mastered and emerging skills.

Functional child goals and parent/guardian goals are also listed on the ISP. Parents/guardians should drive the goal-development process through their involvement in a parent/guardian needs assessment and their participation in the ISP meeting. Child goals should emphasize meaningful participation in daily activities by developing functional skills that are necessary and useful. High quality goals are not domain specific. Goals should have criteria for acquisition and fluency and be specific, measurable, achievable, relevant, and time-bound.

The current ISP requires an assessment of parenting strengths and areas for improvement and lists parent priority issues that are to be based on the family report, child skills, and an analysis of the child's routine. However, review of existing ISPs found the associated goals were not functional. The ISP contained instructions for the parent based on the child's goals. The amount of information and language used needs aligned with the family-centred, social model. Re-aligning the process will improve family engagement in goal development and service delivery, improve service delivery quality, and reduce the time needed to develop the ISP.

Area 2: Recommendations

- Consider opportunities for transitioning newborns from the Neonatal Intensive Care Unit to ECI services;

- Consider opportunities for ensuring seamless transitions for children entering and exiting ECI services which may include development of regulations and inter-agency agreements, and funding ECI providers to support teachers during the transition period;

- ECI services should serve children birth to five years of age. Development of inclusive education and specialized teacher supports are needed after the age of five;

- Review ECI training on service coordination (case management). The role, which may be carried out by the Primary Service Provider should include: (1) informing parents/guardians of their rights; (2) coordination of evaluations and assessments; (3) facilitating parent/guardian participation in the assessment and evaluation; (4) identifying and informing the parent/guardian about resources; (5) coordinating, facilitating, and monitoring service delivery to ensure timelines are met and services are delivered

according to the ISP; and (6) developing a transition plan with the ISP team which includes the parent/guardian;

- Develop and deliver virtual training sessions on the relationship between family needs assessment, parent/guardian goal development, and positive child and family outcomes; and
- Discuss transition plan development with the parent/guardian from the time they enter ECI services and every six months;

Area 3: Confidentiality protection

Outcome: The beneficiary's parent/legal guardian/foster parent is aware of how and where their personal information will be kept and who has access to the information.

Confidential information is the protection of specific, identifying information and limits access, disclosure, retention, and safeguarding of information. To protect the confidentiality of ECI beneficiaries, ECI organizations should abide by specific confidentiality regulations and procedures set forth by MoLHSA and the ECI Coalition. This includes (a) agreeing to a professional code of ethics; (b) data storage requirements; (c) data sharing agreements between organizations; and (d) a consent for release of information form.

Confidentiality Indicators: Georgian ECI Standards require the service provider to maintain confidentiality by:

- Protecting information shared by the ECI beneficiary through correspondence, conversations, and personal meetings;
- Disclosing information only when relevant to service delivery including coordination (e.g., case consultation, service transfer, social services, education services) or child protection (public defender's office, police);
- Storing beneficiary and case review records in a locked cabinet and limiting electronic assess to the program administrator and ECI specialists;
- Maintaining beneficiary and case review records for at least three years from the date of case termination;
- Registering each case termination according to the organization's Internal Regulation requirements;
- Following Internal Regulation requirements for issuing and withdrawing beneficiary documents which includes a dated and signed application unless the information is for MoLHSA program monitoring;
- Obtaining parent/guardian consent before disclosure of confidential information; and
- Sending written notification to the parent/guardian and obtaining their consent before their child's file is sent to another organization.

Findings:

All ECI programmes except for one newly established ECI programme reported having regulations in place. Due to Covid-19 restrictions, onsite visits were not completed and compliance with confidentiality requirements was not evaluated.

Area 3: Recommendations

- Develop standardized data sharing agreements across education, health, and social welfare organizations where such agreements are to the benefit of the family and child to access or improve services;

- Develop guidance to protect family confidentiality in MoLSHA and ECI Coalition evaluation reports when reporting small sample sizes.

Area 4: Protection from violence

Outcome: Cases of child abuse (if any) are detected in a timely manner and with an appropriate response.

Report Indicators:

1. Child protection instructions: ECI program has internal instruction on child protection from violence.

2. Child abuse cases: Number of cases of child abuse detected among ECI beneficiaries in the last 12 months.

Findings:

Indicator 1: Child protection instructions Source: Director	• 86% of directors have internal instruction on child protection from violence.
Indicator 2: Child abuse cases Source: Director	• 72% of directors had no cases of detected abuse • 7 cases of abuse were detected across surveyed organizations according to directors

Children birth to age three and children with disabilities account for the largest percentage of child abuse and neglect cases (Jones et al., 2012). Early identification of maltreatment and the provision of evidence-based prevention measures are needed.

Area 4: Recommendations

- Examine existing ECI Coalition training to determine if content is sufficient to prepare paraprofessionals and professionals to (1) provide parents/guardians with information needed to understand their child's disability (2) coach parents/guardians through strategies that will support their child's developmentally appropriate behavior; and (3) identify signs of child violence (i.e., verbal or physical abuse, neglect);

- Coordinate early identification of maltreatment across health, education, and social welfare organizations for children with delays and disabilities;

- Examine community-level opportunities for parents/guardians of children with disabilities to spend time enjoying community settings, thereby reducing family isolation and stress;

- Connect families to support groups that will enable them to have positive interactions with other adults raising children with disabilities;

- Provide respite care for unexpected crises and planned short-duration breaks for parents/guardians of children with disabilities;

- Use a parent/guardian needs assessment that includes documentation of the family ecology during intake and every six-month re-evaluation to assess and strengthen family supports; and

- Screen all children involved in child protection for developmental and social-emotional difficulties.

Area 5: Early childhood intervention services, the basic principles and individual approach

Outcome: The parent/legal guardian receives services in the natural environment according to the individual needs of the child and family. Families are engaged in the service delivery; the service provider promotes parenting skills and knowledge including strategies to support the child's positive behavior.

The parent/legal guardian is engaged in the process of developing and implementing the Child and Family ISP.

Report Indicators:

1. Engagement in ISP: Family is engaged in the process of developing the Child and Family Individual Service Plan (ISP);
2. Copy of ISP: Family is given a copy of the Child and Family ISP;
3. Natural environment: Services are delivered in the natural environment;
4. Engagement in services: Families are engaged in the service delivery;
5. Parenting skills: Specialist promotes parenting skills;
6. Parenting knowledge: Specialist promotes parenting knowledge;
7. Behavior strategies: Specialist promotes strategies to manage the child's challenging behavior;
8. Home visit record form: Specialist asks families to sign the home visit record form at each visit;
9. ISP review: Specialist reviews the Child and Family Individual Service Plan with the parent/guardian every 6 months.

Findings:

Indicator 1: Engagement in ISP Source: Provider, Parent	• 18% of providers reported 100% of their parents were involved in development of the Child and Family ISP while 23% reported up to 50% of their parents were not involved (see Figure 2). • 77% of parents/guardians reported being involved in writing their child's goals. • 67% of parents/guardians reported involvement in writing family goals.

Indicator 2: Copy of ISP Source: Provider, Parent	• 63% of providers reported always providing parents/guardians with a copy of the Child and Family ISP. An additional 23% very often provided the copy. 7% rarely or never provided the copy and 7% sometimes gave the information to the parent/guardian. • 76% of parents/guardians reported being given a copy of their child's plan.
Indicator 3: Natural environment Source: Provider, Parent, Director	• 60% of providers reported all 8 monthly sessions occur in natural environments. • 81% of parents/guardians reported services take place in the natural environment, although 4% reported some of the visits also taking place at the ECI centre. • 52% of directors reported all 8 monthly sessions occur in natural environments. • 19% of parents/guardians reported their services take place at the centre. • 12% of directors reported half of the sessions occur in natural environments.
Indicator 4: Engagement in services Source: Provider, Parent, Director	• 44% of providers reported never providing services to the child without family involvement. • 44% of directors reported services are never provided to the child without family involvement. • 22% of providers reported no family involvement during 4 to 8 monthly sessions. • 20% of directors reported no family involvement during 4 to 8 monthly sessions. • 93% of providers reported the parent or guardian is mostly with them in the same space when services are delivered while 7% said the parent/guardian is not in the same room or building. • 80% of parents/guardians reported they are with the ECI provider in the same space during the session. • Paraprofessionals were more likely to report the parent/guardian was not in the room with them during service delivery (12% vs 6%).
Indicator 5: Parenting skills Source: Parent	• 58% of parents strongly agreed that providers show them things they can do with their child • 56% of parents strongly agreed that providers involve them in the visit • 23% of parents reported being fully confident in their ability to support their child's needs *during mealtime*

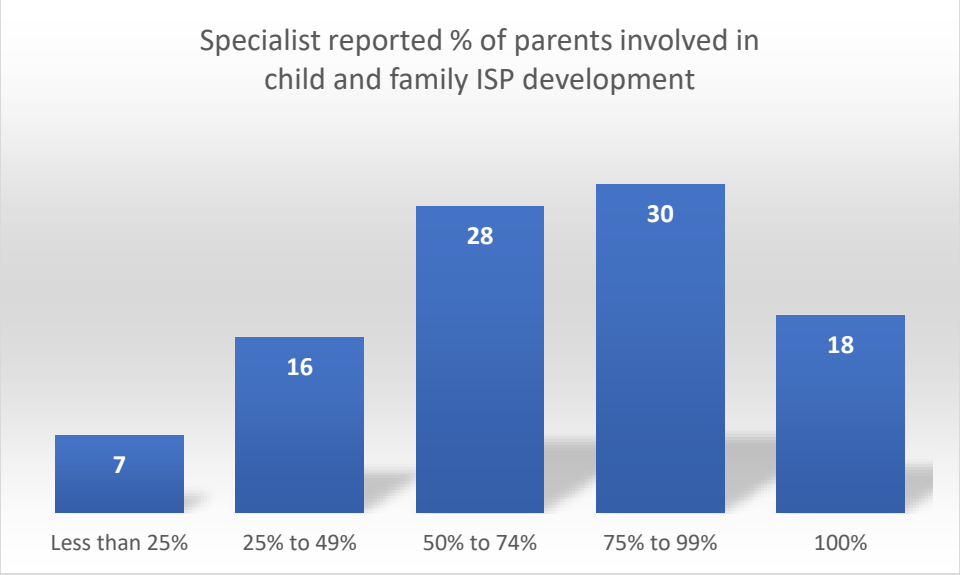
	• 19% of parents reported being fully confident in their ability to support their child's needs *during playtime* • 19% of parents reported being fully confident in their ability to support their child's needs *during outings* • 28% of parents reported being fully confident in their ability to support their child's needs *during bath time* • 34% of parents reported being fully confident in their ability to support their child's needs *during bedtime*
Indicator 6: Parenting knowledge Source: Parent	• 56% of parents reported being fully confident in the knowledge they have about their child's special needs • 33% of parents reported being fully confident in the knowledge they have about resources, including services • 49% of parents reported being fully confident in the knowledge they have about their family's rights to receive ECI services • 38% of parents reported being fully confident in the knowledge they have about child development • 47% of parents reported being fully confident in the knowledge they have about what to do with their child in general during the day
Indicator 7: Behavior strategies Source: Provider, Parent	• 61% of specialists had beneficiaries who needed a behavior plan. The number ranged from one child to 15 cases per service provider. • 37% of parents reported being fully confident they could help their child behave appropriately *during mealtimes* • 28% of parents reported being fully confident they could help their child behave appropriately *during play times* • 24% of parents reported being fully confident they could help their child behave appropriately *during outings* • 40% of parents reported being fully confident they could help their child behave appropriately *during bath time* • 43% of parents reported being fully confident they could help their child behave appropriately *during bedtime*
Indicator 8: Home visit record form Source: Provider, Parent	• 100% of paraprofessionals reported always asking parents and guardians to sign the home visit record form at each visit. • 95% of professionals reported always asking the parent/guardian to sign the form while 3% said they often did this and 2% said they sometimes did this.

	• 88% of parents reported always being asked to sign the home visit record form at each visit. 5% said this never happens.
Indicator 9: ISP review Source: Provider, Parent	• 95% of providers reported they review the plan every six months or more frequently (i.e., monthly, quarterly) with the parent/guardian. • 77% of providers reported reviewing the plan every six months. • 3% (four providers) reported not completing plan reviews with parents/guardians and 3% do the reviews once per year or less than once per year. • 89% or parents/guardians reported the ECI provider talked with them about their child's progress toward plan goals. • 86% of parents/guardians reported the ECI provider talked with them about their family's progress toward plan goals.

According to the specialists, when an ECI takes place it usually lasts an average of 57 minutes (range 30 to 75). There was no observed difference between paraprofessionals and professionals. Parents and guardians reported receiving ECI services twice a week (84%) or more than twice per week (12%).

According to parents/guardians, the ECI session usually lasts an average of 56 minutes. 84% of parents/guardians reported receiving ECI services twice per week and 12% more than twice per week.

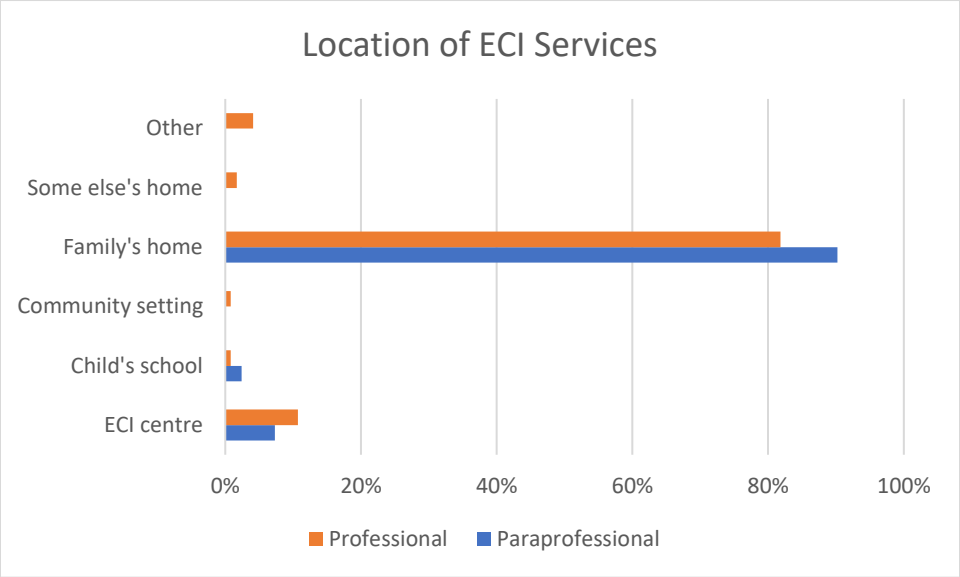
Figure 2. Parent involvement in Child and Family ISP development.



ECI specialists were asked where they usually provide ECI services. Figure 3 provides a breakdown of location as reported by professionals and paraprofessionals. It appears some

parents and providers believe the eight monthly MoLHSA voucher visits should be divided equally between the home and an ECI centre (either as an individual or group session). For example, a small number of providers (n=5) noted the services take place equally across multiple environments (e.g., 4 visits at home and 4 at an ECI center). Speech services were often delivered at the centre. Some speech therapists refused to coach ECI providers to deliver speech-related intervention strategies or travel to families to provide speech services. Although community settings such as parks and grocery stores are also natural environments, most services only take place at the child's home or the ECI centre.

Figure 3. Where professionals and paraprofessionals report providing services.



Providers were asked what they consider to be most important when deciding the focus of an ECI session and ranked the options according to priority with 1 = highest priority and 6 = lowest priority. Directors were asked what their providers considered to be important using the same items. As seen in Table 4, providers and directors both ranked the child's ISP goals as most important, followed by the child's assessment results and what the parent wants to focus on during an ECI session.

Table 4. What providers and directors consider most important for an ECI session.

Most important=1, Least important=6	Providers *Mean (SD)*	Directors *Mean (SD)*
The child's ISP goals	2.44 (1.29)	2.15 (1.39)
The child's assessment results	2.54 (1.34)	2.55 (1.15)
What the parent wants to focus on	3.17 (1.17)	2.80 (1.06)
The child's mood or interests	3.25 (1.53)	3.50 (1.61)
The child's diagnosis	3.65 (1.42)	4.05 (1.19)
Other	5.94 (0.29)	5.95 (0.22)

Directors were asked to share any additional information about their organization and usual ECI practices. Out of nine responses, several themes emerged. Directors emphasized the need to work in the natural environment within the family and child's routine. One organization shared their success obtaining municipal funds to transport providers to the child's home because some

of the villages were not easily reached by public transportation. Another organization working with the municipality on early detection of developmental delay and coordinated referrals between primary health care, kindergartens, and early childhood intervention. Parent involvement was mentioned as a barrier with one director noting,

> *"Therapists do not bring toys on visits, they try to teach parents to use their available resources to plan activities abased on their routine that will develop different skills for the child. Unfortunately, it is often difficult to actively involve the parent."*

Providers were also asked to share any additional information about their usual ECI practices. Extensive paperwork was described as a problem as well as current methods to train new specialists:

> *"The failures of the ECI subprogram service practice in my opinion are due to the incorrect methodology of training specialists. A novice specialist rarely learns to use any technique with a "modeling-observation-feedback" sequence. Basically, teaching has the form of imparting theoretical knowledge, training. Rarely is a specialist given the opportunity to study by observation, then be observed and thus receive feedback. There is a serious lack of supervision and proper feedback."*

The Child and Family Individual Service Plan contains not only assessment results but specific intervention activities. One provider noted,

> *"It is often very difficult to follow the written plan exactly, the child may be interested in other activities during the session and we may not always be able to focus on the goals, although in specific cases it is important to follow these other activities."*

There may be a mismatch between the ECI Coalition philosophy (family-centered, routines-based) and how individual plans are used during sessions (e.g., focus on pre-planned child-centered activities).

Providers also commented on parental expectations. One provider noted, "*The parent has different expectations and has had the child spend all this time with the 'teacher' throughout the session*." Another provider noted, "*it is necessary to inform the parents in detail (before they get involved in the program) about the early program."* There were also concerns around provider safety: "*There are families where our physical safety is in question (family member mental problems, alcoholism, drug addiction)…It would be good in this type of case to have services in the centre*."

Directors were asked to list up to three things they believed would help their ECI providers improve their services. The majority of the responses were related to increased opportunities for additional training and information sharing followed by increased supervision. Parental awareness was also mentioned.

Providers were also asked to list three things they believed would help them improve their ECI services. The most common theme was related to training and continued education (31%), followed by increased pay (20%), and increased parent involvement and responsibility (15%). Based on provider comments, many appear to pay for materials used in home-based activities (paper, glue) with the child and suggest program funds to pay for these materials as well as timely reimbursement of provider costs related to travel. Providers also requested an increase in the number of visits.

Directors were asked to list three things they believed would help them improve the expansion of their ECI services. Top themes included funding, awareness raising activities for the public, parents, and sectors including health care workers, increased early detection, increased opportunities for professional development and training for new specialists, and continued support for the ECI Coalition.

In order to identify common practices, providers were asked on average, out of 8 monthly ECI sessions they delivered, how many of their sessions were delivered in a specific way. Provider's answered by selecting the number of sessions from 0 to 8. Table 5 presents this data.

Table 5. Average number of sessions reported by ECI providers and directors.

Response options ranged from 0 to 8 ECI sessions per month	***Providers***		***Directors***	
	0 *Sessions*	**8** *Sessions*	**0** *Sessions*	**8** *Sessions*
• Delivered ECI session directly to the child without family involvement	44%	1%	44%	4%
• Focus on activities or materials brought by the provider to use during the session	39%	4%	44%	0%
• Tell the family what they should do	35%	13%	48%	4%
• Evaluate if the parent/guardian did what you told them to do at the previous session	1%	45%	4%	44%
• Base the session on the child's performance of skills listed on developmental assessments or curricula	1%	59%	0%	63%
• Number of visits where parents/guardians are likely to be distracted, disinterested, physically distant, or involved in other activities during the home visit.	25%	1%	32%	0%

Twenty-two percent of providers reported providing services directly to the child without family involvement during 4 to 8 sessions. 61% are bringing materials to use during sessions at least one out of 8 sessions. 65% of providers reported they tell families what they should do on at least one of the monthly visits. 75% of providers reported that parents or guardians are distracted, disinterested, physically distant, or not involved in at least one of eight sessions.

A sizeable percentage of services are delivered directly to the child without parental involvement. This suggests suggest:

a. Families may not understand their role in the process of ECI service delivery during and between provider visits;
b. Families may not understand their child's need for repeat learning opportunities during everyday activities in natural environments with familiar materials and people;
c. An assessment of family needs, including their concerns and priorities for their family and child is incomplete or missing;

d. Providers are trying to "teach" from the ISP rather than provide collaborative consultation to the parent/guardian which is less effective; and
e. Providers need supportive, reflective supervision to improve their knowledge and skills in the area of collaborative, coaching-based visits.

Table 6 summarizes mean parent/guardian-reported and provider-reported scores about the provider's knowledge of ECI and behavior during ECI sessions. Higher scores (e.g., > 4) represent higher levels of agreement with each statement. While most ratings between the provider and parents/guardians were similar, there is a discrepancy in parent/guardian and provider reporting on the provider bringing materials to the home. Sixty-five percent of parents strongly agreed providers do this behavior and another 17% somewhat agreed. Only 13% of parents/guardians strongly disagreed this was not taking place. Rural parents were more likely to strongly agree with the behavior (67% vs 64%). Differences were also observed for the item, "knows what my goals are for myself and my family" between rural and urban parents with 75% of rural parents strongly agreeing vs. 64% of urban parents.

Table 6. Provider's behavior and knowledge.

Strongly disagree =1, Somewhat disagree=2, Neither disagree nor agree=3, Somewhat agree=4, Strongly agree=5	**Provider** *Mean (SD)*	**Parent** *Mean (SD)*
• Easy to talk with	4.73 (0.91)	4.86 (0.67)
• Ask the family a lot of questions so we can come up with ideas together	4.59 (1.06)	4.79 (0.77)
• Know a lot about the community where ECI is provided	4.55 (0.82)	4.62 (0.92)
• Know what the parent/guardian goals are	4.61 (0.94)	4.40 (1.07)
• Know what each child's ISP goals are	4.73 (0.86)	4.77 (0.64)
• Show family things they can do with their child	4.75 (0.87)	4.85 (0.62)
• Try to involve the parent/guardian in the visit	4.73 (0.87)	4.81 (0.69)
• Involve other family members during visits	4.46 (0.96)	4.42 (1.08)
• Talk with parent/guardian about their child's progress	4.76 (0.87)	4.89 (0.44)
• Bring materials to use with the child during visits	2.82 (1.60)	4.19 (1.38)
• Use materials and resources available at the home	4.69 (0.89)	4.68 (0.89)

Additionally, as shown in the above table, most parents/guardians like their providers. These general questions provide limited information for improving family quality of life and specific child outcomes through the use of evidence-based practices that support child functional skill development during everyday routine activities.

Providers were asked to rate how often they provided specific informational and emotional support, two additional components of high quality ECI practice. Parents/guardians were asked how much they knew about the same specific areas of informational and emotional support. Table 7 shows higher parent ratings on three of the 11 items (27%). Across items, a higher percentage of parents/guardians in rural areas rated themselves as being "fully confident."

Table 7. Provider's ratings of support and parent's ratings of confidence.

Provider ratings: Never=1, Seldom=2, Sometimes=3, Often=4 ***Parent ratings: Not very sure about this=1, I have some idea about this=2, I mostly know about this=3, I am fully confident about this=4***	**Provider's rating of support** *Mean (SD)*	**Parent's rating of confidence** *Mean (SD)*
• Information about the child's special needs	3.94 (0.26)	3.46 (0.68)
• Information about resources, including services	3.94 (0.23)	3.06 (0.79)
• Information about the family's right to receive ECI services	3.90 (0.30)	3.33 (0.77)
• Information about child development (what comes next)	3.96 (0.19)	3.15 (0.81)
• Information about what parents/guardians can do with their child	3.91 (0.31)	3.36 (0.67)
• Making sure there is a positive atmosphere in the family	3.77 (0.44)	3.37 (0.76)
• Making sure family members respond to each other's needs	3.55 (0.65)	3.40 (0.81)
• Making sure parents/guardians pay attention to all family members	3.55 (0.63)	3.54 (0.68)
• Helping families keep in touch with extended family	2.40 (0.98)	3.52 (0.71)
• Helping families keep in touch with friends	2.25 (1.04)	3.47 (0.74)
• Helping families to know their neighbors	2.02 (1.05)	2.89 (1.06)

ECI services should orient to the family, not only the child with the developmental delay or disability. Parents/guardians should be encouraged to maintain contact with friends, neighbors, and extended family. When parents/guardians are able to maintain relationships and call upon their existing support network the family's quality of life improves and the parent/guardian is better able to support their child with additional needs. Many parents/guardians also know little about their child's development or how to engage their child in family activities, routines, and play. If a provider focuses only on the child outside of the context of the family's everyday routine activities, the family will gain few skills in how to support their child.

Parents/guardians were asked to rate how much they agreed with several statements about their ECI sessions on a scale from strongly disagree = 1 to strongly agree =5. For all but one item (*Visits involve both me and my ECI provider working together*), the percentage of rural parents who selected strongly agree was higher. However, the difference on single items was small (90% rural vs. 91% urban). Three percent of the urban parents/guardians strongly disagreed or somewhat disagreed the ECI visits involved them and their ECI provider working together whereas all rural parents/guardians somewhat agreed or strongly agreed.

Table 8. Parent/guardian's ratings of ECI sessions.

Strongly disagree=1, Somewhat disagree=2, Neither disagree nor agree=3, Somewhat agree=4, Strongly agree=5	**Parent** *Mean (SD)*
• Are a positive experience	4.90 (0.51)
• Give me information I need and want	4.89 (0.53)
• Involve both me and my ECI provider working together	4.83 (0.67)
• Help me make my own decisions	4.75 (0.61)
• Get me playing more with my child	4.82 (0.59)
• Get me interacting more with my child throughout the day	4.75 (0.69)
• Help me take better care of my child	4.75 (0.67)
• Help me take better care of myself	4.42 (0.94)

As reported in Table 8, overall ratings were high. However, encouraging parent/guardian self-care is an important aspect of ECI services and had the lowest average rating (4.42) and largest standard deviation (.94).

Parent/guardian confidence in supporting their child during daily routine activities such as mealtimes, playtime, outings, bath time, and bed time contribute to their child's skill development. The focus of ECI visits should be to improve the child's participation, independence, communication skills, behavior, and social relationships. Parents/guardians were least confident during outings.

Table 9. Parent/guardian's confidence with routine activities with their child.

1 = I am not very sure how to help my child with this **2 = I have some idea about how to help my child with this** **3 = I mostly know how to help my child with this** **4 = I am fully confident and know how to help my child with this**	**Total Sample** % Fully Confident or mostly know	**Urban** *Mean (SD)*	**Rural** *Mean (SD)*
Mealtimes			
• Participate	86%	3.30 (0.79)	3.47 (0.70)
• Become independent	80%	3.20 (0.83)	3.14 (0.90)
• Communicate	74%	3.08 (0.89)	3.28 (0.80)
• Behave appropriately	75%	3.10 (0.81)	3.00 (0.94)
Playtime			
• Participate	76%	3.03 (0.82)	3.18 (0.90)
• Become independent	71%	2.91 (0.84)	3.15 (0.82)
• Communicate	68%	2.92 (0.94)	3.15 (0.77)
• Behave appropriately	68%	2.89 (0.90)	2.81 (1.00)
Outings			
• Participate	78%	3.08 (0.84)	3.03 (0.82)
• Become independent	62%	2.82 (0.97)	2.52 (1.06)
• Communicate	68%	2.87 (0.91)	2.93 (1.02)
• Behave appropriately	66%	2.79 (0.93)	2.74 (1.02)
Bath time			

1 = I am not very sure how to help my child with this 2 = I have some idea about how to help my child with this 3 = I mostly know how to help my child with this 4 = I am fully confident and know how to help my child with this	**Total Sample** % Fully Confident or mostly know	**Urban** *Mean (SD)*	**Rural** *Mean (SD)*
• Participate	85%	3.33 (0.80)	3.50 (0.79)
• Become independent	74%	2.97 (0.96)	3.00 (1.11)
• Communicate	75%	3.11 (0.89)	3.15 (0.99)
• Behave appropriately	78%	3.12 (0.90)	3.07 (0.94)
Bedtime			
• Participate	88%	3.35 (0.75)	3.50 (0.83)
• Become independent	72%	3.00 (0.98)	3.22 (1.01)
• Communicate	82%	3.22 (0.86)	3.36 (0.78)
• Behave appropriately	80%	3.20 (0.84)	3.14 (0.93)

Parents and guardians were also asked to what extent they were confident they know how to help themselves or their family with five aspects of family life: (1) time for themselves; (2) time for themselves and another person; (3) their employment; (4) their hobbies, pastimes, or recreation for themselves or the family; and (5) what their family really needs. ECI services should support parent/guardian goal by providing emotional support during visits, sharing resources with parents/guardians, and encouraging parent/guardian connections with their informal support network (i.e., extended family, friends, neighbors).

Table 10. Parent/guardian's confidence with helping themselves or their family.

1 = I am not very sure how to help my child with this 2 = I have some idea about how to help my child with this 3 = I mostly know how to help my child with this 4 = I am fully confident and know how to help my child with this	**Total Sample** % Fully Confident or mostly know	**Urban** *Mean (SD)*	**Rural** *Mean (SD)*
• Time for myself	62%	2.79 (0.98)	2.90 (0.87)
• Time for myself and another person	64%	2.91 (0.90)	3.00 (0.80)
• Employment for me	63%	2.82 (1.04)	2.76 (1.05)
• Hobbies, pastimes, recreation for me or the family	59%	2.75 (1.01)	2.69 (0.93)
• What my family really needs	79%	3.15 (0.86)	3.40 (0.65)

Parents/guardians were asked if they belonged to a parent or family group for children with special needs including an online or in-person group. They were also asked if they were interested in joining a parent group or club.

Sixty-percent of parents said they already belong to a group; 28% said they would like to join a group; 50% said they might want to join a group and 22% said they did not want to join a group.

Directors were asked if their organization has a parent or guardian club or support group for ECI beneficiaries. 92% do not have a parent club or group although some reported an interest in establishing this type of group.

Area 5: Recommendations

- Ensure the family-centred, routines-based philosophy is reflected throughout each component of ECI service delivery including programme brochures, assessment procedures, and forms;

- Develop and deliver virtual training sessions on consultation-based home visits which include coaching and modeling;

- Review the ISP forms, completion process, and content for alignment with family-centred and consultation-based services;

- Connect child goals to daily routine activities rather than provider-led activities;

- Review the reassessment and progress monitoring forms and process for alignment with family-centred, evidence-based practices;

- Ensure all providers have access to a supervisor who regularly provides reflective consultation which includes modeling and coaching;

- Support providers to deliver emotional support during visits, share resources with parents/guardians, and encourage parent/guardian connections with their informal support network (i.e., extended family, friends, neighbors);

- Develop and implement an incident report form to record concerning parent/guardian behavior or incidents of child or provider injury; and

- Provider safety training and procedures should be reviewed.

Area 6: Feedback and complaint procedures

Outcome: The beneficiary's parent/legal guardian/ foster parent is informed regarding feedback and complain procedures. He/she has the opportunity to express his/her own opinion regarding the quality and scope of services, and the right to receive an adequate response in accordance with the Internal Regulation requirements.

Report Indicators:

1. Complaints: Number of official, recorded beneficiary or legal representative complaints received in the last 12 months;

2. Feedback: Organization or centre collects feedback from the beneficiary or legal representative;

Indicator 1: Complaints Source: Director	• Range: 0 to 20; Average 2 complaints per organization according to directors • 68% of directors reported no complaints.
Indicator 2: Feedback Source: Director	• 92% of organizations collect feedback from the parent/legal guardian.

Directors were asked how their organization collects feedback from parents or guardians about the ECI services they receive. 59% indicated they collect the information through a survey or semi-structured interview whereas 56% indicated using a feedback box and 44% reported using a feedback journal or log. 31% mentioned using telephone interviews. Many organizations use a multi-method approach and frequency of soliciting feedback from beneficiaries ranged from every three months to annually.

Directors were asked how their organization uses the feedback received from the parent or guardian. 41% indicated they use the feedback to improve service quality. 11% of organizations also reported using the information to plan trainings, with one sharing the information with the ECI Coalition. 11% also reported using the information to inform their strategic development plan.

Directors were asked how they determine what staff training is needed. Supervisor sessions or reports were most often mentioned (39%) followed by feedback from specialists (38%). Case reviews and child and family needs in addition to team meetings and organizational strategy planning were also mentioned frequently. Many directors reported using a "generative" process whereby the specialists share openly or through a survey what training they need and then rank order the options by priority.

Parents/legal guardians typically enjoy services provided by ECI providers who are friendly. Brief interviews and surveys that are broad rather than specific yield little helpful information. Specific surveys or interviews with questions that directly ask about intended child and family outcomes as discussed in Area 5 provide the most informative feedback.

Area 6: Recommendations

- Support the ECI Coalition to develop and provide all MoLHSA ECI programmes with an annual parent/guardian survey;

- Require ECI programmes to collect parent/guardian annual survey data or earlier if the child exits from ECI services;

- Financially support the ECI Coalition to analyze and summarize ECI programme data and make improvement recommendations; and

- Create standardized guidelines for receiving parent/guardian complaints, including development of a performance action plan to support the ECI provider and the process for determining if the family should be transferred to a new provider.

Area 7: Requirements of the ECI personnel

Outcome: The service recipients' individual needs are met to the extent possible in each community. The services and the necessary consultations are carried out by trained and qualified staff.

Report Indicators:

1. ECI programs employ at least two professionals from two different disciplines who hold the position of an Early Development Specialist, psychologist, occupational therapist, speech therapist, physical therapist, or special education teacher;

2. Paraprofessionals must hold an ECI certificate;

3. Paraprofessionals must have at least 6 months of practical experience working as a trainee in the ECI program;

4. Paraprofessionals perform specific activities under supervision of an early development specialist or other specialist;

5. All specialists (early development specialists, psychologist, occupational therapist, speech therapist, physical therapist, special education teacher, rehabilitation specialist, nurse, doctor, social worker, orientation and mobility specialist, surdologist, and any other professional who is specialized to work with young children with developmental delays or disabilities must have ECI certificate;

6. All specialists must hold a higher education diploma (except for nurses);

7. All specialists must have at least one year of experience working in the program of early childhood intervention using ECI methods;

8. All specialists must have a health certificate on file (Form NoIV-100/A) updated every three years;

9. All specialists must have a certificate of conviction updated every three years;

10. All specialists must have a team supervisor;

11. All supervisors must hold a bachelor's degree or higher;

12. All supervisors must have at least five years of experience working with children;

13. All supervisors must have at least three years of experience in an early intervention program;

14. All supervisors must hold a certificate or diploma of ECI;

15. All supervisors must hold a certificate of supervision.

Findings:

Indicator 1: Source: Director	• 85% of directors reported employing ECI service providers from at least two different disciplines; 5 organizations did not meet the requirement. • Range of disciplines: 0 to 6 with an average of three different disciplines.
Indicator 2: Source: Director, Provider	• 44% of directors reported 100% of their paraprofessionals had the required ECI certificate. • 70% of paraprofessionals reported holding the required ECI certificate.
Indicator 3: Source: Director, Provider	• 100% of organizations employ paraprofessionals with at least 6 months of experience according to directors. • 92% of paraprofessionals reported having at least 6 months of experience working in an ECI program. • 38% of the paraprofessionals reported having at least 6 months of experience working as a volunteer in the same ECI program where they are currently working. • 54% of directors reported their ECI providers had at least 6 months of practical experience working as a trainee in an ECI program.
Indicator 4: Source: Director, Provider	• 31% of organization directors who employ paraprofessionals reported the paraprofessionals perform their activities under the supervision of a an officially trained supervisor. 46% of the directors reported only employing professionals. • 50% of professionals have an officially trained supervisor according to directors. • 58% of paraprofessionals reported receiving some type of supervision. • 44% of paraprofessionals reported having a peer supervisor from the same ECI program where they work. • 14% of paraprofessionals reported having an external supervisor. • 16% of paraprofessionals reported having no supervision (peer or professional).
Indicator 5: Source: Director, Provider	• 71% of organizations only employ professionals with an ECI certificate according to directors. For other organizations, the percentage of specialists with an ECI certificate ranged from 5% to 88% • 90% of specialists reported having an ECI certificate.

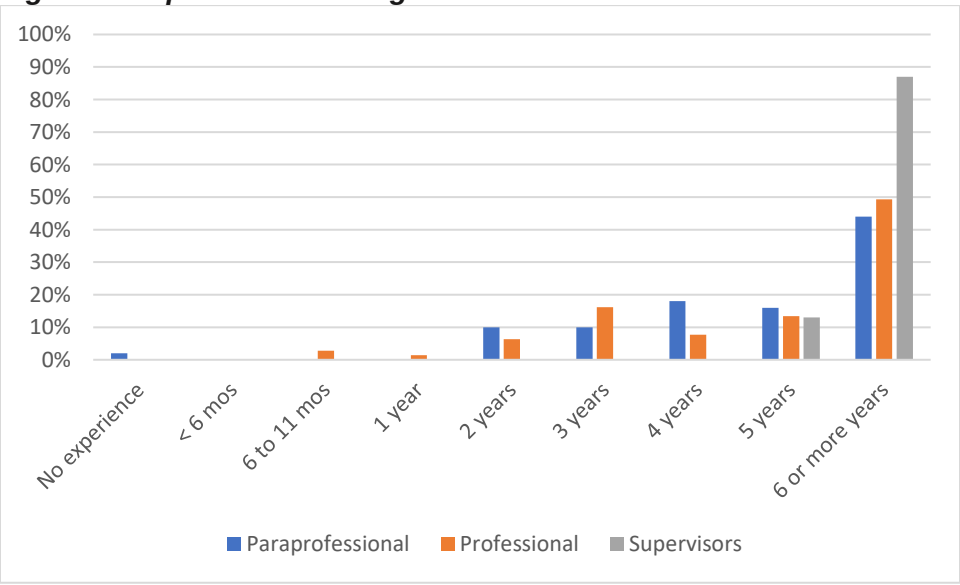
Indicator 6: Source: Provider	• 97% of ECI professionals met the minimum education requirements with 48% holding a master's degree or higher and 49% holding a bachelor's degree. • 92% of paraprofessionals had a bachelor's degree or higher.
Indicator 7: Source: Provider	• 87% of professionals had at least one year of experience working in an ECI program. • 92% of paraprofessionals had at least one year of experience working in an ECI program.
Indicator 8: Source: Provider	• 97% of professionals report their health certificate is on file with their employer. 91% updated their certificate in the last three years while 6% provided the certificate more than 3 years ago and 3% have not provided the certificate. • 98% of paraprofessionals have provided their health certificate to their employer with 94% having done so in the last 3 years. • Across all paraprofessionals and professionals, only 5 had never provided their certificate. Five volunteers had also never provided the health certificate.
Indicator 9: Source: Provider	• 98% of paraprofessionals provided their certificate of conviction within the last three years. • 91% of professionals provided their certificate of conviction within the last three years.4.3% provided their certificate more than 3 years ago. • Across all paraprofessionals and professionals only 7 had never provided the certificate.
Indicator 10: Source: Director, Provider	• 56% of directors reported providing a supervisor for all of their specialists while 24% have no supervision for their specialists and another 8% provide between 3% and 30% of specialists with supervision. • 16% of specialists reporting having no supervision. • 63% of specialists reporting having some form of supervision. • 50% of specialists reported they have a peer supervisor from the same ECI organization where they work. • 13% of specialists reported receiving external supervision.
Indicator 11: Source: Director	• 100% of supervisors had less than 60 assigned cases.
Indicator 12: Source: Supervisor	• 100% of supervisors held a bachelor's degree or higher. Five held a bachelor's degree; 10 held a master's degree; and 1 held a doctoral degree.

Indicator 13: Source: Supervisor	• 100% of supervisors had 5 or more years of experience working with children.
Indicator 14: Source: Supervisor	• 100% of supervisors had 3 or more years of experience working for an ECI programme as a service provider.
Indicator 15: Source: Supervisor	• 63% of supervisors held a certificate of ECI. Of those with an ECI certificate, nine participating supervisors held a local certificate and one held an international certificate.
Indicator 16: Source: Supervisor	• 69% of supervisors held a certificate of supervision. Specifically, 11 of 16 participating supervisors indicated they passed the ECI Supervision training exam.

Thirty-two percent of directors reported employing no paraprofessionals. The percentage of staff employed as paraprofessionals ranged from 12% to 100% with 22% of directors indicating 100% of their staff were paraprofessionals. Directors reported there were no professionals on their staff 18% of the time. Those reporting 100% of their staff were professionals made up 36% of the responses. Only 31% of their organization's paraprofessionals work full time according to the directors.

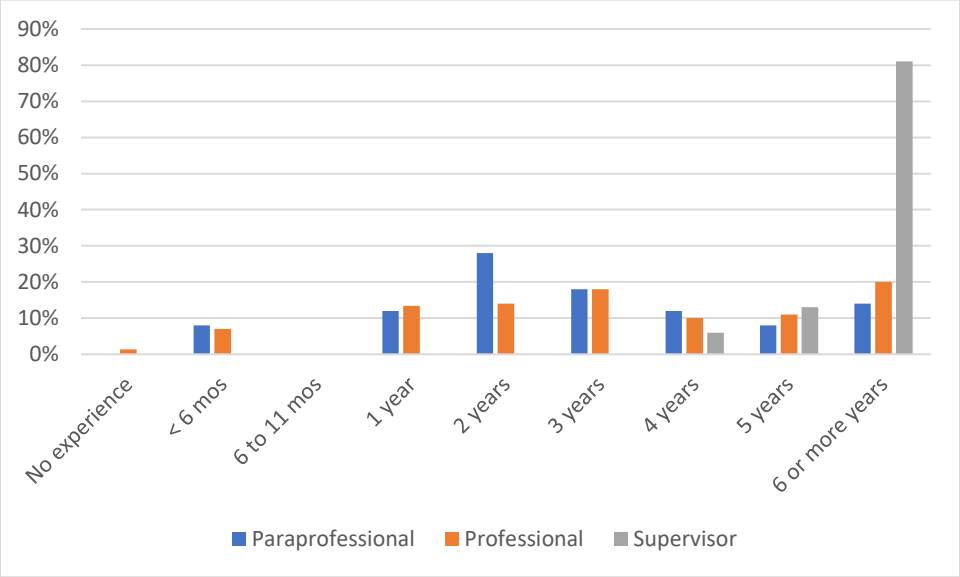
In general, paraprofessionals and professionals have many years of experience working with children. Figure 4 below shows over half of the paraprofessionals and professionals and all supervisors have five to six years of experience working with children.

Figure 4. Experience working with children.



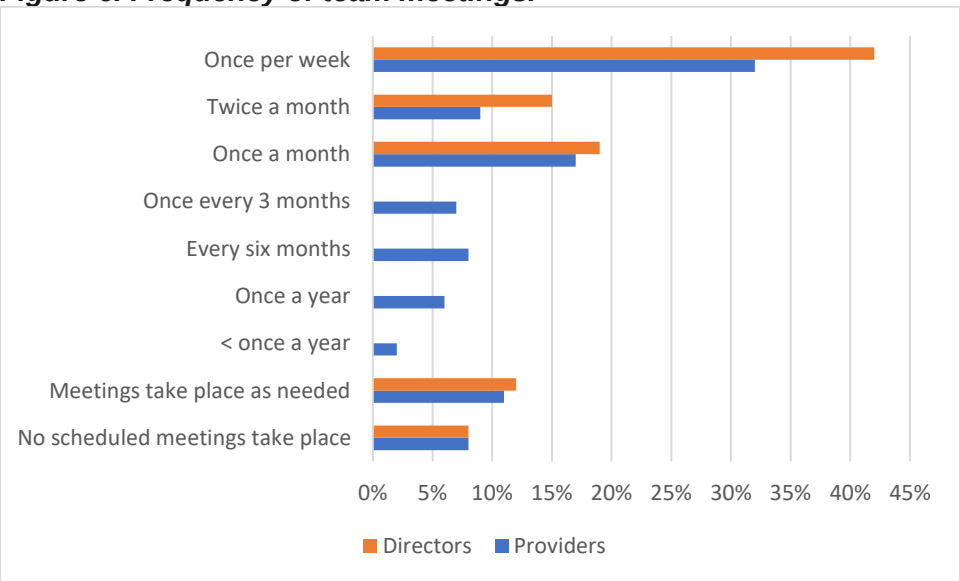
As reported in Figure 5, 60% of professionals and 52% of paraprofessionals had three or more years working in an ECI program. All supervisors had three or more years working in an ECI program.

Figure 5. Years of experience in an ECI program.



Team meetings are to be held once per week. The majority of providers reported meeting less frequently with 68% meeting less than once per week for scheduled multidisciplinary meetings. Forty-two percent of directors reported weekly team meetings take place. Directors were asked to share additional information about regularly scheduled team meetings. Many reported weekly meetings to discuss specific cases through sharing and discussing case information including through the use of video; identifying and resolving administrative issues; and assigning or re-assigning new cases. Administrators and program managers attend all or a portion of the meeting which lasts between one to four hours. All or some developmental specialists attend the meeting.

Figure 6. Frequency of team meetings.



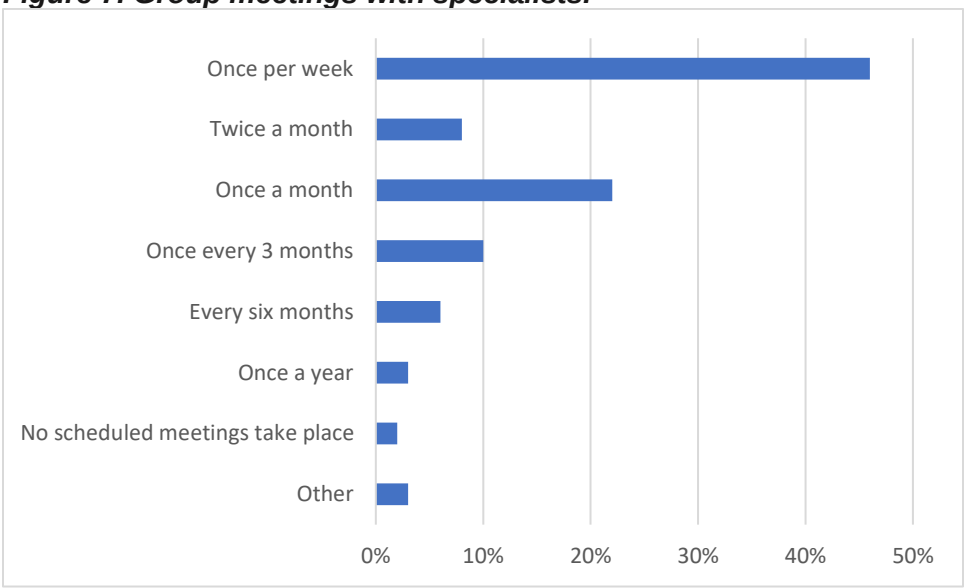
46% of providers reported team meetings with specialists for case reviews, feedback, professional growth, or internal training happen once per week and 22% reported team meetings happen once per month. Providers were also asked to share additional information about these meetings. Most providers reported the purpose of the meetings is to discuss cases, especially specific issues or challenges and share advice, recommendations, and strategies.

Fifty-two percent of providers (49% paraprofessionals, and 54% of professionals) reported children on their caseload usually see more than one service provider as part of their services (e.g., ECI provider on Tuesday, speech therapist on Saturday). 59% of directors reported children usually see more than one service provider during one out of eight monthly sessions. Given a sizeable number of children are seeing multiple providers, regular team meetings are essential to achieve quality interdisciplinary services.

Providers were asked why some children see multiple providers. 52% reported children require speech therapy in addition to sessions with a developmental specialist. One provider commented, "Children with disabilities go to behavioral therapy, sensory therapy, rehabilitation, Denver therapy and speech therapy. They are busy for 2-3 hours during the day (including early visits). Some parents may believe adding additional service hours is necessary for their child, most of the time the parent wants the child not to receive one type of therapy and to receive different types of services." While some children receive these additional services four times per week others may attend separate sessions four to five days a week when paid for by their parents.

Directors were asked why some children see different providers and how often they see each provider. The need for speech services was most commonly noted (55%). Several directors reported the child sees the additional specialist for 2 or 4 of the 8 monthly sessions. Others reported the child spends 4 sessions with the developmental specialist and 4 with another specialist (therapist).

Figure 7. Group meetings with specialists.



Supervision

Within the field of ECI, supervisors help ECI program administrators by serving as team leaders or provide external monitoring and coaching. Oversight may include record reviews to ensure paperwork compliance including adherence to timelines, quality, and confidentiality requirements. Supervisors assess the quality, completeness, and appropriateness of documentation, service delivery, and the need for training related to:

- **Intake.** This includes the process of gathering information from the family and informing them about ECI services and the process of developing an Child and Family Individualized Service Plan; informing parents/guardians about their rights; and gathering evidence about the child's development, health, and social history;

- **Assessment for Service Planning.** This includes compliance with the required assessment process, protocols, and timelines including involvement by a multidisciplinary team of certified ECI professionals from at least two different disciplines; documenting the family's resources, priorities, and concerns; and identifying the child's present levels of functional development using one of the three approved assessment measures;

- **Child and Family Individualized Service Plan Development.** This includes compliance with required dates, timelines, content, and parental and team involvement. Service delivery goals, settings, and frequency are also reviewed for quality and compliance with standards and regulations;

- **Service Coordination.** If complementary health, education, social welfare, or other community services are received by the child or family, the supervisor examines coordination across services;

- **Service Sessions.** Paperwork is examined for completeness and quality, including dates and signatures, what took place during the visit and the plan for the next visit. The length of the visit should match the specified length and frequency in the child's ISP. Supervisors may also serve as a coach. This includes helping ECI providers (a) navigate the day-to-day stress of their work; (b) navigate emotions related to compensation or organizational challenges; (c) build their confidence and feelings of self-efficacy; and (d) gain additional knowledge and skills. Individualized reflective supervision is recommended through the use of collaborative coaching. Supervisors may also provide targeted group sessions to discuss specific cases, strategies, or compliance topics;

- **Provider Certification.** Supervisors may examine paperwork for compliance with required credentials and experience and assist ECI providers to develop a plan to acquire required certification;

- **Transition.** This includes examining documentation for evidence of transition support to early childhood education or other appropriate services with parental involvement in compliance with standards and regulations; and

- **Special Topics.** Trauma informed practices, use of assistive technology, positive behavior intervention supports, universal design for learning, authentic assessment practices, family engagement through collaboration and coaching, and early education

and care for children with higher intensity or more complex intensity physical or developmental needs are common.

ECI supervisors have advanced competencies and skills to:

- Understand and be able to use and interpret screening, assessment, and data collection tools for the purposes of program planning, progress monitoring, and program evaluation;
- Guide ECI providers to recognize the family as a source of support and influence on the child's life and use practices and procedures that ensure family engagement during all phases of service delivery;
- Understand evidence-based, culturally appropriate practices necessary for effective home visits that promote functional skill development;
- Demonstrate knowledge of and promote adherence to ethical practices, ECI Standards, national and municipal legislative regulations, and ECI program policies, procedures, and program guidelines;
- Promote coordinated services compliant with regulations, policies, procedures, and guidelines which support the family unit, are complementary, unduplicated, and focused on family identified strengths, needs, and priorities;
- Understand the roles and responsibilities of a supervisor and use reflective practice to identify their own professional goals and participate in professional development activities to improve their professional practices;
- Understand the importance of community partnerships and have the ability to identify, build, and maintain collaborative partnerships with other community service organizations;
- Assist in the recruitment and selection of ECI program personnel, performance evaluation, and professional development recommendations;
- Provide crisis intervention and prevention for program families or provide consultation and education to staff.

ECI supervision in Georgia

Within the context of Georgia, supervision originated within ECI programmes out of necessity. Those with the most experience working as ECI providers stepped into supervisory positions. Training on supervision was subsequently provided by an international consultant through support from OSF and formed the basis of the Georgian supervisor certificate training program.

ECI certificate training program. The supervisor training program is meant for providers with higher education and at least five years of work experience with children and three years of continual work in ECI. The ECI Coalition provides the training which occurs over six months. Participants attend sessions for three consecutive days followed by independent work on exam requirements between sessions spread out every two months. Live virtual or written coaching is used between sessions to support completion of the required portfolio exam contents.

The exam requires the submission of two complete ECI cases demonstrating adherence to all standards, protocols, and documents. Videos demonstrating family-centered practices are also required in alignment with parent-mediated intervention techniques. A rubric specifies criteria for a passing exam score. A professional team of ECI Coalition members reviews and rates the portfolio exams according to the criteria.

Focus of supervisor training:

- Forms of supervision
- State regulations of the supervision process
- Supervisors' terms of reference
- Planning of the supervision process
- Principles of effective ECI team guidance
- Effective transition of children from the ECDS sub-programme to educational settings
- Coaching
- Supervision instruments
- Use of the ECDS supervision instrument in practice with feedback
- Workplace stress management
- Identification and referral of parent or guardian mental health issues
- Domestic violence identification and referral according to State rules
- Prevention of domestic violence through parent education

Supervisor requirements according to ECI Standards. Team (peer) supervisors must have a bachelor's degree and five years or experience working with children. Organizations providing an ECI sub-programme should have a supervisor with higher education, five years of experience working with children, three years of experience working in the ECI programme, a local or international ECI certificate or diploma, and a local or international supervision certificate or diploma.

Table 11. Supervisors' education and credentials

	Bachelor's degree or higher *%**	5 years early childhood experience *%**	3 or more years of ECI experience *%**	ECI Certificate *%**	Supervision Certificate *%**
National	100%	100%	100%	63%	69%
Ajara	100%	100%	100%	0%	100%
Guria	100%	100%	100%	0%	100%
Imereti	100%	100%	100%	50%	50%
Kakheti	100%	100%	100%	33%	100%
Samegrelo-Svaneti	100%	100%	100%	0%	100%
Samtxkhe-Javakheti	100%	100%	100%	100%	100%
Tbilisi	100%	100%	100%	75%	63%

Percent of supervisor within region that hold qualification.

The amount of time participating supervisors had been working in their position as a supervisor varied. Fifty percent reported working as a supervisor for one year or less. An additional 31% reported working as a supervisor for 2 to 5 years and 13% reported working as a supervisor for six or more years. The majority (69%) provide supervision for one ECI programme. Fifty-percent of supervisors reported working 11-20 hours per week as a supervisor and 44% reported working less than 10 hours per week as a supervisor.

Thirty-five percent of the sample has supervised for at least three years while 40% have supervised for less than six months. The majority (80%) provide supervision for one ECI programme that is registered with MoLHSA. Fifty-percent of supervisors provide supervision for less than ten hours per week the the other half provide supervision for 11-20 hours per week.
The ECI Standards require each ECI sub-program to have at least one full-time supervisor for every 60 children served. If the organization has 60 children and the supervisor works part-time, two part-time supervisors are required.

According to directors, 27% of them do not have supervision from a supervisor and 27% have between 51-60 cases assigned to each supervisor. 27% of directors reported between 1 and 30 cases assigned to each supervisor while 18% reported each supervisor had between 31 and 50 cases. Participating supervisors reported they supervised between 1 and 10 ECI providers each month. On average, they supervised six ECI providers each month (SD = 2.6).

Supervisors must meet minimum requirements specified in their job description. During supervision, the supervisor must use the required form which prompts the supervisor to comment on the following service dimensions:

- Specialist's relationship with the parent or guardian;
- Specialists relationship with the child;
- Specialist offers specific information and ideas for development of the child's skills; and
- Specialist clearly plans and agrees upon the next visit with the parent or guardian;

Supervision Received

62% of specialists receive supervision at least once per month. 31% of specialists reported receiving supervision once per month. 37% of paraprofessionals reported receiving supervision at least once per month. 33% receive supervision every six months. 19% of supervisors reported supervising more than once per week; 19% supervised once per week; 6% supervised twice per month; and 19% supervised once per month.

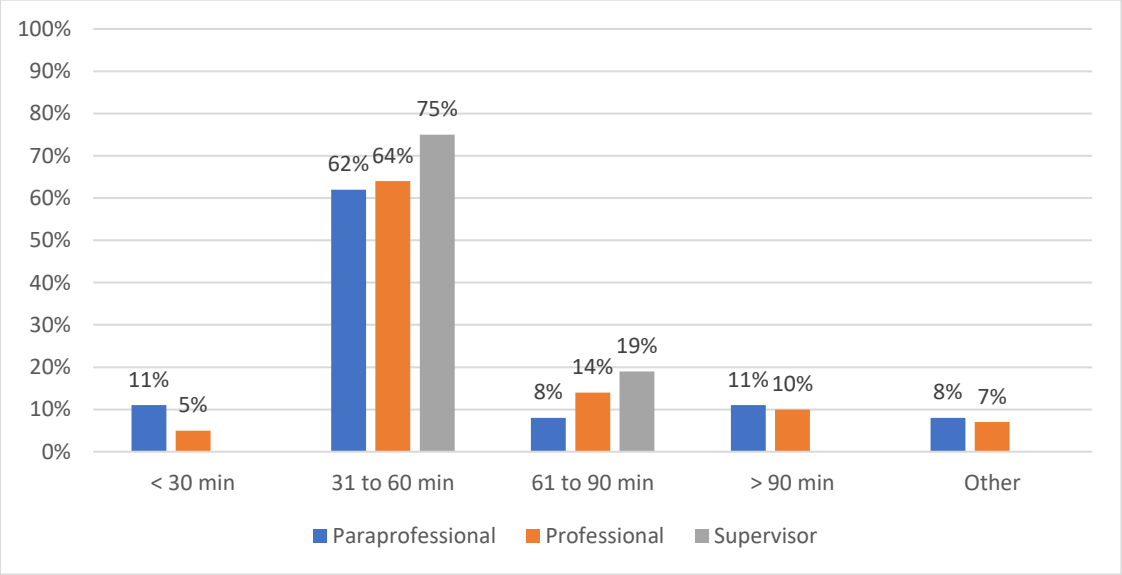
Thirty-three percent of directors reported their paraprofessionals don't receive supervision. 8% said supervision is received once per month. 21% said supervision takes place once per month or more frequently.

One director commented that supervision is not carried out by an ECI supervisor but conducted by a professional psychologist or psychotherapist. Two directors said they have no supervisors because they do not employ paraprofessionals and one commented, "If you are new to the start several times a week or once and the more experienced at least once a month." An additional director noted that supervision depends on the need and another director indicated supervision has been provided by the ECI Coalition in connection with their trainings.

One provider wrote this about supervision, *"It should be once a month but so far it is not worth it"* indicating the quality of supervision may be an issue. Others commented *"I always turn to him [supervisor] when I see the need for it"* and *"Specialists help each other in the form of supervision. We do not have an official supervisor"* revealing there may be some different preferences for and conceptualizations of supervision among providers.

Most specialists and paraprofessionals reported supervision sessions lasting 31 to 60 minutes (see Figure 8). Based on supervisor report, supervision sessions lasted either 31 to 60 minutes (75%) or 61 to 90 minutes (19%).

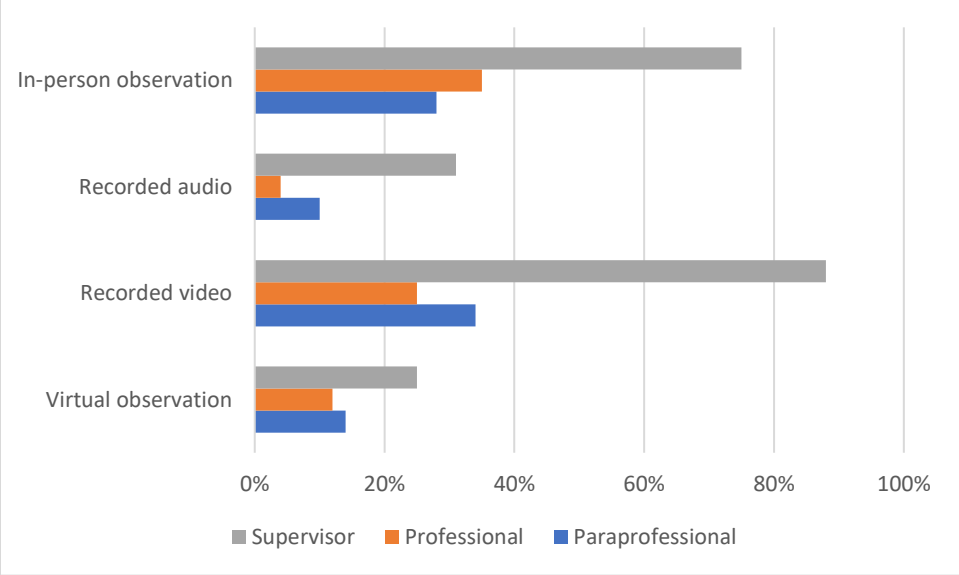
Figure 8. Average supervision session length.



Providers were asked which observation activities had been used in the last six months (see Figure 9). Professionals were more likely to report in-person observation compared to paraprofessionals who reported most often receiving supervision through recorded video observation by the supervisor.

Professional supervision is to be carried out at least once a month, through the Internet, using a video recording, or through the direct observation of the ECI session.

Figure 9. Type of supervisor observation in the last six months.

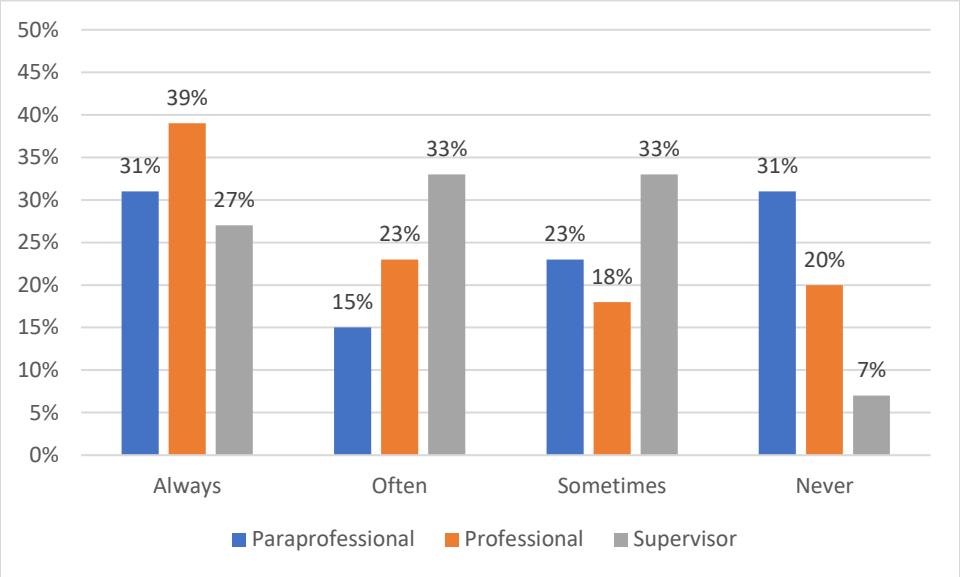


38% of providers reported their supervisor provides them with verbal feedback during supervision. 18% reported receiving written feedback and 16% said they jointly review video or audio of the session with their supervisor. There were no observed differences in the type of feedback received by paraprofessional and professionals. However, a higher percentage of paraprofessionals reported audio/video recordings with their supervisor during the session (20% vs 17%). Based on supervisor report, 94% reported providing verbal feedback in the last six months, 88% provided joint review of audio/video recordings of a session; and 56% provided written feedback in the last six months.

Table 12. Supervisor's practices during supervision.

Always=1, Most of the time=2, About half the time=3, Sometimes=4, Never=5	Paraprofessional *Mean (S.D.)*	Professional *Mean (S.D.)*	Supervisor *Mean (S.D.)*
• Share observation feedback right away	1.69 (1.05)	2.10 (1.42)	1.60 (0.51)
• Emphasize provider's strengths	1.24 (0.44)	1.59 (1.02)	1.20 (0.41)
• Use reflective process to discuss observations (asks open-ended questions)	1.58 (0.78)	1.72 (1.04)	1.64 (0.63)
• Identify next steps	1.60 (0.76)	1.52 (0.89)	1.36 (0.50)

Figure 10. Frequency of supervision form use by supervisors.



Sixty-five percent of directors reported supervisors share their suggestions with them about topics for future and staff training and 35% of directors said supervisors occasionally do this.

To assess service quality ECI providers were asked to record ten minutes of their service delivery. Providers were randomly assigned to record the beginning, middle, or end of their visit. A randomly selected subset of the sample recordings representing different regions was analyzed according to a practice rating form. The form contained widely recognized best practices. The first ten minutes included 18 practice ratings; the middle ten minutes also included 18 practice ratings; and the last ten minutes included nine practice ratings.

Prior to sample ratings, the international and national consultant established interrater agreement by reviewing and rating example recordings. Rating differences were discussed and resolved.

Adherence can be defined as a behavior that the provider engaged in or did. For example, “Used active listening skills with parent/guardian.” These items are scored as either “yes” or “no” and a provider met criteria if they demonstrated 80% or more of the items during the 10-minute interval. Quality can be defined as how well the provider engaged in the behavior. Items were scored on a five-point scale. To meet criteria, they needed to have a mean score 4 or above. Items were grouped across two service delivery dimensions: interpersonal skills and service delivery behaviors (e.g., Focused on functional skill development in the context of routines).

As reported in Table 13, over half of the providers demonstrated good interpersonal skills during the beginning and end of the visit and just under half demonstrated high quality. Recordings showed respect for families and children during these time periods with good use of active listening. However, providers most often focused their interactions directly with the child during the middle of the visit. While the parent/guardian may have been physically present, they were typically minimally involved and the activity was often directed by the ECI provider.

Providers scored low on items aligned with family-centred, consultation-based services such as inviting the parent/guardian to set the agenda for the visit; consideration of the family’s needs not only the child’s needs; support for the parent/guardian and child interactions; and the provider making a direct connection between the parent’s/guardian’s actions and the child’s development.

Table 13. Adherence and quality ratings for ECI service delivery.

	Percent of providers meeting quality cutoffs		
	First 10 minutes of session	Middle 10 minutes of session	Last 10 minutes of session
• Interpersonal			
○ Adherence	62%	8%	62%
○ Quality	46%	8%	46%
• Delivery			
○ Adherence	31%	15%	38%
○ Quality	0%	15%	15%

Supervision Challenges

- The ECI Coalition does not receive funding to provide the supervisor training unless the training participants pay for this service;

- The ECI Coalition has a professional team that reviews submitted portfolios of supervisor trainees. The portfolios are reviewed against specific criteria and applicants must pass the criteria to receive their supervisor certificate. Without funding, this places a heavy burden on the ECI Coalition portfolio review team;

- Those who wish to become supervisors must pay for their own transportation and accommodation to reach the supervision training site;

- Supervisors are paid twenty Georgian Lari (~$6.00 USD) for one hour of supervision. The amount is not commensurate with the workload. ECI organizations receive no budget for case management and service coordination and supervisors end up taking on this additional work. Organizations are not using a primary service provider model, which would place case management within the ECI provider's responsibilities.

- Funding is not provided by MoLHSA when services are delivered virtually;

- Funding for supervision is restricted to one hour per month per child and not based upon provider need;

- The Home Observation Rating Scale was proposed to MoLHSA to use as part of the supervision process. MoLHSA did not approve use of the tool.

Supervision, when it includes individualized coaching and facilitated reflection, is an important form of professional development that increases the likelihood of positive outcomes for providers, families, and children. Supervisors play an important role in strengthening a provider's knowledge, skills, and use of evidence-based, recommended practices.

Supervision should be consistent with the principles of adult learning theory and focus on building the capacity of paraprofessionals, professionals, and specialists delivering ECI services. Supervision should be a collaborative process, based on both the goals of the ECI provider and the supervisor's assessment of the provider's knowledge, skills, and practices. Feedback may be affirmative, evaluative, directive, or informative.

Coaching may be connected to a larger professional development initiative by the ECI Coalition and MoLHSA based on the outcomes of a provider needs assessment. Without coaching, providers are not likely to transfer knowledge gained through decontextualized training to their practice with children and families (Joyce & Showers, 2002). To improve practices, providers need to connect information to what they already know and are ready to learn next; to apply new strategies and receive supportive feedback. Supervision may be delivered in a group format, individually, or a combination and done on site or virtually.

For supervision to be effective, there should be shared understanding about the goals of supervision by the person providing supervision and the person receiving supervisor. Supervision is most meaningful and effective when guided by a provider's action plan, which includes their immediate improvement goals and identified needs to reach their goal. The process of developing an action plan should be collaborative and guided by the supervisor. Action plans help the supervisor provide meaningful, specific feedback based on data. Supervisors should receive training to use a variety of open-ended questions (i.e., objective, interpretive, comparative) and how to provide different types of supportive and constructive feedback.

Area 7: Recommendations

- Secure MoLHSA funding based on hours employed, not caseload, to provide regular supervision for every ECI provider;

- Secure MoLHSA funding for the ECI Coalition to provide supervision training free-of-charge with a travel stipend if the supervisor provides supervision for at least two years following their certification;

- Develop a supervision manual. The manual should provide the expected roles, responsibilities, and activities of supervisors, including which are prioritized, and describe the process for provider goal setting and observation and feedback expectations;

- At least once per year, supervisor fidelity checks should be carried out against a rubric by the ECI Coalition. These may be completed virtually through observation and review of documentation;

- Supervisors should receive incentive in the form of recognition and increased compensation;

- Strengthen a shared philosophy and approach to ECI service delivery across specialists and MoLHSA-supported ECI services with emphasis on a primary service provider model, family-centred services, and service delivery that supports the child's functional skill development in natural environments and routine activities.

Area 8: The ratio of beneficiaries and service professionals

Outcome: The number of beneficiaries for one staff member is optimal in order to deliver high quality services and also protect the service provider from stress and fatigue.

Report Indicators:

1. Visits per day: Each specialist should provide no more than 5 beneficiary visits per day;
2. Visits per week: Each specialist should have no more than 30 beneficiary visits per week;
3. Hours per week: Each specialist should work no more than 40 hours per week.

Findings:

Indicator 1: Visits per day Source: Provider	• Providers see cases four days per week with one day reserved for case reviews. 21% of providers reported 21 or more ECI sessions per week, placing them above the 5-visit limit over four days per week.
Indicator 2: Visits per week Source: Provider	• 21% of providers reported 21 or more ECI sessions per week, placing them above the 5-visit limit over four days per week. • An average of 14 sessions are provided each week with a range from 1 to 35. • The number of sessions provided per month ranged from 5 to 160 with an average of 52.
Indicator 3: Hours per week Source: Provider and Director	• 97% of service providers reported working 40 hours per week or less • 35% of directors reported working 31-40 hours per week with 6% work more than 40 hours and 24% work less than 10 hours per week, and 38% work 20 hours or less per week.

The State Social Service Agency under MoLHSA provides a monthly ECI service voucher covering eight sessions per month delivered by a State-approved program selected by the parents of an eligible child. To be eligible, the child must have a documented developmental or emotional delay or diagnosed disability by a neurologist or medical professional. Each voucher is equivalent to $57 USD.

Service providers reported averaging 8 assigned cases with a range from 1 to 29 assigned beneficiaries. The number of visits per week ranged from 1 to 35.

Service providers were asked if they provided services for more than one ECI organization or centre and if they provide privately paid ECI services outside of their current position. Figure 11 below shows the percentage of providers who work for multiple ECI organizations and Figure 12 shows the percentage of providers who provide privately paid services outside of their current position. Very few providers reported providing private services in addition to their position within a MoLHSA organization.

Figure 11. Service providers providing services for multiple ECI organizations or centres.

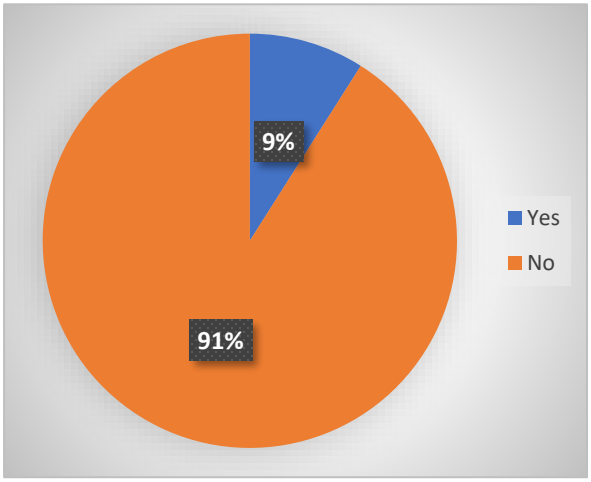
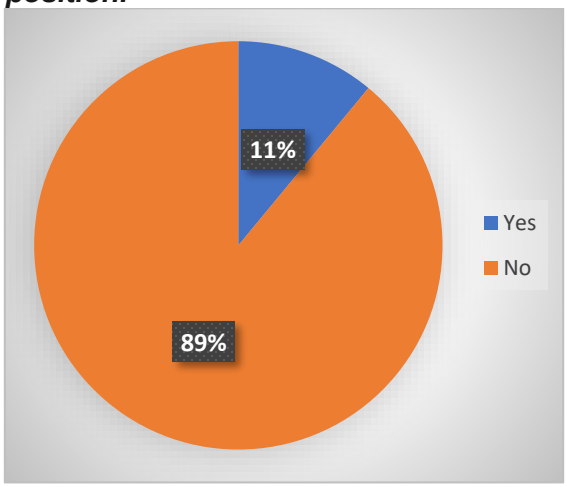


Figure 12. Service providers providing privately paid services outside current position.



Thirty-seven percent of parents/guardians reported their child receives private services that they pay for in addition to services offered by the ECI organization.

Area 8: Recommendations

- Maintain primary service provider caseloads at the required level of five visits per day across four days with one day reserved for case consultation and paperwork;
- Reduce the number of weekly primary service provider caseload visits from 30 to 20 to reflect the recommended daily caseload;
- Consulting, specialist providers may have higher caseloads if their support to team members is less frequent (i.e., once per month) or of decreased duration (i.e., less than 60 minutes);
- MoLHSA monitoring of caseloads to document human resource needs and prevent waiting lists, program quality, and staff fatigue.

Area 9: Termination of services / leaving the services

Outcome: The parent/legal guardian/foster parent is informed regarding the terms of termination of services, which is proved by the signature. The service provider discontinues its services if there is no need to further extend the services or when a service recipient violates the pre-agreed rules.

According to the standards, services may be terminated for any of the following reasons:

- The child has reached the appropriate level of development according to his/her age according to the child's assessment report and the conclusion and signature of the assigned transdisciplinary team;

- The legal representative/foster parent is not involved in the process of providing the services (developing ISP, achieving the functional results/tasks to be achieved with the child, refusing to perform activities provided in the ISP);

- The environment is not safe for the specialist or his/her rights have been violated during service delivery. This category includes:
    - The specialist has reached the maximum capacity and cannot safely include a new beneficiary during his/ her working hours;
    - The beneficiary's residence is located in an area outside of the geographical area defined by the service provider;
    - The beneficiary's residence is not reachable by public transportation. Under these circumstances, services may be delivered at the centre with transportation expenses covered by the beneficiary.

Report Indicators:

1. Refuse to provide services: Number of providers who officially refused to provide services to the parent/legal guardian in the last 12 months;

2. Exit services: Number of children on the service provider's caseload who exited ECI services because they no longer needed services;

Indicator 1: Refuse to provide services Source: Director, Parent	• Providers reported refusing between 0 to 4 beneficiaries; average of less than one refusal per organization. • Providers refused to provide services to 12 beneficiaries (8% of cases) in the past 12 months. • 68% of directors reported no refusals in the last 12 months. 20% of organizations had 1 refusal. • 71% of parents/guardians reported being placed on a waiting list before services began. • 40% of directors reported no children birth to 2 years 11 months were on a waiting list in the last 12 months; 31% of directors had

	no children 3 to 4 years 11 months on a waiting list; and 50% of directors had no children 5 to 6 years 11 months on a waiting list.

Specialists reported the following reasons for refusing cases:

- Three cases reported an interpersonal problem between them and the parent: *"A tense relationship…" "The parent had an incorrect and inadequate attitude towards me"* and one case of parent complaint with the specialist reporting, *"I did not like the parent."*

- Four cases were refused due to location: *"It was far away and I could not walk," "Lived in a village where the road is bad," "They lived far away and I could not go."*

- One case was due to a lack of parent participation: *"…parent failed to participate in the evaluation process and thought it was a lie and an unnecessary process itself refusing such services."*

- One case was due to the child's age: *"Turned 7 years old."*

- One case was due to a change in position and a lack of time.

- One case was due to the specialist's own health problem.

ECI service providers reported on the percentage of children who were served and percentage of children who exited the program in the last 12 months.

Directors and program coordinators reported on the percentage of children who were served and percentage of children who exited the program in the last 12 months. The number of children between birth and 2 years 11 months who were served ranged from 1 to 75 children; children age 3 to 4 years 11 months ranged from 2 to 64 children; and children 5 to 6 years 11 months ranged from 3 to 146 children.

Directors and program coordinators reported on the percentage of children who exited because they no longer needed services in the last 12 months. The number of children between birth and 2 years 11 months who no longer needed services ranged from 0 to 1 children; children age 3 to 4 years 11 months ranged from 0 to 5 children; and children 5 to 6 years 11 months ranged from 0 to 11 children.

Area 9: Recommendations

- Require ECI organizations to document and report annually to MoLHSA and the ECI Coalition the number of children birth to 2 years, 11 months and 3 to 5 years 11 months who (a) exited because they no longer require services as determined by ECI team evaluation; (b) were withdrawn from services by their parent/legal guardian; (c) were refused services; or (d) were referred to another service due to age or need.

- Document and analyze the percentage of children exiting services because they no longer require services as an indicator of service quality.

- Investigate the reason families are placed on a waiting list to inform actions necessary to reduce the waiting period to no more than 45 days.

- Offer virtual visits to rural families who would otherwise not receive services due to transportation difficulties.

Area 10: Team planning and in-service training

Outcome: The service provider takes care to increase and maintain the quality of the services.

Report Indicators:

1. Monthly team meetings: Transdisciplinary team meetings at least once a month within the timeframe stipulated by the internal agreement of the organization;

2. Group meetings: Group meetings with specialists to review cases, obtain feedback, support professional growth, and provide internal training;

3. Staff training: Determination of staff training needs;

4. Supervisor training suggestions: Supervisors share their suggestions about topics for future staff training.

Indicator 1: Monthly team meetings Sources: Director, Providers	• 76% meet at least once a month with 15% meet twice a month and 42% meeting once per week. • 58% of providers reported they attend team meetings at least once a month. • 32% of providers reported attending team meetings once per week. • 9% of providers reported attending team meetings twice per months. • 17% of providers reported meeting once per month. • 39% of providers reported they discuss cases during team meetings.
Indicator 2: Group meetings Sources: Providers	• 76% of providers reported there were ECI group meetings with specialists at least once per month (i.e., case review, feedbac, professional growth, or internal training).
Indicator 3: Staff training Sources: Providers	• 23% of providers shared advice, recommendations, and strategies with team members. • 12% of providers reported discussing issues and challenges.
Indicator 4: Supervisor training suggestions Sources: Director, Supervisors	• 65% of directors frequently receive supervisor training suggestions based on their work with the paraprofessionals and professionals. • 100% of supervisors indicated they share ideas for future training or professional development with directors.

Area 10: Recommendations

- Fund the ECI Coalition to develop, distribute, and analyze an annual needs assessment survey for all MoLHSA ECI providers;

- Fund the ECI Coalition to develop both asynchronous online modules and synchronous training based on the outcomes of the annual assessment of provider learning needs;

- Support the ECI Coalition to develop and share templates for case reviews;

Summary of Recommendations

Practice Area	Current Strengths	Improvement Opportunities
Area 1: ***Information about the service and the beneficiary***	• Internal regulations are in place	• ECI Programme brochures • Collection and use of data to inform ISP development • Follow the ISP service type during delivery • Transition to kindergarten
Area 1 Recommendations: 1. Develop and distribute an example brochure and template to all MoLHSA-approved ECI programmes; 2. Develop regional ECI referral networks that meet quarterly for two years and bi-annually once referrals have stabilized and pathways developed; 3. Develop and deliver virtual training sessions on the link between assessment, Child and Family Individual Service Plan development, service delivery, and progress monitoring; and 4. Formalize and finance the transition to kindergarten by developing a shared understanding of kindergarten skills beyond academics and recognizing kindergarten support within the ECI provider's caseload.		
Practice Area	**Current Strengths**	**Improvement Opportunities**
Area 2: *Equal access to services, family involvement, and inclusiveness*	• 76% of providers are using Ministry approved assessment tools in the allotted time frame. • Most providers know a lot about the community where they provider services. • Providers share information with parents about their right to receive ECI services. • Providers speak with parents about their child's transition.	• A third of parents are not fully confident on how to help themselves and their family with knowledge of resources and services. • Parents do not fully understand their right to receive services.
Area 2 Recommendations: 1. Consider opportunities for transitioning newborns from the Neonatal Intensive Care Unit to ECI services;		

2. Consider opportunities for ensuring seamless transitions for children entering and exiting ECI services which may include development of regulations and inter-agency agreements, and funding ECI providers to support teachers during the transition period;
3. ECI services should serve children birth to five years of age. Development of inclusive education and specialized teacher supports are needed after the age of five;
4. Review ECI training on service coordination (case management). The role, which may be carried out by the Primary Service Provider, should include: (1) informing parents/guardians of their rights; (2) coordination of evaluations and assessments; (3) facilitating parent/guardian participation in the assessment and evaluation; (4) identifying and informing the parent/guardian about resources; (5) coordinating, facilitating, and monitoring service delivery to ensure timelines are met and services are delivered according to the ISP; and (6) developing a transition plan with the ISP team which includes the parent/guardian;
5. Develop and deliver virtual training sessions on the relationship between family needs assessment, parent/guardian goal development, and positive child and family outcomes; and
6. Discuss transition plan development with the parent/guardian from the time they enter ECI services and every six months; and

Practice Areas	Current Strengths	Improvement Opportunities
Area 3: *Confidentiality protection*	• Confidentiality regulations are in place and comprehensive. • All ECI programmes have internal ECI regulations except on new programme.	There were no significant needs in this area.

Area 3 Recommendations:

1. Develop standardized data sharing agreements across education, health, and social welfare organizations where such agreements are to the benefit of the family and child to access or improve services; and
2. Develop guidance to protect family confidentiality in MoLSHA and ECI Coalition evaluation reports when reporting small sample sizes.

Practice Areas	Current Strengths	Improvement Opportunities
Area 4: *Protection from violence*	• ECI programmes recorded cases of child abuse.	• 86% of directors had internal instruction on child protection from violence.

Area 4 Recommendations:

1. Examine existing ECI Coalition training to determine if content is sufficient to prepare paraprofessionals and professionals to (1) provide parents/guardians with information needed to understand their child's disability (2) coach parents/guardians through strategies that will support their child's developmentally appropriate behavior; and (3) identify signs of child violence (i.e., verbal or physical abuse, neglect);

2. Coordinate early identification of maltreatment across health, education, and social welfare organizations for children with delays and disabilities;
3. Examine community-level opportunities for parents/guardians of children with disabilities to spend time enjoying community settings, thereby reducing family isolation and stress;
4. Connect families to support groups that will enable them to have positive interactions with other adults raising children with disabilities;
5. Provide respite care for unexpected crises and planned short-duration breaks for parents/guardians of children with disabilities;
6. Use a parent/guardian needs assessment that includes documentation of the family ecology during intake and every six-month re-evaluation to assess and strengthen family supports; and
7. Screen all children involved in child protection for developmental and social-emotional difficulties.

Practice Areas	Current Strengths	Improvement Opportunities
Area 5: *Early childhood intervention services, the basic principles and individual approach*	• Most parents are with the ECI provider during the session. • High use of the home visit record form by paraprofessionals and most professionals. • Almost all providers review the ISP every six months. • Most providers speak with the parent about the child's progress toward ISP goals. • Parents report providers are easy to talk with, ask them questions, and show them things they can do with their child. • Almost all parents report ECI sessions as a positive experience that gives them information they need and want and that gets them playing more with their child and able to make their own decisions.	• Greater involvement of parents in the development of the ISP, including goal writing, is needed. • Services should be delivered in natural environments across all 8 sessions as a rule. • Some providers focus sessions on child goals rather than what the parent wants to work on. • Over 30% of providers are telling parents what to do rather than working jointly with them which contributes to parent distraction, disinterest, and lack of engagement. • 44% of providers are delivering ECI sessions directly to the child without family involvement. • Around 40% of providers are focusing their sessions on

		activities or materials the provider has brought to the session. • Parents need more information on resources and child development. • Parents may benefit from information on how to access their existing network of friends, family members, and neighbors. • Roughly half of parents do not have time for themselves, employment or recreation. • Parents need more information on how to support their child during everyday routine activities, especially outings.

Area 5 Recommendations:

- Ensure the family-centred, routines-based philosophy is reflected throughout each component of ECI service delivery including programme brochures, assessment procedures, and forms;
- Develop and deliver virtual training sessions on consultation-based home visits which include coaching and modeling;
- Review the ISP forms, completion process, and content for alignment with family-centred and consultation-based services;
- Connect child goals to daily routine activities rather than provider-led activities;
- Review the reassessment and progress monitoring forms and process for alignment with family-centred, evidence-based practices;
- Ensure all providers have access to a supervisor who regularly provides reflective consultation which includes modeling and coaching;
- Support providers to deliver emotional support during visits, share resources with parents/guardians, and encourage parent/guardian connections with their informal support network (i.e., extended family, friends, neighbors);
- Develop and implement an incident report form to record concerning parent/guardian behavior or incidents of child or provider injury; and
- Provider safety training and procedures should be reviewed.

Practice Areas	Current Strengths	Improvement Opportunities
Area 6: *Feedback and complaint procedures*	• Most providers collect feedback from the parent/legal guardian.	• Consider standardizing surveys • Consider focusing surveys on parent/guardian confidence and family quality of life outcomes
Area 6 Recommendations: • Support the ECI Coalition to develop and provide all MoLHSA ECI programmes with an annual parent/guardian survey; • Require ECI programmes to collect parent/guardian annual survey data or earlier if the child exits from ECI services; • Financially support the ECI Coalition to analyze and summarize ECI programme data and make improvement recommendations; and • Create standardized guidelines for receiving parent/guardian complaints, including development of a performance action plan to support the ECI provider and the process for determining if the family should be transferred to a new provider.		
Practice Areas	**Current Strengths**	**Improvement Opportunities**
Area 7: *Requirements of the ECI personnel*	• Most ECI programmes employ providers from at least two different disciplines. • Most paraprofessionals and professionals have the required amount of experience. • Professionals meet the education requirements and almost 50% have a master's degree. • All supervisors have the required education and experience requirements. • Virtually all professionals and professionals have a health certificate and certificate of conviction on file.	• Not all providers and supervisors hold the required certificate. • Over 80% of paraprofessionals have no internal or external supervision.

	• All supervisors had less than 60 assigned cases as is required.	

Area 7 Recommendations:

- Secure MoLHSA funding based on hours employed, not caseload, to provide regular supervision for every ECI provider;
- Secure MoLHSA funding for the ECI Coalition to provide supervision training free-of-charge with a travel stipend if the supervisor provides supervision for at least two years following their certification;
- Develop a supervision manual. The manual should provide the expected roles, responsibilities, and activities of supervisors, including which are prioritized, and describe the process for provider goal setting and observation and feedback expectations;
- At least once per year, supervisor fidelity checks should be carried out against a rubric by the ECI Coalition. These may be completed virtually through observation and review of documentation;
- Supervisors should receive incentive in the form of recognition and increased compensation.
- Strengthen a shared philosophy and approach to ECI service delivery across specialists and MoLHSA-supported ECI services with emphasis on a primary service provider model, family-centred services, and service delivery that supports the child's functional skill development in natural environments and routine activities.

Practice Areas	Current Strengths	Improvement Opportunities
Area 8: *The ratio of beneficiaries and service professionals*	• Virtually all providers reported working 40 hours per week or less.	• 21% of providers reported 21 or more ECI sessions per week, placing them above the 5-visit limit over four days per week.

Area 8 Recommendations:

- Maintain primary service provider caseloads at the required level of five visits per day across four days with one day reserved for case consultation and paperwork;
- Reduce the number of weekly primary service provider caseload visits to 20 from 30 to reflect the recommended daily caseload;
- Consulting, specialist providers may have higher caseloads if their support to team members is less frequent (i.e., once per month) or decreased duration (i.e., less than 60 minutes).
- MoLHSA monitoring of caseloads to document human resource needs and prevent waiting lists, program quality, and staff fatigue.

Practice Areas	Current Strengths	Improvement Opportunities
Area 9: *Termination of services / leaving the services*	• There was less than one provider service refusal per organization.	• 71% of parents/guardians reported being placed

		on a waiting list before services began. • Few children birth to 2 years, 11 months are existing the services. 95% of directors reported no children birth to 2 years, 11 months exited services. •

Area 9 Recommendations:

- Require ECI organizations to document and report annually to MoLHSA and the ECI Coalition the number of children birth to 2 years, 11 months and 3 to 5 years 11 months who (a) exited because they no longer require services as determined by ECI team evaluation; (b) were withdrawn from services by their parent/legal guardian; (c) were refused services; or (d) were referred to another service due to age or need.
- Document and analyze the percentage of children exiting services because they no longer require services as an indicator of service quality.
- Analyze the relationship between service duration and service exit. Infants and toddlers may not be existing because of late identification and service delivery (e.g., waiting list).
- Investigate the reason families are placed on a waiting list to inform actions necessary to reduce the waiting period to no more than 45 calendar days.
- Offer virtual visits to rural families who would otherwise not receive services due to transportation difficulties.

Practice Areas	Current Strengths	Improvement Opportunities
Area 10: *Team planning and in-service training*	• 76% of providers reported there were ECI group meetings with specialists at least once per month (i.e., case review, feedback, professional growth, or internal training). • Most supervisors share ideas for future training or professional development with programme directors.	• A small percentage of team meetings focus on discussing issues and challenges the provider is experiencing.

Area 10 Recommendations:

- Fund the ECI Coalition to develop, distribute, and analyze an annual needs assessment survey for all MoLHSA ECI providers;

- Fund the ECI Coalition to develop both asynchronous online modules and synchronous training based on the outcomes of the annual assessment of provider learning needs; and
- Support the ECI Coalition to develop and share templates for case reviews.

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