To the Graduate Council:

I am submitting herewith a dissertation written by Donald Vance Thompson entitled "The Refinement and Validation of a Home-Based Program Development and Evaluation Instrument for Special Education Programs Serving Handicapped Children Ages Birth Through five and Their Families." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Educational Administration and Supervision.

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We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

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and Dean of the Graduate School

THE REFINEMENT AND VALIDATION OF A HOME-BASED PROGRAM DEVELOPMENT AND EVALUATION INSTRUMENT FOR SPECIAL EDUCATION PROGRAMS SERVING HANDICAPPED CHILDREN AGES BIRTH THROUGH FIVE AND THEIR FAMILIES

A Dissertation

Presented for the

Doctor of Education

Degree

The University of Tennessee, Knoxville

Donald Vance Thompson
August, 1991

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DEDICATION

This dissertation is dedicated to my wife

Janet Mullennix Thompson

and

my sons

Vance and Daniel.

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I would like to express deepest appreciation to my major professor, Dr. Norma Mertz, for shepherding me through this process. Her commitment to excellence made me produce a better product. Special thanks are also extended to my other committee members for their encouragement and assistance: Dr. Olga Welch, Dr. George Harris, and Dr. Charles Hargis.

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Finally, I wish to thank my family and friends for their encouragement, love, and prayers. Without their support, I would have given up (Phil. 4:13).

ABSTRACT

The purpose of this study was to validate a program evaluation and program development instrument which contained the essential elements or most promising practices related to identifying and serving young handicapped children utilizing a home-based service delivery model.

The investigation involved sending a survey to all of the replication sites of a nationally validated home intervention program for young hearing impaired children and having the program supervisors rate the 222 item instrument along two dimensions: the relationship of each item to program quality, and whether or not the item was being implemented in their program. Survey items were categorized into the following domains: Public Awareness/Child Find, Screening, Referral and Diagnosis, Census, Assessment and Individualized Family Service Plan, Parent Advisor Program Implementation, Staff Recruitment and Selection, Staff Development, Staff Supervision, Funding and Financial Management, Support Services, Transitioning From Home-Based to Center-Based Programs, Materials and Equipment Lending Library, Measurements of Achievement/Satisfaction.

Completed surveys were received from 79 of the 185 sites, yielding an overall response rate of 43 percent. The responses of all supervisors completing the survey were used to compute means and standard deviations for each of the 222

survey items. All of the items met the criterion for inclusion in the validated instrument and are reported with their means and standard deviations.

The responses were categorized into three groups, a High Child Achievement group, a Lower Child Achievement group, and a No Child Achievement Data Reported group, based on child progress data submitted to Project SKI*HI. The item weights assigned by the High Child Achievement and Lower Child Achievement sites were analyzed to determine if the High Child Achievement sites perceived certain items as being more indicative of program quality than did the Lower Child Achievement sites. Results indicated that the High Child Achievement sites placed more value on almost all of the program quality indicators than the Lower Child Achievement sites did. Further, the High Child Achievement sites also were implementing more of the program quality indicators than the Lower Child Achievement sites were.

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CHAPTER I

OVERVIEW OF THE STUDY

Introduction

Changes in federal laws, and the regulations which interpret those laws, are dramatically impacting the way school systems provide special education services and the populations to whom services are provided. Just as school systems were appearing to be comfortable with providing special education and related services to all school-aged handicapped children as required under the Education of All Handicapped Children's Act of 1975 (Public Law 94-142), Congress passed the Education of the Handicapped Act Amendments of 1986. The new law, Public Law 99-457, proved to be much more comprehensive than Public Law 94-142, authorizing the provision of special education and related services to additional segments of the population.

Part B of Public Law 99-457 mandated educational services to all handicapped children, ages three through five, by July, 1991. This change extended downward the mandatory availability of services to children not previously served in a consistent manner in all states. Part H of Public Law 99-457 was even more far-reaching. Section 671 states:

> Congress finds an urgent and substantial need to enhance the development of handicapped infants and toddlers and minimize their potential for developmental delay; reduce the education costs to

> our society, including our schools; minimize the likelihood of institutionalization; and enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps.
>
> It is therefore the policy of the United States to provide financial assistance to states to develop and implement a statewide, comprehensive, coordinated, interdisciplinary program of early intervention services for handicapped infants and toddlers and their families; facilitate coordination of payments for early intervention services from various public and private sources; and enhance the capacity to provide quality early intervention services and expand and improve existing services.

In support of its findings and policy, Congress funded the Part H grant program which enables States to provide early intervention services to birth through two year old handicapped children and their families. Though Part H was discretionary, all States elected to participate.

Part H of Public Law 99-457 is unique from all other special education initiatives in at least three ways:

1. Extended Population Parameters

It is the only Department of Education program which focuses exclusively on meeting the needs of birth through age two handicapped children. This age category of children has traditionally been served through Department of Health and Human Services programs.

2. Mandated Coordination of Services

Part H required that each Governor establish an Interagency Coordinating Council to advise and assist in planning, development, and implementation of statewide interagency services to infants and toddlers.

3. Mandated Family Service Planning

The role of the family as it relates to the development of infants and toddlers with handicaps is strongly recognized in Public Law 99-457. A written, Individualized Family Service Plan (IFSP) which contains the following components is required for each handicapped child:

A. An objective assessment of the child's present levels of performance in physical development, cognition, speech and language skills, psychosocial development, and self-help skills;

B. The family's strengths and areas of need as they relate to the child's development;

C. Child and family outcomes that are anticipated, along with criteria, timelines, and procedures used for determining progress;

D. The specific early intervention services needed to meet the unique child and family needs including frequency, intensity, and method of service delivery;

E. The designation of a case manager responsible for implementing the IFSP and coordinating with other agencies and individuals;

F. A plan for transitioning the child from the infant and toddler (birth through two) programs of Part H into the services provided to older children under Part B.

Since states are nearing the required implementation date, programs are being quickly established to meet these

federal demands. With the absence of clear guidelines for best practices, states are proceeding toward implementation of new programs without a distinct understanding of what is appropriate educational planning for children in this age category.

Because of federal requirements that parent assessment and family service planning be a part of each child's program, and because of the ages of the children for whom services are being planned, home-based models are receiving strong consideration in most states. Home-based programming, though not without its potential shortcomings, appears to be a workable model for many children in this age category. It affords the opportunity to involve families, gather the required information, implement programs, and avoid one of the most frustrating problems in special education -- transportation. However, no validated best practices guidelines exists for home-based program development. What is needed is a validated, best practices instrument for home-based programs which contains the domains required by Public Law 99-457. Ideally, the instrument should contain activities or procedural steps that program developers could implement in order to achieve a level of quality in that particular domain. To be most effective, such an instrument would have each item weighted so that program developers could use the instrument as both a needs assessment tool and a planning tool for program enhancement. Item weighting would afford the program

director the opportunity to choose from among the many different activities those that are rated as most related to program quality. These could then be added to the program individually or in clusters, following the pace that best meets the program's needs. A validated, best practices instrument such as this could also meet the needs of existing home-based programs that are striving to develop strategies to insure that the critical components of Public Law 99-457 are satisfied.

A growing body of literature (Bronfenbrenner, 1974; Schow and Watkins, 1980; Affleck et al., 1982; Moxley-Haegart and Serbin, 1983; Shafer, 1984; Hanson, 1985) supported the value of parent-oriented, early intervention programs for young handicapped children, as well as the importance of the home as the early educational setting (Baker, 1976; DeBerry, 1984; Karniski, 1986), yet little information existed which identified "best practices" for delivering quality home-based educational services for handicapped children in the birth to five age category. A need, therefore, existed for identifying indicators of program quality which related to providing home-based services to young handicapped children.

One way of accessing program quality information for home-based programs was to gather data about best practices from those who work in home-based programs which have demonstrated success in serving young handicapped children and their families. Given that there existed a need for a

validated best practices instrument, it seemed only logical to seek to validate a best practices instrument using input from those persons who work in nationally validated programs. Doing so, however, presented its own set of unique circumstances. There were only five early childhood special education programs which had some type of home-based component which were identified in the 1990 edition of the National Diffusion Network publication, EDUCATIONAL PROGRAMS THAT WORK. Of these, two (Portage Project and MAPPS) were primarily curriculum projects that had wide distribution, but did not receive regular feedback from adoption sites. A third (Peoria 0-3 Project) was serving only eight children with home-based services at the time this study was initiated and had no replication sites providing home-based services. Only Project SKI*HI and INSITE Model had a pool of active replication sites from which to draw respondents.

INSITE Model, an outgrowth of Project SKI*HI, was developed by SKI*HI Institute and utilizes the same service delivery model as Project SKI*HI. The two programs differ in the curriculums used and the populations served. INSITE serves multi-sensory impaired children, while Project SKI*HI serves hearing impaired children. Both target children ages birth through five and their families. INSITE Model received validation by the Program Effectiveness Panel (PEP) in 1989, while Project SKI*HI was first validated in 1978 and revalidated in 1984. Since its origination, Project SKI*HI had

been replicated at more than 240 sites in the United States, had served more than 12,000 hearing impaired children, and had encouraged each adoption site to monitor child achievement on a quarterly basis, affording an opportunity to compare the respondents' opinions about program quality indicators with child achievement data.

Of the two available programs from which to choose respondents, Project SKI*HI appeared to be the more logical choice. It was older and had more adoption sites. It had gone through validation twice. Many of the INSITE adoption sites were SKI*HI replication programs that had added INSITE to meet the needs of the multi-sensory impaired child. Because of this, many INSITE programs were directed by SKI*HI project directors. Finally, the child achievement data collected on INSITE children would be more difficult to compare across sites since the children had more than one sensory handicap.

The staff of SKI*HI Institute, a center devoted to developing support materials for Project SKI*HI adoption sites, foresaw the need for providing materials to guide the new, generic home-based programs which would spring from the mandate of Public Law 99-457. In 1989, it published The Management of Home-Based Programs for Infant, Toddler and Preschool Age Handicapped Children, a volume written by SKI*HI adoption site personnel. Designed to help planners of programs for children with various handicapping conditions, this work contained both general and specific guidance for

assisting program planners in developing and implementing home-based programs for young handicapped children.

The final chapter in this volume, entitled "Program Evaluation", was written by this investigator. This chapter contained an instrument which represented a first attempt at satisfying the need for a program evaluation and program development tool which described best practices for home-based programming for young handicapped children, while helping programs meet the requirements of Parts B and H of Public Law 99-457. It contained a large number of stimulus items that were believed to be related to providing quality home-based programming. This instrument, however, had not been put through the rigors of validation. The items included in the instrument, though gleaned from early childhood special education literature or contributed by a small panel of early childhood special education experts, had not been weighted by a national panel of experts to determine their value as indicators of program quality. As a result, the instrument lacked the utility that would have been present if it had been validated and put in a format where the program developer or supervisor could know the strength of each item in relation to program quality for home-based early intervention programs. Consequently, its potential value could not be tapped and the need for a program evaluation and program development tool which could be used by program planners, developers, and

supervisors to assist in developing new or enhancing existing home-based early intervention programs went unmet.

Statement of the Problem

The requirements of Public Law 99-457 were clear. Young handicapped children were to be served. What was not clear, however, was how to deliver those services in a quality manner. Many of the programs being planned nationwide would be delivering services in the home, due to the ages of the children being served and the emphasis on family involvement. However, there was not an instrument which contained clear, validated, weighted items identifying best practices for delivering home-based services to young handicapped children and their families. No one had done an in-depth study of existing home-based programs which had proven effective in addressing the needs of young handicapped children and their families to determine the indicators of program quality or best practices that should be considered by new programs. In the absence of such standards, program planners, developers, and supervisors lacked the information needed for making meaningful decisions related to establishing, implementing, and improving services to young handicapped children and their families.

Purpose

The purpose of this study was to validate a program evaluation and program development instrument which included the essential elements or most promising practices related to identifying and serving young handicapped children utilizing a home-based service delivery model. This research effort was intended to result in a useful, concise tool which could be used by those who were planning new programs, implementing new programs, or seeking to enhance existing programs. It was intended that the items contained in the validated instrument be statements of procedure or activity on which there was consensus among early childhood special educators who managed home-based programs that the procedures and activities related to program quality. The resulting instrument was to be designed so that it could be used either in its entirety or in sections, depending on the needs of the program using it. Further, the item weights and standard deviations for each item were to be published with each item so that program administrators could choose those items which had the greatest relation to program quality as their starting points for proposed change. This investigator further proposed to ascertain whether those program directors of programs which had higher child achievement results perceived certain items to be more indicative of program quality than did directors of programs which had smaller child achievement gains. The

validated instrument which emerged from this research effort was intended to serve two purposes:

1. It will serve as an evaluation tool for programs to use in determining how their program compares to a set of nationally validated criteria for serving infants, toddlers, and preschool age handicapped children using a home-based service delivery model;
2. It will serve as a needs assessment and program development tool which programs can use to identify weaknesses and establish both long term goals and short term objectives for overcoming those weaknesses;

Research Questions

The research questions that this study sought to address were as follows:

1. What are the program quality indicators for which there is national consensus among directors of home-based early intervention programs serving hearing impaired children?
2. Do program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?

Significance

With the date for implementation of Public Law 99-457 imminent, programs that are being established to meet the mandates of the law needed a tool to help guide them as they developed and sought to enhance their delivery of quality home-based services to handicapped children and their families. Surprisingly little information was currently available which identified "best practices" for delivering quality home-based educational services. Therefore, this research effort helps to satisfy the need for identifying indicators of program quality which relate to providing home-based services to young handicapped children. It gives established home-based programs a tool which can be used to assess strengths and set goals for future program enhancement. It gives new home-based programs a road map for developing quality early intervention services. It will help meet a policy development need by providing information about the components of quality home-based programming to policy makers who are being asked to fund new programs. Finally, the investigation of what program directors believe to be best practices with very young handicapped children should make a significant contribution to early childhood special education literature, since it taps a previously unexplored body of knowledge. Having additional information about what works should be welcomed by those in the field of early childhood

special education who are working hard to see the field established.

Definitions

Early Intervention. Seeking children between birth and school age who either have or are at risk for having handicaps or other conditions which may adversely affect development and then providing services to lessen these potential effects.

Home-Based Program. A service delivery model which involves sending teachers or parent advisors into the homes of young handicapped children to either remediate developmental problems or prevent their occurrence.

Home Intervention. The provision of services to handicapped children in their homes.

Program Evaluation. The comparison of existing program practices with a set of standards which have been adjudged to be "Best Practices." The purpose of program evaluation is to provide information for the decision-maker.

Best Practices. Strategies, procedures, and techniques that have been agreed upon by a recognized panel of experts as the best means of delivering services to a specified population.

Program Quality Indicator. An individual item which contains either a strategy, a procedure, or a technique which has been agreed upon by a panel of experts as being a component of "Best Practice".

Parent Advisor. A professional trained to provide early intervention services to young handicapped children and their parents following a home-based intervention model.

Case Management. The coordination of early intervention services for young handicapped children and their families.

Validity. The ability of a test to measure what it purports to measure.

Assumptions/Limitations/Delimitations

1. Regional variations may exist with regard to what works, and thus, best practice. Further, state and local opinions about "what will work" may greatly influence what can be tried. These variations could make the validated instrument more useful for some states and regions than others. This investigator looked at regional responses to determine the extent to which variation existed. This information is reported so the reader can tailor the information to her particular region if desired.

2. Laws vary from state to state which influence how services can be delivered, thereby influencing how respondents may have rated certain items as being related to program quality. No attempt was made to control for this limitation.

3. Regional variations existed in the skill level of people available for employment which may have influenced the

respondents' views of the feasibility of certain items. No attempt was made to control for this limitation.

4. Existing practices in the replication sites may have tended to limit what the respondents were willing to identify as "best practice." Discrepancies between item ratings by implementation status have been reported by domain so the reader can see the effect of this limitation.

5. Each respondent was asked to identify herself and her program. This could have biased the responses that were given since respondent anonymity was not encouraged. The opportunity for follow-up interaction, which was needed, seemed to outweigh this delimitation.

7. All of the respondents in this study were specialists working with hearing impaired preschoolers and their families. It was assumed that their responses had applicability to programs designed to serve children with other disabilities.

8. The children served at the various replication sites which report child achievement data to the SKI*HI Institute vary in terms of ethnic, gender, and racial makeup. No attempt was made to control for these differences.

Procedures

Multiple data sources were used in the study. Surveys were sent to supervisors of programs replicating a nationally validated home intervention program. Each was asked to

provide demographic information, to assign values to 222 stimulus statements believed to be indicators of program quality related to home-based services, and to indicate whether or not her program was implementing each of the stimulus statements. Aggregated child achievement data from a secondary source were used to stratify the respondent pool into three groups: High Child Achievement, Lower Child Achievement, and No Child Achievement Data reported. Measures of central tendency and dispersion were computed for each survey item, controlling for various conditions. The data were analyzed utilizing Lotus 1-2-3 software.

Organization of the Study

This study has five chapters. The first chapter consists of the introduction, statement of the problem, purpose, research questions, significance of the study, definition of terms, assumptions, limitations and delimitations, a summary of the procedures, and the organization of the study. Chapter II contains a review of the early childhood special education literature related to the study, along with a description of Project SKI*HI. Chapter III provides the description of the methodology used in the study. Chapter IV contains the data analysis. Chapter V contains the summary, findings, conclusions, and recommendations of the study.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

The passage of Public Law 99-457 resulted in a flurry of activity in every state to devise appropriate programs to meet the needs of handicapped children in the birth through five age category. Providing comprehensive services to this segment of the population, and especially to those who are birth through two, is a new phenomenon. Many of the programs which are emerging are utilizing a home-based service delivery model. This, too, is a relatively new phenomenon for the field of special education.

Services to children in the targeted age category, birth to five, generally are provided via one of three delivery models: home-based, center-based, and combination home/center-based programs. The decision as to the type of program to establish may be influenced by a number of factors, including the following: the incidence of the handicapping condition/s of the children to be served, population density, availability of financial and human resources to serve children, the focus of the persons planning the program of services, and the philosophical orientation which is adopted by the program. For example, one may strongly believe that a traditional,

center-based, group therapy program is needed for young deaf children to develop their maximum potential; however, if a family lives in a remote area far removed from a major metropolitan area, their deaf child may be the only one of his age for many miles. Similarly, program planners may maintain that providing the service in the child's home is critical to program success. If this is the case, a home-based program will likely be planned even though the program may be in a major metropolitan area with sufficient numbers of handicapped children to allow for quality center-based programming. At the risk of grossly over-simplifying a very complex issue, it may be said that center-based programs tend to focus on the child alone, while home-based programs tend to view the child as an integral part of a family unit.

The purpose of the present research effort was to validate an instrument which could be used by both existing and emerging home-based programs to identify areas of need and develop strategies to meet those needs. While there are some curriculum programs which have achieved national recognition as being worthy of adopting or adapting to meet local needs, this author was unable to locate a definitive, validated instrument which could be used to assist in home-based program planning, development, implementation, and evaluation.

An integral part of the development of the Home-Based Program Evaluation Instrument which has been validated was a review of the early childhood special education literature.

Doing so produced key components which are included in the instrument. This chapter provides a summary of the significant material available in the early childhood special education literature related to the provision of quality in-home services. A description of Project SKI*HI, the nationally validated, home-based program whose replication site directors served as respondents to the validation survey, is also included in the chapter.

Home-Based Programs for Young, Handicapped Children

Home-based programs for young, handicapped children vary in terms of populations served, program content, focus, intensity, and mission; however, many share a common theoretical foundation. An understanding of the postulates on which home-based programming rests gives the reader a point of reference for reviewing the programs which have grown from them.

Reese (1983), an advocate for in-home services, averred that providing services in the home enhanced parent-child interaction because the home was a more natural setting than a school or a clinic, and the home yielded many more opportunities for spontaneous communication. She asserted that an effective program for young handicapped children must 1) begin intervention as soon after birth as possible; 2) be within the home environment; 3) include the parent as the

primary language model; and, 4) be provided in as natural a way as possible. Facets of home life that she identified which provide opportunities for spontaneous communication included eating, playing, bathing, and dressing.

Meleen (1988) alluded to many of these same assumptions in her in-depth study of the home-based option available in Head Start, the colossal federal program aimed at "breaking the poverty cycle" and providing young, disadvantaged children a chance to succeed in public education. She asserted that because intervention took place in the immediate family environment, home-based programs had tremendous potential to affect the child's development by affecting the parent-child interaction. Central to most home-based programs, she maintained, was recognition of "... the critical nature of the early years of development and the role of parents as primary educators of their children" (Meleen 1988:1).

It is interesting to note that one of these touchstones, the importance of parents being involved in their children's education, is viewed as central to the current Home School movement. Lines (1986:2) stated in her report, Home Instruction: an Overview, which was funded by the Office of Educational Research and Improvement of the U.S. Department of Education, that "Home schoolers appear to share at least one thing--a firm belief that parents can and should be deeply involved in the education and development of their own children."

Watkins (1989a) identified common threads which related to quality home-based programming:

1. The training of parents as the prime facilitators of their young child's development.
2. The importance of early identification and intervention.
3. The critical nature of the home as the setting for early intervention.
4. The importance of early intervention as it relates to the psycho-emotional well-being of the parents.

These will be used to frame the exploration of available research.

Training of Parents as Prime Facilitators

Commenting on the central role of the family with regard to the education of young handicapped children, Bronfenbrenner (1975:470), in his in-depth study of the effectiveness of early intervention, made the following assertion:

> The family seems to be the most effective and economical system for fostering and sustaining the child's development. Without family involvement, intervention is likely to be unsuccessful and what few effects are achieved are likely to disappear once the intervention is discontinued.

Bloom (1981) made similar claims, concluding that parent involvement was the key to long-lasting improvement in a child's competence.

From a policy standpoint, training parents to intervene with their children aligns well with Public Law 99-457, Title

1, Part H, Section 671 (a) Findings (4) which states that a goal of the law is "to enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps."

Although early intervention program staff generally recognize the need for the parents to assume a central role in their child's development, many have become increasingly aware of the complexity of the task of equipping parents to fulfill this role. Giving the parent a curriculum and breaking tasks down into achievable steps is a beginning, but other issues must also be addressed. Many early intervention programs are emphasizing the need for improving parent-infant interaction as a natural basis for enhancing both parent and infant skills.

Some researchers have suggested that deficiencies in parent-infant interactions contribute to developmental delays (Allen, Affleck, McQueeney, and McGrade, 1982). Moran and Whitman (1985) discussed an interactive deficiency model of parenting. Within this model,

> less effective parents have been characterized as less interactive, less verbal, less warm, and more authoritarian (Kogan, Wimberger, and Bobbitt, 1969; Ramey, Farran, and Campbell, 1979); nonstimulating, less contingently responsive, and less playful (Field, 1980); understimulating (Bakeman & Brown, 1980); overcontrolling and overdemanding (Hess & Shipman, 1968); and less knowledgeable of normal child development (Field, Widmayer, Stringer & Ignatoff, 1980). (p. 74)

Other researchers have contended that children form unique patterns of information processing as a result of their

interaction patterns with their mothers (Hess and Shipman, 1968), and that a child's intelligence is significantly affected by the mother's behaviors and attitudes (Ramey, Farran, and Campbell, 1979).

Hess and Shipman (1965) found that the mother's teaching style was a more accurate predictor of her child's performance on a number of tasks than either the parent's level of intelligence or social class. They observed mothers of four year olds using an etch-a-sketch with their children. From these observations, the researchers assigned each parent an educational teaching style. Some parents encouraged the curiosity of their children while others completed the task for them. This, according to the authors, stifled the child's opportunity for thinking and coming to conclusions independently. The implication is that some parents adopted informal teaching strategies through which their young children were encouraged to be curious, active, information seekers, while others did not. This study aligns well with that of White, Kaban, and Attanucci (1979), who found that on many occasions mothers restricted the development of their young children by using too simple or too little language when responding to their overtures.

Although it seems reasonable to assume that parents can be taught to understand their child's unique needs, can be equipped to carry out appropriate interventions, and can be motivated to stimulate their child so that maximum benefit is

achieved, it is important to look to current research to determine the success of efforts to train parents as facilitators. In doing so, a series of questions will serve as subheadings for exploring available research.

1. Can parents be taught to intervene with their child?

In "Parents as Language Trainers: Language Programming with Developmentally Delayed Children", Lombardino and Mangan (1983) presented the results of their work with parents of six children, ages one to four, with medical diagnoses of developmental delay, who also demonstrated receptive and expressive language delays of at least nine months. The parents were given 10 weeks of training by the University of Florida Speech and Hearing Clinic. The training was designed to teach the parents strategies and techniques for enhancing their child's language skills through both structured teaching sessions and free play activities in the home. At the conclusion of the 10 week training period, participating parents showed significant improvement in their use of the following language stimulation techniques: referencing, parallel talking, questioning, replying, and demanding. Project children demonstrated mastery of approximately 64 % of the items trained at home. The authors emphasized the importance of training in the context of naturally occurring activities such as play and caregiving.

Moran and Whitman's (1985) study of play-oriented parent training also speaks to this issue. Five mothers of developmentally delayed infants were recruited through an early intervention program. The quality of stimulation in each home was assessed via the Home Observation for Measurement of the Environment (HOME) scale developed by Caldwell, Heider & Kaplan (1966). Further, mother-infant dyads were evaluated as a preselection measure to insure that social interactions were deficient. All infants included exhibited language delays of three months to one year. Home-based services were provided to each mother, teaching them ways of developing toy play skills in their children. The investigators found that after training, the mothers were able to demonstrate the skills that were taught. In addition, the mothers and their children showed increased responsiveness to one another, and the children initiated play more frequently than was observed prior to the training. The reciprocity improvement was considered significant by the authors, who alluded to the work of Field (1979) which indicated that "the level of reciprocity in the parent-child interaction predicts later developmental status" (Moran & Whitman, 1985:94).

Jones (1985) noted positive results from her attempts to train parents of physically and mentally handicapped infants and preschoolers to enhance their children's speech skills. As a way of providing speech services for more children than she could personally see on an individual basis, she devised

a parent training program which included the use of video taped lessons which the parents used at home with their children. In order to test the effect of this novel procedure, a sample of 15 children and their parents was selected from the population of 90 preschool, handicapped children in Jones' caseload. Data were gathered from the sample via questionnaires, observations, developmental tests, and other instruments. Results indicated that 100 % of the parents in the sample followed through with the interventions designed to reach targeted speech goals. All of the parents demonstrated an awareness of the right sequence of speech development objectives, and all of the children registered significant receptive language gains.

Not all authors share equal enthusiasm for training parents to intervene with their handicapped child. Rodger (1986) questioned the appropriateness of conceptualizing the parent in a therapeutic role. She asserted that the stress associated with having a handicapped child was compounded by professional attempts to assign "teaching" or "therapy" duties to the already overburdened parent. She urged professionals to realize that parents were caregivers first and therapists second.

One of the first systematic attempts to assist mothers to become more effective with their children's intellectual and social development was initiated by Gordon (1973). This

parent education program, conducted through the University of Florida, had two basic aims:

1. To provide the mother with specific activities through which she might teach her child, beginning as early as three months of age.
2. To enhance the mother's self-esteem by helping her have a sense of control over her own future and that of her child.

The mothers who volunteered for the program had children between the ages of three months and two years. They were visited weekly in their homes by a specially trained parent educator who was paired with the parent on the basis of similar cultural and community backgrounds. The parent educator presented concrete activities for the mother to do with her child and explained each activity's importance with regard to child development. She modeled the activity, then observed the mother engaging in the task with her child. At age two, the once-a-week home visit was combined with a play group time. In this phase of the project, dyads of four mothers and their children came together at one of the mother's homes for four hour sessions. During this block of time, each child received 15 minutes of tutoring from the parent educator, then engaged in selected play activities for the remainder of the time. They were read to or handled books themselves and they learned group games. The results of this home-based parent education program were encouraging.

Children tested at 12 months of age outperformed control group children on general tests of development. At 24 months, project children achieved significantly higher developmental scores than did control group children. Of equal significance was the finding that the mothers of project children increased their sense of power as informal teachers.

One might assume that if training parents to be significant teachers of their young handicapped children was effective, it would result in positive home environment changes. Bennett et al. (1986) investigated this in a study sponsored by the Handicapped Children's Early Education Program. Families of 23 young handicapped children, ages birth to five, were divided into experimental and control groups. Differences in home environment were assessed prior to and after participation in a home intervention program. A case manager was assigned who coordinated assessments and developed an Individualized Education Program (IEP) on each child, taking into account the home environment and the parent's teaching style. Each family was assessed, pre and post, using the Home Observation for Measurement of the Environment (HOME) Inventory (Bradley & Caldwell, 1978), a multi-faceted measure of the quality of stimulation apparent in the homes of young children. At the conclusion of the program, which consisted of six months of weekly home visits, control group homes remained unchanged, but treatment homes had changed. Maternal involvement, availability of play materials, and the overall

rating of the home environment had markedly increased, leading the authors to conclude that by treating a young child as a part of a family system, changes can occur which help to nurture the child's development.

One problem which often surfaces with parents of sensory impaired children is a sense of anomie with regard to communication. When deaf children fail to respond to auditory stimuli, parents tend to stop stimulating them. Visually impaired children experience similar visual stimuli deprivation unless the parents are trained to be attuned to these needs. With training, however, these deficiencies can be overcome. Affleck et al. (1982), in a study of relationship focused intervention with families of at risk or blind infants, detected greater parent responsiveness to their infants' communication needs and attempts than was observed in non-treatment parents. Parents in the treatment group were more attuned to changes in their child's awareness of the parents' communication attempts. These findings are congruent with those of Kelly (1982), who observed that both the frequency and the duration of positive caregiver interactions with their handicapped infants increased significantly as a result of home-based programming.

Although most home-based early intervention programs focus on the mother as the facilitator, Revelj (1985) chose to study fathers of young handicapped children. Specifically, Revelj wanted to know the impact of home-based programming on

fathers. In a program which stressed modeling early child development information, appropriate communicative and physical interactions, and participation in care-giving and play activities, Revelj found that all participating fathers expressed positive reactions to the training. All participating fathers also scored better on the post-test, both in terms of quality and quantity of interaction time with their delayed young children.

Fathers were also the target population of Pfannenstiel and Honig (1988) who studied 67 first-time, low-income fathers to ascertain their perceptions of their knowledge of child development and care. The subjects were randomly assigned to treatment and control groups during the second trimester of pregnancy. The treatment group was given three hours of training to sensitize the fathers to fetal and infant characteristics, and the need for responsiveness to infant states and distress. Soothing techniques were demonstrated with dolls. Fathers were videotaped postnatally while feeding their month old infants. Post-testing indicated that the treatment fathers scored significantly higher than the control group fathers in their knowledge and skill in dealing effectively with infants.

One of the most famous of all early intervention programs for young handicapped children is the Portage Project. Developed in Wisconsin in the late 1960's and early 1970's, the Portage Project utilizes a home-based service delivery

model. At the time when Shearer and Shearer (1972) first reported on the project, services were being provided to 75 children, ages birth to six, who previously had been diagnosed as being behavior disordered, emotionally disturbed, mentally retarded, physically handicapped, vision impaired, hearing impaired, culturally deprived, or speech and language impaired. Utilizing the Early Childhood Curriculum Guide (Shearer et al., 1972) the staff of Portage Project were able to train the parents to assess, implement, and reassess their child following the structured teaching schema recommended by the project. Portage Project was so successful in implementing its program that it was able to achieve national validation and to be disseminated across the nation as a model program. As of March 23, 1990, Portage Project had trained 553 people at 405 different sites to use its materials.

2. Do parent interventions produce positive child outcomes?

In Child Success Through Parent Training: Final Report, 1980-1983, Schafer (1974) reported evaluation results of a transdisciplinary service delivery program developed at Texas Women's University, which trained parents of developmentally delayed/handicapped children ages birth through three. In this particular study, parents received support and training from social workers, speech therapists, physical therapists, and occupational therapists. The goal of the program was to

empower the parents to become managers of their child's program by learning and carrying out assessment, planning, and intervention activities. Ongoing assessment of both child and parent progress was done throughout the project. Results indicated that the children of project parents made statistically significant gains across a broad range of developmental areas and the parents learned to utilize the early intervention team as consultants rather than as primary caregivers.

Kuzovich and Yawkey (1982) analyzed the effects of parent play routines with their developmentally delayed children. Thirty-two low income families were divided into experimental and control groups of 16 families each. Six months of home visits were given to the experimental group families, providing them with information and modeling play activities. Pre and post-tests were administered to parents and children. The children whose parents received support through home visits demonstrated significantly higher quantities of imaginative play on the post-test than did the control group children. The effect was noted in both the home and school setting.

Alexander and Clark (1979) reported on a parent education program which was implemented by Macquarie University of Sidney, Australia. Weekly home visits were made to the mothers of four year old children over the period of a school year. The program goal was to introduce the mothers to

activities, ideas, and materials to try with their own children. Rather than talk down to the mothers, every attempt was made to offer the materials, ideas, and activities in an informal, friendly way so that the mothers were encouraged to think of themselves as informal teachers. An evaluation of this program concluded that these children did as well as children of similar age and background who were taught in a traditional school based program.

Hearing impaired children normally present great language and reading deficits. However, Horton (1976) found that second grade hearing impaired children whose parents received training in language stimulation scored as well in reading on the Metropolitan Achievement Test as normally hearing second graders did.

Price and Bochner (1984) studied the effects of parent training on the language acquisition of 11 developmentally delayed children ages one through 55 months, in their natural environment. She found that the children were making strong language gains at the completion of the parent training program. A follow-up study done one year after the parent intervention was completed revealed that some of the children continued to make good progress, even though formal intervention had ended.

The New Parents as Teachers Project was a program undertaken to provide information and services to first-time parents, from the third trimester of pregnancy until their

child's third birthday. Interventions were designed to render educational guidance and lessen the stress associated with parenting an at-risk child. Pfannenstiel and Seltzer (1985), reporting on the project, found that children whose parents participated scored significantly higher in intelligence, achievement, auditory comprehension, language, verbal skills, and social development than non-treatment children. Their work adds validity to Honig's (1988) assertion that the quality of care-giving can influence the cognitive and social development of very young children.

3. Are data gathered by parents reliable?

Since most home-based programs that train parents to intervene with their handicapped child depend on the parents to record the progress their child is making, it is reasonable to question whether parent self-report measures are reliable and how well parent-gathered assessment data compare to data gathered by professionals who work with the child. Only one study was located which spoke to this issue.

Schafer et al. (1987) compared the differences in parent and professional assessment results after parent training. Parents of 31 developmentally delayed children ages one to 27 months participated in the project which taught parents to assess their child's developmental status. Results indicated that no initial differences were noted in parent/professional

assessment of motor, social, or language domains. Differences were initially observed in self-help and cognition, but these differences disappeared in four and 12 months, respectively.

4. Are the gains which result from parent interventions sustained over time?

Revicki and Self (1980), in the Parent Education Follow-Through Program Study, noted that disadvantaged children whose parents had received language stimulation training prior to their child attending school outscored the norm group in reading achievement through third grade. Similar findings were reported by Collins (1980), who wrote about the long-term impact of the Home Start Program. Children whose parents were taught through Home Start to maximize the language learning potential of the home environment had significantly higher reading achievement scores through second grade than did non-treatment children.

Herzog (1985) found that the effects of early home language stimulation by parents of young deaf children were still evident four to seven years after treatment.

Other researchers have found positive correlations between training parents as prime facilitators and child intelligence. Rescorla (1979), reporting on the Early Training Project in Nashville, found that inner city, disadvantaged children whose parents were taught to provide

communicative interaction with their infants scored higher in intelligence than the norm for inner city disadvantaged children five years after the intervention.

5. Is there a positive correlation between the level of parent involvement and child outcomes?

Some researchers have concluded that child gains correlate with the degree to which parents participate. Simmons-Martin (1983) found direct, positive correlations between the extent of parent involvement in early home intervention and the gains experienced by young, hearing impaired children. These results were consistent with those recorded by Lovaas et al. (study cited in Hall & Klein, 1983) who concluded that the more extensive the parental involvement with their child's training, the greater the gains registered one year after program termination.

Moxley-Haegart and Serbin (1983) investigated the effects of parent training in child development on parent motivation as it related to child achievement. They found that the parents of delayed children who received parent education demonstrated better participation and their children made greater gains than the comparison group of parents and children.

Bronfenbrenner (1975) did a comprehensive review of child-oriented and parent-oriented early intervention

programs. His analysis revealed that those programs which stressed parent involvement registered greater child achievement gains and longer sustained effects than those programs which focused on direct child intervention by program staff. Though this study did not focus on within-program parent participation, but rather contrasted the outcomes of programs which encouraged parent participation with those which stressed direct professional involvement with the child, the results lend support to the assertion that the rate of parent involvement varies positively with child outcomes.

Many clinic based programs for young, handicapped children recognize the need for parent training and involvement in order to elicit maximum child gains; however, most fail to provide it. Cartright and Ruscello (1979) surveyed 18 clinics and training institutions in communicative disorders throughout the United States and Canada. Eighty-nine percent of the 115 respondents stated that parent involvement was an essential component of any quality program. Of these, though, only 51 % indicated that their centers had such programs. Of those who claimed to involve parents, 61 % stated that the most frequently used method of involving parents was to give them handouts, reading lists, and other written materials. This aligns well with Baker's (1976:64) statement that parents most often assumed the role of "uninformed spectators, receiving just enough information about the methods being employed to be accepting of them."

The importance of training parents to help facilitate the development of their young, handicapped children has been attested to by numerous other investigators including: Hasenstab and Horner, 1982; Filler and Kasari, 1981; Honig, 1981; Mulick and Pueschel, 1983; Snow, 1984; Bruder and Bricker, 1985; Casto & Mastropieri, 1985; and Strain & Smith, 1986.

In summary, the early childhood special education literature and research indicate that parent training is indeed possible, is effective, yields reliable data, and results in gains which are evident after formal intervention has ceased. Further, the degree to which parents are involved in their child's program is related to the outcomes achieved by the child.

The Importance of Early Identification and Intervention

Smith & Strain (1984), in a position paper prepared for distribution by the Council for Exceptional Children, identified three primary reasons for intervening early with handicapped children: "to enhance the child's development, to provide support and assistance to the family, and to maximize the child's and family's benefit to society" (p. 2). Moore (1984) indicated that the value of early intervention for handicapped children was a concept which had been recognized for a number of years. Citing the 1939 work of Skeels as a

seminal study which demonstrated the value of early intervention for preschool, institutionalized children, Moore (1984) alluded to a follow-up study of the same children conducted by Skeels (1966). In this study,

> all of the experimental children who received early intervention were self-supporting 21 years later; by contrast, the control group had only 50% self-supporting members, five of whom were institutionalized (Moore, 1984:48).

Moore, who opted for home-based services for blind infants, detailed the following reasons for early intervention:

1. The child's first years set the pace for and influence greatly all subsequent development (Peterson, 1982).
2. Unattended handicapping conditions frequently interplay and lead to additional developmental deficits.
3. Early intervention programs benefit parents by teaching them constructive parenting patterns and educational methods.
4. The longer a developmental delay or handicapping condition remains unattended, the greater the amount of time needed to correct the difficulty (Reynolds & Birch, 1977).
5. Early intervention makes sense from a monetary standpoint for it is cost effective (Swan, 1981).

In their discussion of the steps that communities can take to prevent mental retardation and improve the quality of life for handicapped individuals, Kappel and McWhorter (1986) identified early identification and intervention as important

components in assuring the health of infants, young children, and families. Their admonition to communities was in keeping with child development research which indicated that human learning and development was more rapid during the preschool years (McNulty et al., 1983). While it could be argued that early intervention is important for all handicapped children, most researchers would agree that it is particularly important for children who have sensory handicaps that interfere with language learning abilities. Many researchers posit that children have a "critical language learning period" that must be tapped if language skills are to develop to their fullest potential. Further, it is assumed that if this threshold of opportunity is missed, the child will not develop language naturally (Northern and Downs, 1974; White, 1975; Languis, Sanders and Tipps, 1980; Boothroyd, 1982 and Simmons-Martin, 1983).

Early intervention for sensory impaired children is designed to offset the deficits which result from decreased sensory input. Children who have one or more sensory impairments do not receive all the information that children without impairments are able to encode. As a consequence, these children start out behind their age peers and frequently fall further behind as they get older (Kershman, 1981). This is especially true for hearing impaired children (DeFrancesca, 1972).

Clark (1979) compared the effects of early home intervention with late home intervention for hearing impaired infants and young children. Statistically significantly higher language scores were registered by early treatment children who received an average of 11 months of home intervention prior to age two and one-half when compared to children who received no treatment prior to age two and one-half. Covert (1984) found similar results while conducting follow-up research for Project SKI*HI revalidation. Twenty-seven children from the states of Utah, Georgia, Tennessee, and Arkansas who began receiving SKI*HI services prior to age two and one-half were compared with an equal number of children who began receiving SKI*HI services after age two and one-half. Even though the late treatment children had hearing losses which were more than 10 decibels milder on average than the early treatment group, the early treatment group registered statistically superior language gains.

A study by Watkins (1987) revealed that the benefits of the early intervention through Project SKI*HI were not short-lived. Students, ages six to 13, who had received early intervention services, demonstrated significantly better language skills than those of similar age and handicapping condition who had not received home-based early intervention services.

Watkins (1985) compared the language skills of young hearing impaired children while controlling for age at which

amplification was fitted. Those children who were amplified early and wore hearing aids longer demonstrated better language skills than children with similar hearing losses who were fitted with amplification later and had worn hearing aids for less time.

Schweinhart & Weikart (1980) presented convincing data to support the value of early intervention. In the Ypsilanti/Perry Preschool project, 123 children from poor black families participated in a longitudinal study. Half of the children received no treatment and served as a control group, while the other half received 12 1/2 hours per week of education which emphasized problem solving and active learning. A high degree of interaction between the children, and between adults and children was maintained. Weekly home visits were made to arouse parent interest in the child's learning. Forty-eight measures of school and life success were collected in this longitudinal study. At age 15, participants were found to be outperforming children who were in the control group. In fact, those who had participated in the quality preschool program were found to have statistically significantly lower rates of special education placement, school dropout, and grade retention than control group subjects 15 years after preschool program participation. In addition, significantly fewer children from the experimental group had been involved in crime. By the end of high school, 19 % of treatment group children were special education

participants compared to 39 % of the control group children. Higher reading and math scores for participants were noted at all grade levels. Barnett (1985) estimated that the per participant savings were about $26,000.

Collins (1984), reporting on 19 years of Head Start research, concluded that the preschool experience very positively impacted the lives of low income and minority children. Other studies (Barnett, 1985) indicated that children from higher economic strata benefited similarly in terms of educational skill enhancement, but the effects may not have had the same economic implications due to the lower projected rates of welfare participation. Larson & Draper (1984) studied educationally advantaged children from preschool through the fourth grade and found that those children who received early intervention were adjudged to be more socially competent than those who had not had early intervention services.

Not all researchers share enthusiasm for early childhood education. Horn's (1981) reanalysis of the work of Darlington et al. (1980) indicated that the I. Q. enhancements which were attributed to preschool program experiences disappeared over time, along with the positive effects of preschool on later school performance.

Importance of the Home as the Early Educational Setting

Many researchers cited positive effects from providing services to handicapped children in their homes. The home is normally viewed as a secure environment where both the child and the parents feel free to express themselves (Jones, 1985). Hall and Klein (1983) described the home as the "natural environment" where "functional training" could be immediately applied by the child as new skills emerge. The home is the traditional place where infants and toddlers spend the majority of their time. By providing services to the parent/s and the child in the security of their own home, the parent may be less fearful of asking questions and attempting activities than they would be in a less familiar setting. Also, since one of the goals of many home-based programs is to have the parent repeat the targeted activities at various times throughout the child's waking hours (Spradlin & Seigel, 1982), providing the services in the home allows the parent advisor or teacher to make realistic assignments and challenges. To illustrate, if the goal is to have the child learn to attend to environmental sounds and the teacher tells the mom to take the child to the door when the doorbell rings or to the dishwasher when it is in use, but the parent does not have electricity in the home, no follow-through will occur. By being in the home on a regular basis, the teacher can incorporate child goals into the daily regimen of

activities that the parent does, thereby turning routine tasks such as folding clothes into opportunities to help the child develop motor skills or expand language skills.

Karniski et al. (1986) studied two groups of infants who suffered from Failure to Thrive. Seventeen of the infants were placed in foster medical placement homes while 18 infants were admitted to the hospital for care. The children placed in homes made significantly more progress than those infants placed in a hospital setting. In addition, the cost of the home program was less than 25 % of the cost of the hospital program.

The New York City Board of Education Office of Educational Evaluation investigated the effects of Project Speak, a home-based language development program for preschool handicapped children (E. H. A., Part B. Flow-Through Entitlement's Project Speak. O.E.E. Evaluation Report, 1981-82., (1983)). As a part of the program, parents were provided with two, 50 minute home visits per week which were designed to encourage language development, demonstrate appropriate interventions, and teach the parents to reinforce the language acquisition skills of their severely to profoundly handicapped children. The effects of the program were measured by both formal assessments and project-developed indices. The children participating in the project made significant improvement in both receptive and expressive language abilities. The parents of participating children showed an

increase in their use of the home environment for language stimulation activities. Further, there was also an indication that the program had a positive effect on the language development of the parents.

Gotts (1989) reported on the outcomes realized from the Home-Oriented Preschool Education (HOPE) program. Findings suggested that parenting skills, school-family relations, school performance, and child adjustment were positively related in HOPE's home visitor program. These conclusions corroborated those of Tizard and Rees (1974) who reported that severely language delayed two year olds were able to "catch up" by age four when their home environments were altered to be more conducive to normal development (cited in McDade and Varnedoe, 1987:20).

The staff of 35 Minnesota early intervention programs were surveyed by DeBerry (1984) to ascertain their beliefs and preferences related to home-based and clinic-based programs. A majority of those surveyed indicated that they believed that home-based services were more likely to result in maximizing the learning of handicapped children.

Paciorek (1983) studied the effects of a home-based program to enhance the developmental skills of motorically involved young children. Twice weekly home visits were provided to monitor program implementation. Treatment children made statistically significant gains over comparison children.

In an effort to identify the factors predictive of later intellectual development, Lee and Burchinal (1987) did a longitudinal study of the effects of early intervention on the cognitive development of children who were identified as at risk for mild retardation due to socio-economic status. One hundred forty-seven children were randomly assigned at birth to one of three groups: a home-based intervention group, a center-based intervention group, and a control group. Maternal IQ measurements were taken, along with an index of biological risks which indicated historical factors in the children's development. Each child's temperament was measured with the infant behavior record of the Bailey Scales of Infant Development. Parental attitudes were measured and the stimulation in the home was assessed via Caldwell's Home Observation Measurement of the Environment (HOME). Thirty-five percent of the observed variance in the children's IQ scores at age 54 months was explained by the following factors: day care center attendance, environmental stimulation, task orientation, maternal IQ, and a biological risk index. This figure was significant at the .0002 level. Quality of the home and task orientation, as measured during infancy, contributed significantly as independent variables. When this model was applied to the data on the children receiving home-based intervention, 57 % of the variance in IQ scores was accounted for, compared to 29 % of the variance being explained in children receiving center-based services.

Home environmental stimulation was significantly related to IQ in both the home-based group and the center-based group, with significance levels of .004 and .012 respectively.

The components of the home environmental stimulation identified as important included the following:

1. organization of the environment
2. provision of appropriate toys
3. maternal involvement with child
4. equipment/toys/experience
5. pride/affection
6. stimulation of mature behavior
7. physical and language stimulation
8. maternal warmth
9. absence of punishment
10. provision of appropriate toys
11. maternal involvement with child
12. independence from maternal control.

White and Watts (1973) studied the home environments of highly competent and less competent children to see how they differed. Social competence was assumed when the child demonstrated the abilities necessary to attract and maintain the attention of adults and peers in socially acceptable ways. Non-social competence included weakness in language facility, intellectual ability, decision-making, and concentration. The authors found that mothers of more competent children "interact more with them, teach them more often, encourage

them more often, initiate activities with them more often and are more successful in controlling their children" in regard to both boredom and destructive tendencies (White and Watts 1973:199). Moreover, the authors indicated that differences began to appear in children toward the end of their first year of life as the language skills and physical movement around the home environment increased. They posited that mothers of more competent children had decided that a young child and an immaculate home were incompatible; therefore, the mothers were not disturbed if the child's play activities produced a mess.

Another important aspect of providing home-based services as opposed to clinic services for handicapped young children is the cost factor. Barnett et al. (1988) did a cost-effectiveness analysis of alternative intervention approaches for language impaired preschool children. The forty children in his study were divided into one of four groups: home-based, center-based, combination and no treatment. The findings indicated that the home-based program resulted in greater language gains per dollar than the other program alternatives.

Importance of Early Intervention for Psycho-Emotional Support for Parents

Early intervention for handicapped children is important, not only for the children, but also for their parents. Schlesinger & Meadow (1972) studied parents of young hearing

impaired children and found that parents who discovered that their child was handicapped often went through an acceptance process similar to the grief cycle. Until the parent worked through the denial, anger, and introspection stages and reached a level of acceptance, little progress could be made in teaching the parent to appropriately intervene with her child.

Parents need support and special skills for coping with having a handicapped child (Beckman-Bell, 1981; Singer, 1985; Meyer, 1986). Increased rates of divorce, suicide (Gallagher et al., 1984), and child abuse (Klein & Stern, 1971) have been documented in families with handicapped children. In addition to the stresses which often accompany the birth of a normal child such as fatigue, financial pressures, and role confusion (Salisbury, 1987), having a handicapped child frequently brings additional pressures. These include having to deal with atypical child behaviors, additional or unusual caregiver responsibilities, and abnormal reactions from family and friends (Beckman, 1983; Ramey et al., 1980; Calhoun & Calhoun, 1980).

Often the parent is viewed as the primary client by the home-based service provider, with their child being seen as a secondary client. Program staff frequently find that the child's needs will not be effectively met by the parent until the parent's needs are addressed and the parents have reached

a level of comfort with their situation (Olshansky, 1962; Mueller & Leviton, 1986).

That having a handicapped child places stress on the bonding process has been noted in the early childhood special education literature (Klein et al., 1988; Greenberg, 1983). "Parents often feel rejecting or resentful of their handicapped child" (Bennett et al., 1986:6). Tennen, Affleck, & Gershman (1986), in their study of 42 mothers of infants with severe perinatal complications, found that the more severe the child's condition was perceived by the parent, the greater the extent of self-blame. Leigh (1987) recognized this occurrence and provided suggestions to parents of hearing impaired children to reduce stress so that natural attachment could occur.

Honig (1989), in her study of families served through the Syracuse Family Development Research Project which focused on at-risk infants born to unwed dropout mothers, identified four major categories of risk factors affecting infants and young children:

1. sociocultural and demographic factors;
2. biomedical risks;
3. personal-social risk factors;
4. family history factors.

She found that when a high quality infant-toddler-preschool program was supported with an outreach home visitation program, buffering, or a reduction of risk to infant

development, was noted. This led the author to conclude that a program of support for the parent reduces developmental risk for the child.

Honig and Park (1988) studied 403 24-month old toddlers from three cultures: native French middle class, immigrant North African Moslem, and immigrant Black African, to determine the correlates of language adequacy. Their findings indicated that stress in the family, regardless of culture group, was associated with delayed language, while culture group membership, per se, was not. The authors concluded that family variables were implicated in child language development while demographic, socioeconomic, medical, biological, and interpersonal variables were not.

Psycho-emotional support for parents is regarded as a key component of quality home intervention services by many writers (Rotter, 1974; Olsen and Allen, 1975; Moses, 1985; and Phillips, 1987). Watkins (1989:13) pointed out that these

> parent support services should include early and regular contact with a caring, helping professional who offers emotional support and realistic hope, genuinely listens to and understands the parents, and provides constructive programming that helps the child grow and the parents deal positively with their sensory impaired child.

Vadsay et al. (1986) studied the effects of early home intervention on the level of grief and stress felt by parents of handicapped children. Parent stress levels were recorded before, during, and after intervention services were offered. Significantly reduced rates of depression, grief, and stress

were noted in the 45 parents who participated in the study when rates before home visits were compared with those taken during and after intervention.

Home-based programming has been found to provide subtle support for parents. Shinman (1984), who reported on the trends in early childhood education in the United Kingdom, indicated that home-based programming may have a long-term effect on parent attitudes toward education. Parents of 20 children who took part in the First Educational Priority Area Action Research Project were found, five years later, to have far more positive attitudes toward education than did a comparable group who did not participate in the project (cited in Armstrong and Brown, 1979). Anders and Costerton (1979) reported that the greatest difference between participants and non-participants in the South East London Educational Home Visiting Scheme was that those mothers who had taken part saw their role as "extremely" or "very important" ; whereas, those not taking part saw their role as being less important.

Affleck et al. (1983; 1984) studied 46 high risk infants nine months after expected delivery, using their mothers as informants. The Perception of Baby Temperament (PBT) scales and the Profile of Mood States were administered to the mothers. Of interest was the fact that mothers who reported lesser degrees of depression and anxiety were more likely to rate their babies higher on the PBT.

These studies demonstrate that young, handicapped children and their families need services and profit from home-based programs designed to meet their unique needs. Despite this, few instruments exist for assessing home-based program effectiveness, and those that do are limited to specific facets of programming. A search of the literature failed to identify a tool which could be used by existing home-based programs to identify ways of strengthening a variety of components of their programs. Further, the literature search yielded no instrument which could meet the needs of persons charged with the responsibility of planning, developing, and implementing new programs.

Project SKI*HI

Rationale

Given that a need existed for a validated program quality instrument, it seemed only logical to seek to validate such an instrument using input from those persons who worked in nationally validated programs. Only five early childhood special education programs having some type of home-based component were identified in the 1990 edition of the National Diffusion Network publication, EDUCATIONAL PROGRAMS THAT WORK. Of these, two (Portage Project and MAPPS) were primarily curriculum projects which had wide distribution, but did not

receive regular feedback from adoption sites. A third (Peoria 0-3 Project) served only eight children with home-based services at the time this research effort was initiated. Further, Peoria 0-3 Project had no replication sites providing home-based services. Only Project SKI*HI and its sister project, INSITE Model, had a pool of active replication sites from which to draw respondents.

Of the two available programs from which to choose respondents, Project SKI*HI was the logical choice. It was older and had more adoption sites. It had gone through validation twice. Many of the INSITE adoption sites were SKI*HI replication programs that had added INSITE to meet the needs of the multi-sensory impaired child. Because of this, many INSITE programs were directed by SKI*HI project directors. Finally, the child achievement data collected on INSITE children would be more difficult to compare across sites because the children had more than one sensory handicap. Since SKI*HI replication site project directors became respondents for the study, a description of the SKI*HI model is included in this literature review.

Description

Project SKI*HI is a home-based early intervention program for hearing impaired children which was developed by Dr. Tom Clark and the Department of Communicative Disorders staff of

Utah State University. Funded by a grant from the Handicapped Children's Early Education Program (HCEEP), the program was developed during the 1972-75 time period and was the culmination of 12 years of research by Dr. Tom Clark (Clark, 1986).

Project SKI*HI is an early intervention model which has three components: Early Identification, Home Intervention, and Supportive Services. A curriculum for the home intervention program was developed which includes the following: the Home Auditory Program, Home Hearing Aid Program, Home Communication Program, and Home Language Program. Emphasis is placed on identifying the hearing impaired child as early as possible, using a variety of strategies including birth certificate high-risk screening and follow-up (Clark & Watkins, 1985).

Once a child is determined to be hearing impaired, (and frequently even during the "at risk" stage) a teacher or parent advisor is assigned who makes weekly home visits of one to two hours duration. During these visits, the parents are provided information about their child's hearing status, and lessons are taught which include information on anatomy and physiology, understanding audiograms, and understanding the child's unique needs. Weekly challenges are left and the parent's and child's progress are charted in the four curriculum areas. The parent advisors are sensitized to parents' emotional needs and are encouraged to give support

and to help parents access professional services when the emotional stress level warrants it.

Each of the curriculum areas is designed to help the child achieve maximum use of residual skills. To illustrate, young deaf children babble just as normally hearing children do; however, they stop babbling when they do not receive the reinforcement that they need. The Home Communication Program is designed to help parents understand the needs of their child with regard to communication. The natural response of the parent is to stop stimulating the child when it is discovered that the child is deaf. Parents are taught to respond to all communication attempts made by the child (Watkins, 1987).

The rationale behind Project SKI*HI is that language-learning normally occurs in the home. Child development research indicates that the normal child achieves linguistic competence by age four (McNeil, 1966). Further, the age at which language is thought to develop most rapidly is two and one-half. Research indicates that the earlier services are provided, the more the child benefits. Clark (1979) found that children enrolled in the SKI*HI program an average of 13.8 months prior to age two and one-half, demonstrated better language skills than children who received 21 months of intervention who were enrolled after age two and one-half.

The major goal of the SKI*HI program is to equip the parents to become the most important teachers in their young

hearing impaired child's life. Foundational to this parent intervention model is the belief that if the parent can be taught to provide the stimulation that the handicapped child needs, the child can receive services that are far superior to those that would be received from a limited number of hours of therapy. Certainly, the opportunity for quantitatively superior intervention exists when the primary care givers are taught to stimulate the child throughout the child's waking hours.

In addition to working with the parents, the parent advisor shares information with others who provide care to the child. Depending on the family situation, extended family members may be included. In some situations, other care givers such as day care and nursery school workers are served by the parent advisor. Activities from the targeted curriculum components are modeled with the child and the care givers are "challenged" to perform the activities a specified minimum number of times throughout the week. Charting techniques are taught and encouraged, so that care givers can record their efforts and the child's responses.

A unique aspect of Project SKI*HI is that services are often delivered by professional level part-time staff who have received special training prior to entering service as parent advisors. The benefits of this type of service delivery model are numerous, and include the following:

1. Services are delivered in the home, where the parent and the child are at a maximum comfort/acceptance level.
2. The parents/primary care givers are taught the skills necessary to help their child develop needed skills.
3. The modeling of activities with the child aids in the bonding process.
4. The parent advisor is able to show the parent how to use common items in the home to stimulate the child.
5. The parent advisor is afforded the opportunity to observe the family unit in its natural setting and attempt to fine tune the child's program to fit the value structure of the home.
6. Transportation problems which account for so much absenteeism in center-based programs are avoided.
7. Parents are taught to recognize their child's growth, record data daily, and assist in quarterly child progress assessments.
8. Parents become aware of the unique needs of their child and qualified to advocate for the services their child needs.
9. Every effort is made to contract with parent advisors who are in close proximity to the family, reducing travel time and expense.
10. Hiring specialists in the child's locale and training them to become parent advisors results in families

developing allies in the community who can assist them in advocating for needed services.

11. Using part-time contract staff and paying them only for services rendered, training and travel, keeps costs at a minimum level.
12. Opening part-time employment opportunities to professionals who may not be interested in full-time employment allows individuals in this situation to render services during available times and keep or further develop their professional skills.

As indicated previously, Project SKI*HI has demonstrated its value by producing child outcomes which far exceed those that result from more traditional approaches. Further, the service delivery model which is used by Project SKI*HI and many of the curriculum areas addressed in the SKI*HI curriculum and its sister curriculum, the INSITE curriculum, provide the necessary tools to use in addressing the needs of children who present a variety of handicapping conditions.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to validate a home-based program quality and program evaluation instrument which contained the domains required by Public Law 99-457. The intent was to have each item in the instrument weighted as to importance so that program developers could use the instrument as both a needs assessment tool and a planning tool for program enhancement. This chapter summarizes the methods and procedures utilized to gather the data and perform the analyses needed to validate the Home-Based Program Evaluation Instrument (see Appendix A). It is divided into the following sections: Introduction, Subjects, Design, Description of the Instrument, Data Collection, and Data Analysis.

Subjects

The respondent group identified to participate in this study included all of the program directors of United States Project SKI*HI adoption sites listed by the National SKI*HI Institute in Logan, Utah (see Appendix C). Project SKI*HI is a nationally validated early intervention program serving

hearing impaired children ages birth through five and their families (see Chapter II for a description of Project SKI*HI). Project SKI*HI program directors were selected for the following reasons:

1. Project SKI*HI is one of only four nationally validated home-based programs currently approved for dissemination by the Joint Dissemination Review Panel.
2. Unlike most of the other validated programs, Project SKI*HI maintains ongoing contact with many of its adoption sites in an attempt to insure that the quality programming which led to SKI*HI's validation is upheld by its adoption sites.
3. Project SKI*HI maintains a national data base on all replication sites which choose to participate by submitting data. This feature of the SKI*HI program made it attractive since it established the possibility of having a second data source for validity checking.
4. Two of the other nationally validated projects, Portage Project and MAPPS, are primarily curriculum programs. They neither maintain ongoing contact nor receive data from their replication sites.
5. The fourth nationally validated program, INSITE Model, has been adopted by many of the same sites as those using Project SKI*HI. Choosing both INSITE and SKI*HI would have resulted in a duplication of responses. Further,

the number of INSITE sites reporting child achievement data is small.

Since all of the Project SKI*HI program directors were included, sampling techniques were not utilized.

The original list of SKI*HI adoption sites which was used as a master list for mailing contained 241 U. S. sites. Some of these, however, were no longer using SKI*HI material and were dropped from the study (see Data Collection for further explanation). Surveys were received from 79 of the 185 sites on the revised replication site list, yielding an overall response rate of 43 %.

Forty of the responses were from sites which reported data to SKI*HI Institute. This represented a return rate of 70 % from the 57 sites reporting child achievement data to SKI*HI Institute.

Design

The present research effort is a validation study. Validating an instrument may involve various processes, depending on the type and purpose of the instrument being validated. Common to all, though, are content, criterion-related, and construct validity concerns which must be addressed before an instrument can be considered valid (Wiersma, 1985). First, the content of the instrument must be examined to determine if it contains a representative sample

of the behavior domains that it purports to measure. Frequently, experts in the field of study are called upon to examine the content and satisfy this concern. Second, criterion-related validity, which has to do with the effectiveness of an instrument in predicting an outcome in specified situations, must be appraised. It is assessed by comparing instrument responses to some external criterion, usually information gathered either at about the same time (concurrent validity) or at a future date (predictive validity). Finally, construct validity, which is an attempt to determine whether certain measures actually depict a particular conceptual idea, must receive attention. It is the most difficult to check since it is involves the accumulation of information over time from a variety of sources. Ideally, a validated instrument should attempt to attend to all of these elements. In the final analysis, though, an instrument can only be considered to have high validity if it yields the information that the decision maker needs (Cronbach, 1970:121).

For the purposes of this study, validation of the instrument involved was addressed in the following ways:

1. Content Validity -- The items on the instrument were originally scrutinized by two small panels of experts in early childhood special education (see the next section, Description of the Instrument, for further explanation). The items underwent further scrutiny by the Project

SKI*HI directors who served as the respondent group. Each was given the opportunity to challenge, rate, and suggest items. Item weights were assigned based on responses of this panel of experts. Items that were weighted by a majority of the respondents as being related to program quality were considered valid.

2. Criterion-Related Validity -- A modified version of the concurrent validation procedure of comparing data from two sources gathered simultaneously was used. The 1989-90 aggregated child achievement data for each program submitting data to SKI*HI Institute were used to stratify the respondent group into three groups: High Child Achievement, Lower Child Achievement, and No Child Achievement Data Reported groups. The responses of the High Child Achievement and the Lower Child Achievement groups to the individual items were analyzed to determine if differences existed.

3. Construct Validity -- The ultimate test of construct validity of the instrument involved in this study would be to assess its effects on home-based programs that adopt it for use. Since this approach is impractical for the study being conducted, construct validity has been approached by looking at the actual practices of the programs in the high child achievement group. Each program director was asked not only to rate each item, but also to indicate if that item was being practiced by

her program. If the items which were weighted as related to program quality also tended to be items which were being implemented by the high child achievement program group, the instrument could be assumed to have construct validity.

Description of the Instrument

A 1988 review of the literature on early intervention programming for young handicapped children revealed a number of elements which related to program quality. This list of program quality indicators was shared with the director and the eight regional coordinators employed by the Tennessee Infant Parent Service (TIPS), Tennessee's statewide early intervention program for hearing impaired children. Their opinions and ideas were solicited for further enhancing the list of program quality indicators. The revised list of indicators was then critiqued by a national panel of 11 experts, most of whom either directed or had extensive work experience in home-based early intervention programs for the hearing impaired. Individual items were scrutinized and edited. Additional items which had been overlooked were added as panel members made suggestions. (It should be noted that only five of these panel members were among the respondent pool identified as current SKI*HI program directors.) Preliminary content validity for the items and the domains

into which the items were categorized was established by this panel of experts. These data were incorporated into the Home-Based Program Evaluation Instrument (Appendix A), which was subsequently published by the SKI*HI Institute as a chapter in The Management of Home-Based Programs for Infants, Toddlers and Preschool Aged Handicapped Children.

The Home-Based Program Evaluation Instrument was divided into 14 domains (see Table 3.1). Within each domain, a number of stimulus statements or items were listed which had been identified as relating to program quality. In reality, the stimulus statements reflected legal mandates from either legislation or case law, were statements derived from empirical research reported in the literature, originated from curricula and/or position papers on key program components related to program quality, or represented expert opinion as to the task-analyzed steps for reaching the desired result for that particular domain. The number of stimulus statements varied from four in the "Census" domain to 38 in the "Public Awareness/Child Find" domain, with the total number of stimulus statements or items in all domains being 222.

At the end of each stimulus statement were three response columns. The "Yes" and "No" columns allowed the respondent to record whether or not the behavior described in that particular stimulus statement was being implemented in the program that the respondent directed. If the respondent felt that her program not only did the activity that the item

described but did it in an "Exemplary" manner, a plus (+) could be recorded in the "Yes" column. The third column afforded the respondent the opportunity to rate each stimulus statement as to the perceived strength of its relationship to program quality, utilizing a six-point, Likert-type scale.

Data Collection

Copies of the Home-Based Program Evaluation Instrument (Appendix A) and completion instructions were mailed to the all Project SKI*HI adoption site directors. Each program supervisor was asked to give feedback on her specific program by completing the "Yes" and "No" columns on each item on the instrument. Each program director was also asked to assign a value to each item by completing the item "Weight" column. The subjects were instructed to read each stimulus statement and rate the item's relationship to program quality or effectiveness, using the following Likert-type scale:

1 - Strongly Agree
2 - Agree
3 - Undecided, but probably Agree
4 - Undecided, but probably Disagree
5 - Disagree
6 - Strongly Disagree

Respondents were given the opportunity to suggest wording changes which would help clarify each item and were encouraged to suggest new items that they deemed important program quality referents.

Two forms of the instrument were used. Form A (see Appendix A and Table 3.1) contained all of the 14 domains and their items in their original order. Form B contained the same domains and items as those found in Form A; however, the ordering of the domains was shifted to reflect the ordering found in Table 3.2. Form B differed from Form A in the ordering of the domains and in the ordering of the response columns. This approach was designed to allay the impact of respondent fatigue caused by the length of the instrument on how the items were rated. Rearranging the domains on the alternate form of the instrument was done to afford the opportunity to evaluate whether the items presented early in the instrument were rated differently from those presented later in the instrument. Utilizing a table of random numbers, half of the respondents were given Form A, while half were given Form B.

In addition to either Form A or B of the Home-Based Program Evaluation Instrument, each respondent was asked to complete a 20 item demographic data sheet (Appendix A). This sheet contained items which allowed the Home-Based Program Evaluation Instrument data to be scrutinized by geographic region, size of program, length of years the program had been operating, and other factors. The data sheet requested the name and phone number of the person completing the survey so that any needed telephone follow-up could be accomplished. Because of the nature of the study, having this information

TABLE 3.1: HOME-BASED PROGRAM EVALUATION INSTRUMENT (Form A)

DOMAIN	NUMBER OF ITEMS
Public Awareness/Child Find	--- 38 Items
Screening	--- 10 Items
Referral and Diagnosis	--- 8 Items
Census	--- 4 Items
Assessment and IFSP	--- 26 Items
Parent Advisor Program Implementation	--- 8 Items
Staff Recruitment and Selection	--- 14 Items
Staff Development	--- 21 Items
Staff Supervision	--- 28 Items
Funding and Financial Management	--- 20 Items
Support Services	--- 18 Items
Transition Services	--- 11 Items
Materials and Equipment Lending Library	--- 6 Items
Measurements of Achievement/Satisfaction	--- 10 Items

TABLE 3.2: HOME-BASED PROGRAM EVALUATION INSTRUMENT (Form B)

DOMAIN	NUMBER OF ITEMS
Staff Recruitment and Selection	--- 14 Items
Staff Development	--- 21 Items
Staff Supervision	--- 28 Items
Funding and Financial Management	--- 20 Items
Support Services	--- 18 Items
Transition Services	--- 11 Items
Materials and Equipment Lending Library	--- 6 Items
Measurements of Achievement/Satisfaction	--- 10 Items
Public Awareness/Child Find	--- 38 Items
Screening	--- 10 Items
Referral and Diagnosis	--- 8 Items
Census	--- 4 Items
Assessment and IFSP	--- 26 Items
Parent Advisor Program Implementation	--- 8 Items

was deemed more critical than was insuring the anonymity of the respondent.

A cover letter explaining the benefits of this effort, both to the project director and to the field of home-based early childhood special education, accompanied the survey (see Appendix D). A letter of support from Dr. Thomas C. Clark, founder of Project SKI*HI, was also included (see Appendix D), as was a stamped, self-addressed envelope.

Two weeks were originally allotted for completion and return of the surveys. At the end of the two week period, only 24 completed surveys had been received; therefore, telephone follow-ups were initiated. Two hundred phone calls were made to adoption sites to inquire about the surveys and to encourage the program directors to respond. Follow-up surveys were then mailed to the program directors who indicated that they either had not received the survey or had already discarded it. In some instances, it was found that the person listed by Project SKI*HI as the program director was no longer employed there. The phone calls also revealed that a number of the listed as SKI*HI adoption sites no longer considered themselves to be active adoption sites. Several had been small programs serving a limited population. When the hearing impaired children enrolled either completed the program or exited for other reasons, and no other hearing impaired children were identified, the program folded. In other instances, the trained persons left the program and the

persons hired to replace them chose to utilize a different approach. One of the sites listed as an adoption site was a university program which provided training to potential program users but did not serve children. Notes were made of these discrepancies, and this information was shared with Project SKI*HI. Soon thereafter, Project SKI*HI initiated its own campaign to clarify the status of each adoption site. As Project SKI*HI staff became aware that sites were no longer using the SKI*HI model, the information was shared so that the present research project could proceed with information which was as accurate as possible.

Attempts to reach some of the sites were unsuccessful. After four attempts at different times of the day failed, efforts were discontinued. Extra efforts were expended, however, in an attempt to receive replies from the sites which had reported child achievement data to SKI*HI Institute. A second survey was mailed to each of the 26 sites from which responses had not been received. Another round of phone calls was also made to these sites, telling them that the survey was enroute.

Of the 241 sites listed on the SKI*HI REPLICATION SITE LIST, follow-up by mail and phone resulted in a reduction of the active replication sites from 241 to 185. From this number, 79 useable surveys were returned, representing a 43 % response rate from the revised number of sites. Forty of these 79 responses were from sites which reported 1989-90

child achievement data to SKI*HI Institute, representing 70 % of the 57 sites which reported child progress data.

Data collection proved to be a greater problem than was anticipated. The large number of sites which no longer considered themselves to be adoption sites was not anticipated. Neither was the small rate of return from those who were using the SKI*HI model. In addition, known factors which contributed to the low return rate were the length of the instrument and the time of year it was mailed.

Data Analysis

Fully completed surveys contained 222 separate item weights, 222 indications of item implementation status, and 20 demographic data indicators, for a total of 464 bits of information from each site. In order to analyze this information, the responses on the 79 useable surveys were entered first into two dBASE databases (two were required because of the large number of fields). These were then imported into Lotus 1-2-3 spreadsheets for analysis.

Each item on the Home-Based Program Evaluation Instrument was rated on a Likert-type scale and assigned a value from 1 (Strongly Agree) to 6 (Strongly Disagree), reflecting the degree to which each program director perceived that item to be related to quality home-based programming. Mean ratings and standard deviations were computed across the total sample

for each program quality indicator to provide a measure of the extent to which each program quality indicator was viewed as important by the program directors. Those items which had means of 3.50 or lower were placed in the revised "Home-Based Program Evaluation Instrument", while items with mean scores of 3.51 or greater were dropped. Each item which passed muster for inclusion in the revised instrument is presented in Appendix E with the mean score and standard deviation so that future users would not only know that the item was deemed related to program quality, but could also know the extent to which the item was valued. Mean scores for each domain were also computed and reported so that future users of the instrument would be able to target particularly critical domains.

Two forms of the instrument were mailed. Form B differed from Form A in the ordering of the domains and in the ordering of the response columns. The concern this approach was designed to allay was whether the length of the instrument had an impact on how the items were rated. Rearranging the domains on the alternate form of the instrument afforded an opportunity to evaluate whether the items presented early in the instrument were rated differently from those presented later in the instrument. This test was designed to serve as a measure of reliability. Form B also reversed the response columns, so that the first column contained item rankings while the last two columns recorded whether that

particular item was being implemented in the respondent's program. In this instance, the concern being addressed was whether current practice in the respondent's program influenced the respondent's ratings of the importance of the items. This control also was designed to serve as a measure of reliability.

Mean ratings were computed separately for Form A and Form B respondents, both by item and by domain, to determine if differences existed in how the two groups rated the items. The item and domain means were also compared for larger (20 or more children enrolled) and smaller (less than 20 children enrolled) programs and for relatively new adoption sites (less than five years) and older adoption sites (five or more years). Region of the country also served as a control variable. While specific outcomes with these control variables were not predicted, the results were reported for potential use by program administrators.

In order to answer the second research question, "Do those program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?", the respondents were stratified into three categories utilizing the 1989-90 aggregated child achievement data reported to SKI*HI Institute (Appendix B). The categories were: High Child Achievement, Lower Child Achievement, and No Child Achievement Data Reported.

Responses from the High Child Achievement and the Lower Child Achievement groups were analyzed to determine if differences existed in the perceptions of the two groups. Item and domain means and standard deviations were reported for each group. These data give the administrator the opportunity to zero in on those items which were ranked as most significant by directors of programs which have demonstrated their ability to make significant child achievement gains.

CHAPTER IV

PRESENTATION OF DATA AND FINDINGS OF THE STUDY

Introduction

The purpose of this study was to produce a clear, validated program evaluation and program development tool containing weighted indicators of program quality related to providing in-home services to young, handicapped children and their families. The goal was to construct the instrument in such a way that it could be effectively used by established and newly developing home-based programs. In pursuing this aim, a great deal of data were collected. This chapter contains the data analysis and findings of the study. The data presented were collected via surveys which were mailed to all directors of Project SKI*HI replication sites in the United States. The instrument was designed to tap the respondents' perceptions of the key ingredients involved in providing exemplary home-based programming for handicapped children between the ages of birth and five. The information supplied by each program supervisor was entered into computer databases and spreadsheets. Means and standard deviations were computed for each item and each domain, using all surveys. These same measures of central tendency and dispersion were also computed on various subsets of the data,

using the demographic data supplied by each site as control variables. All analyses were performed in relation to the two research questions which guided the study:

1. What are the program quality indicators for which there is national consensus among directors of home-based early intervention programs serving hearing impaired children?
2. Do those program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?

Findings and results of the study are organized and discussed as they relate to these two research questions. The first section presents the data which relate to question one. The data are presented by domain. Domain headings include the domain number and the name of that particular domain. Means and standard deviations for the program quality indicators included in each domain are presented and discussed by domain as are suggested guidelines for how the results might be used.

The second section presents data related to research question two. In it, the responses of program directors from programs which had higher child achievement are compared with those of directors of programs which registered smaller child achievement gains to determine if differences existed in their delineation of the elements critical to quality programming.

Data Interpretation Guidelines

Means and standard deviations were computed for each of the 222 items in the Home-Based Program Evaluation Instrument, both individually and by domain. Figures containing these data are presented throughout the narrative in the form of line graphs. Supporting data for each line graph can be found in tabular form in the appendices as indicated. The program quality indicators by domain, along with their means and standard deviations, appear in the Appendix E. The line graphs provide a visual image of the weights assigned to each item. The X-axis legend of each graph identifies the program quality indicators in that particular domain. The Y-axis legend contains item weight categories which potentially range from 1 (Strongly Agree that the item relates to quality programming) to 6 (Strongly Disagree that the item relates to quality programming). The weight categories vary from graph to graph based on the dispersion of the data in that particular domain. It is important to note that **the smaller the number, the stronger the item is related to program quality**. In general, appendices F and G contain the data on each program quality indicator, showing the item mean, standard deviation and the number of respondents who rated each item.

Research Question Number One: What are the program quality indicators for which there is national consensus among directors of home-based early intervention programs serving hearing impaired children?

The Home-Based Program Evaluation Instrument contained 222 indicators of program quality. These were grouped into 14 domains. Table 4.1 shows the domains, the number of items in each domain, and the domain means. Figure 1 also displays the average item weights by domain. The domain means varied from 1.338 to 2.123. Domain means provide a general view of the weights assigned to the items in that particular domain. They should not, however, be interpreted to mean that all of the items in a particular domain have equal value or that all of the items in one domain are more closely related to program quality than the items in another domain having a higher domain mean. Domain means tend to be strongly influenced by the homogeneity of the responses to the individual items. They can be interpreted as a depiction of the trend of the data only. For example, from Figure 1 it can be noted that program directors tended to place the greatest value on the items related to the services that actually occur in the home -- Parent Advisor Program Implementation items (Domain 6). Similarly, one could also say that program directors tended to place less value on items related to supervision of staff -- Staff Supervision (Domain 9).

TABLE 4.1: HOME-BASED PROGRAM EVALUATION INSTRUMENT WITH DOMAIN MEANS

DOMAIN	NUMBER OF ITEMS	DOMAIN MEAN
1. Public Awareness/Child Find	38	2.114
2. Screening	10	1.595
3. Referral and Diagnosis	8	1.465
4. Census	4	1.849
5. Assessment and Individualized Family Service Plan	26	1.479
6. Parent Advisor Program Implementation	8	1.338
7. Staff Recruitment and Selection	14	1.890
8. Staff Development	21	1.544
9. Staff Supervision	28	2.123
10. Funding and Financial Management	20	1.741
11. Support Services	18	1.595
12. Transition from Home-Based to Center-Based Program	11	1.404
13. Materials/Equipment Lending Library	6	1.633
14. Measurements of Achievement/ Satisfaction	10	1.970

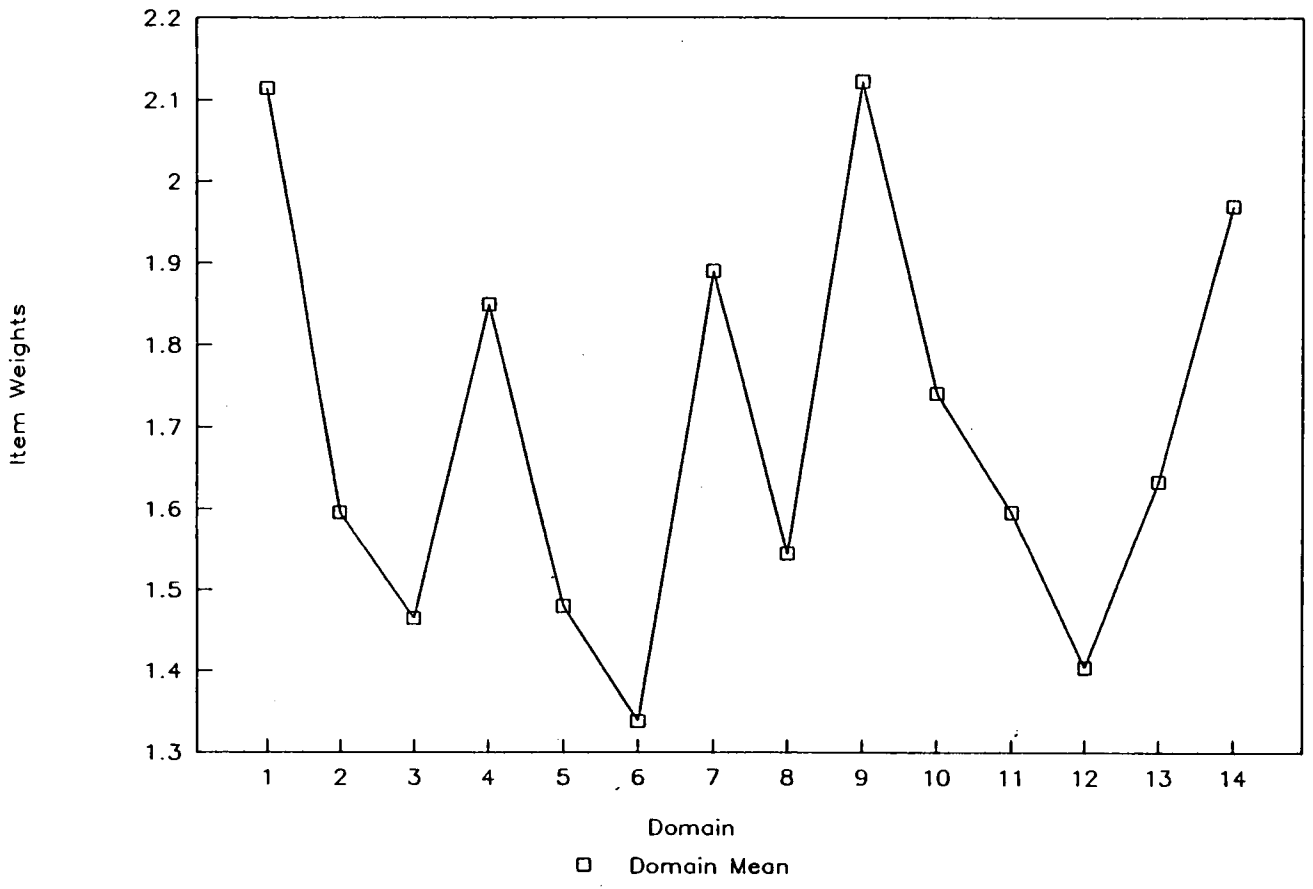


Figure 1. Average Item Weights by Domain for All Surveys

Prior to sending the surveys, a decision was made that all items which presented a mean score of 3.50 or less would be considered to be related to program quality and would be retained as a part of the validated instrument. Though the strength of the relationship to program quality varies from item to item, **all items were valued sufficiently for inclusion in the validated instrument.** As will be seen from a review of the information which follows, not a single item was weighted at 3.0 or greater.

Domain 1: Public Awareness/Child Find

Locating handicapped children early in life is one of the challenges facing those who wish to provide early intervention services. Figure 2 displays the indicators in this domain along with the mean weights assigned to each indicator. All of the items in this domain are related to early identification, although some are more strongly related than others. Item weights in this domain varied from 1.486 (Indicator 2) to 2.909 (Indicator 8). (Actual indicators and their corresponding means and standard deviations can be found in Appendix E.1. These data are presented in tabular form along with numbers of respondents in Appendix F.1.)

Of all the items related to a quality public awareness/child find program, program supervisors indicated that the development of a brochure describing the program of

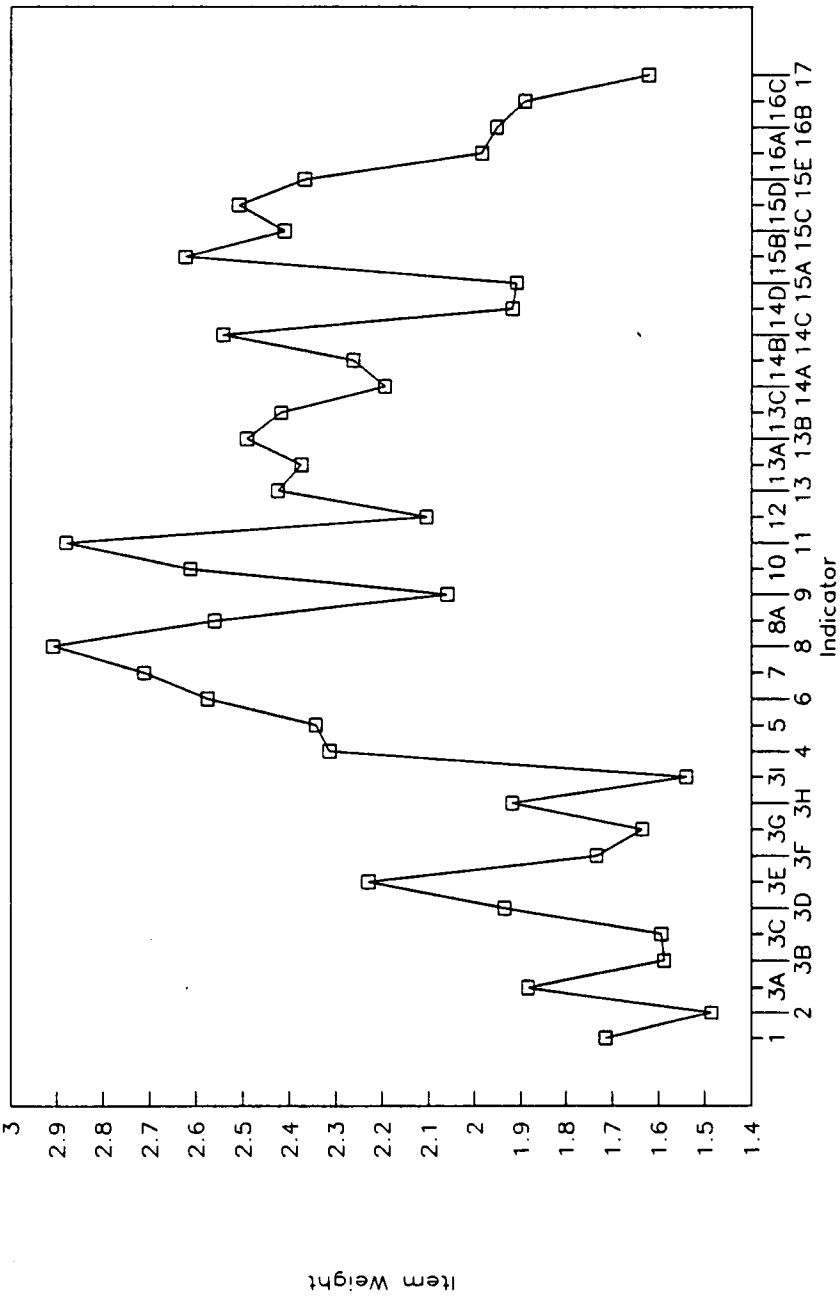


Figure 2. Average Item Weights for All Surveys Public Awareness/Child Find Domain

services available in the home as most important (Indicator 2). While all of the indicators in this domain were deemed to have merit, the more important ones tended to cluster around the dissemination of the brochure. This is as one would expect, since little benefit would be derived from developing a brochure without having plans for its dissemination. From looking at the responses to the various targets for brochure dissemination, one can see the usefulness of having the mean scores available. By ranking the agencies/organizations by the order of importance assigned by the program supervisors, a dissemination plan could be formulated. The data suggest that brochure dissemination should be done in the following order:

1. "at risk" clinics (1.540)
2. public health departments (1.587)
3. pediatricians' and general practitioners' offices (1.594)
4. hospital nurseries (1.635)
5. school systems (1.734)

The program supervisors also highly valued visits from other programs serving infants and young children (Item 17). The implication of this finding is that programs in the developmental stage might want to include an emphasis on encouraging visits from other service providers as a way of encouraging child find. Similarly, the implication for established programs is that consideration be given to the

degree to which visits from other agencies serving similar populations are encouraged.

Some of the items which were weighted as less important may have more merit for some programs than for others. For example, secondary data analysis by numbers of children served and by size of geographic region served revealed that the larger the program, the more value it placed on radio and television public service announcements and newspaper coverage. In order for programs to receive maximum benefit from the instrument, consideration must be given to the indicator content, the standard deviation of the item, and the assigned item weight when determining which practices to add.

Domain 2: Screening

The items in this domain relate to locating from among the general population of newborns and young children, those children who are "at risk" of being handicapped. The range of item weights within this domain was from 1.339 (Item 8) to 1.969 (Item 1) (see Appendix E.2). Program supervisors weighted all items in this domain as important indicators of quality home-based programming (see Figure 3; also Appendices E.2 and F.2); however, Items 5, 6, 7, and 8 were highly valued. Strong emphasis was placed on free screening (Indicator 5) of infants before they ever leave the hospital (Indicators 6, 7, 8). Logically, these responses make sense.

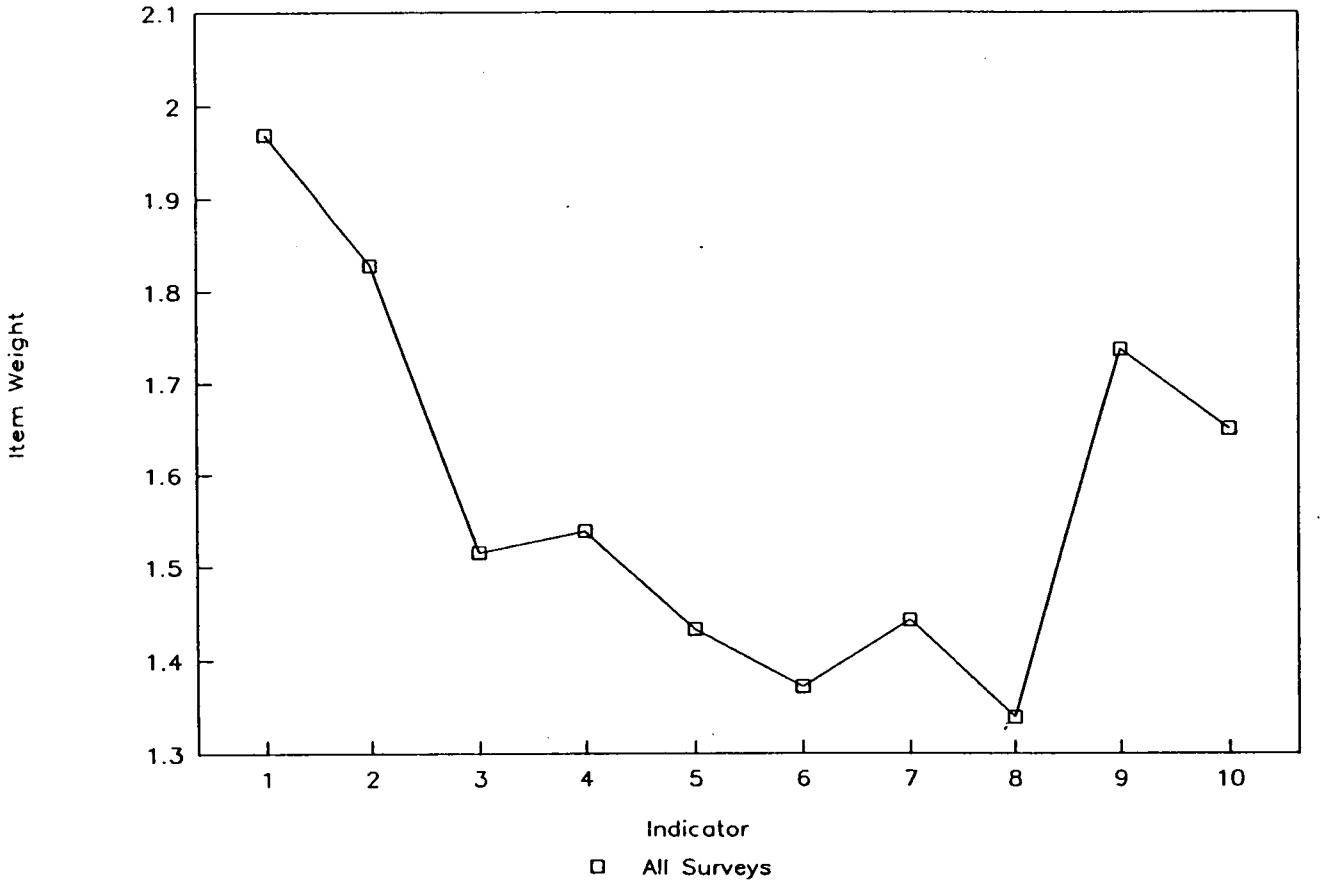


Figure 3. Average Item Weights for All Surveys Screening Domain

If the child can be identified while still in the hospital, intervention can be initiated sooner. Based on these responses, home-based early intervention programs using this instrument as either an evaluation tool or a program development guide would want to consider how the screening of newborns is being done in their area and encourage hospitals to screen all infants, especially those in intensive care nurseries.

Domain 3: Referral and Diagnosis

The indicators in this domain refer to procedures and strategies for following up on the children identified through the screening process as being "at risk". Figure 4 shows the Referral and Diagnosis domain program quality indicators with their mean weights, which varied from 1.296 (Indicator 7) to 1.718 (Indicator 6) (Appendices E.3 and F.3 contain more detailed information). One can see that all indicators in this domain were highly valued by program supervisors, but four stand out as being perceived as very important to program effectiveness. Of chief importance is having the child's handicaps diagnosed by qualified individuals (Indicator 7). Similar weight was given to insuring that all areas of suspected disability were considered (Indicator 8). Program supervisors weighted the acknowledgement of referrals (Indicator 5) and quick contact with referred families

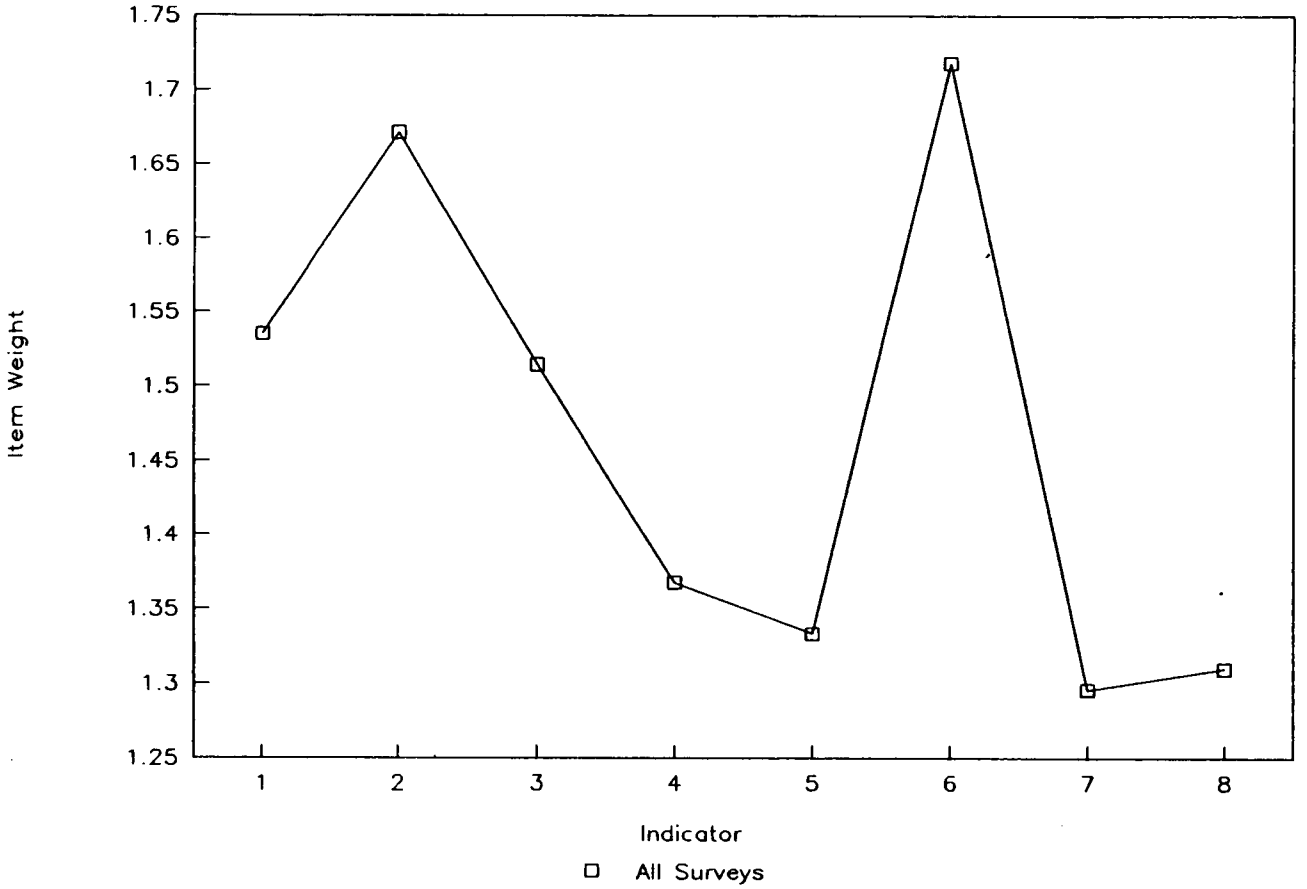


Figure 4. Average Item Weights for All Surveys Referral and Diagnosis Domain

(Indicator 4) as very important as well. These data imply that programs using this instrument for program evaluation or development purposes would want to consider the qualifications of individuals who perform diagnostic services and the scope of the evaluations being performed. Further, they suggest that in order to keep referrals coming, attention should be given to the degree to which referrals are acknowledged and the time required for making contact with the families referred.

Domain 4: Census

The items in this domain all relate to keeping an accurate count of the children who are identified through the referral and diagnosis process. Figure 5 shows the program quality indicators in this domain. Item weightings varied from 1.532 (Indicator 2b) to 2.482 (Indicator 2c) (see Appendices E.4 and F.4 for specific indicators and data). All programs which receive government funding are required to maintain an accurate census of handicapped children (Item 1). As can be seen in Figure 5, program supervisors highly valued the keeping of an accurate census, but placed more value on keeping local school systems (Item 2b) and the lead agency for implementing P. L. 99-457 (Item 2a) informed. Although the data do not give a reason for this weighting, it is suspected that these weightings reflect the commitment of program

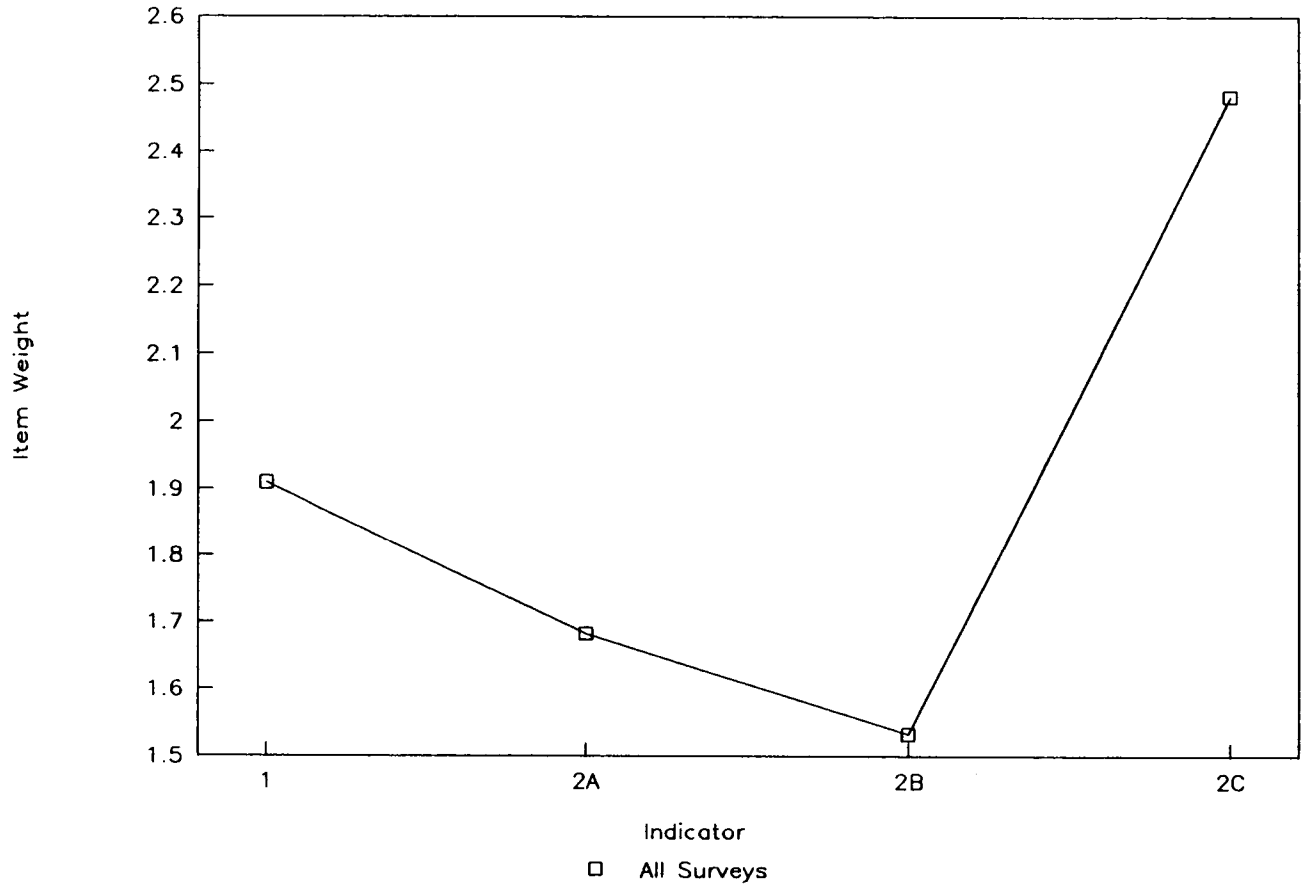


Figure 5. Average Item Weights for All Surveys Census Domain

supervisors to service delivery. Insuring that those who will serve the children when they reach age three are made aware of the children so they can plan appropriate programs is probably of more value to the program supervisors than is the keeping of numbers which are used to generate funding. The implication arising from these data is that programs using this instrument as a development tool would want to establish procedures to insure that appropriate agencies charged with responsibility for handicapped children are informed of each child's existence and future need for service.

Domain 5: Assessment and Individualized Family Service Plan

The items in this domain deal with assessing and developing an appropriate educational plan for all children who have been diagnosed as handicapped and who are being reported on the census. Item weights within this domain varied from 1.143 (Indicator 4a) to 2.048 (Indicator 18) (see Appendices E.5 and F.5 for actual indicators, means, standard deviations, and numbers of respondents).

Prior to the passage of P. L. 99-457, individual states were free to either serve or not serve young handicapped children. As a result, many of the programs that emerged for children in the birth to three age category did not require the development of an individualized education plan for service delivery. As Figure 6 shows, though, the directors

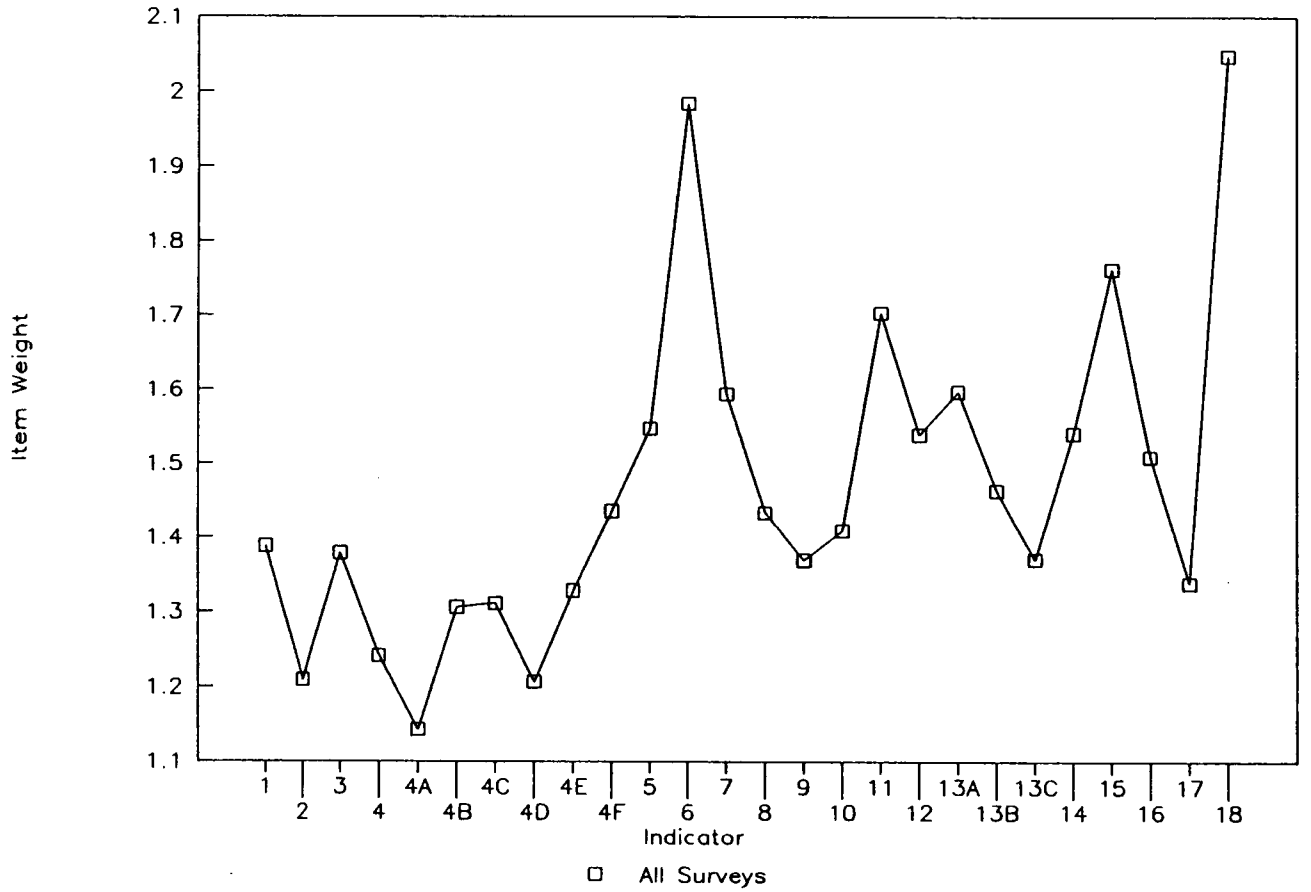


Figure 6. Average Item Weights for All Surveys Assessment and IFSP Domain

of SKI*HI replication sites surveyed placed high value on having a written plan (Indicator 1) for service delivery . The strongest emphasis in this domain was placed on assessing the child's present levels of performance in all developmental areas (Indicator 4a). In fact, all of the more highly valued items in this domain, except the determination of eligibility indicator (Item 2), clustered around the Individualized Family Service Plan (Indicators 4a-f). These findings suggest that persons using this tool as a program evaluation instrument would want to carefully scrutinize their family service plan, using the instrument items (4a-f) as benchmarks. Further, program administrators would want to insure that the assessment data used in developing the IFSP were updated regularly (Item 17).

Domain 6: Parent Advisor Program Implementation

The indicators in this domain pertain to provision of services within the home. As one would expect from supervisors of home-based programs, the items in this domain were all highly valued. Figure 7 shows the strength of the item weightings in this domain (see Appendices E.6 and F.6 for indicators and supporting data). All item weights were less than 1.5 except for Indicator 3 (1.836), the writing of lesson plans. Item 2, equipping parents with the skills needed for helping their child reach targeted goals, was weighted as not

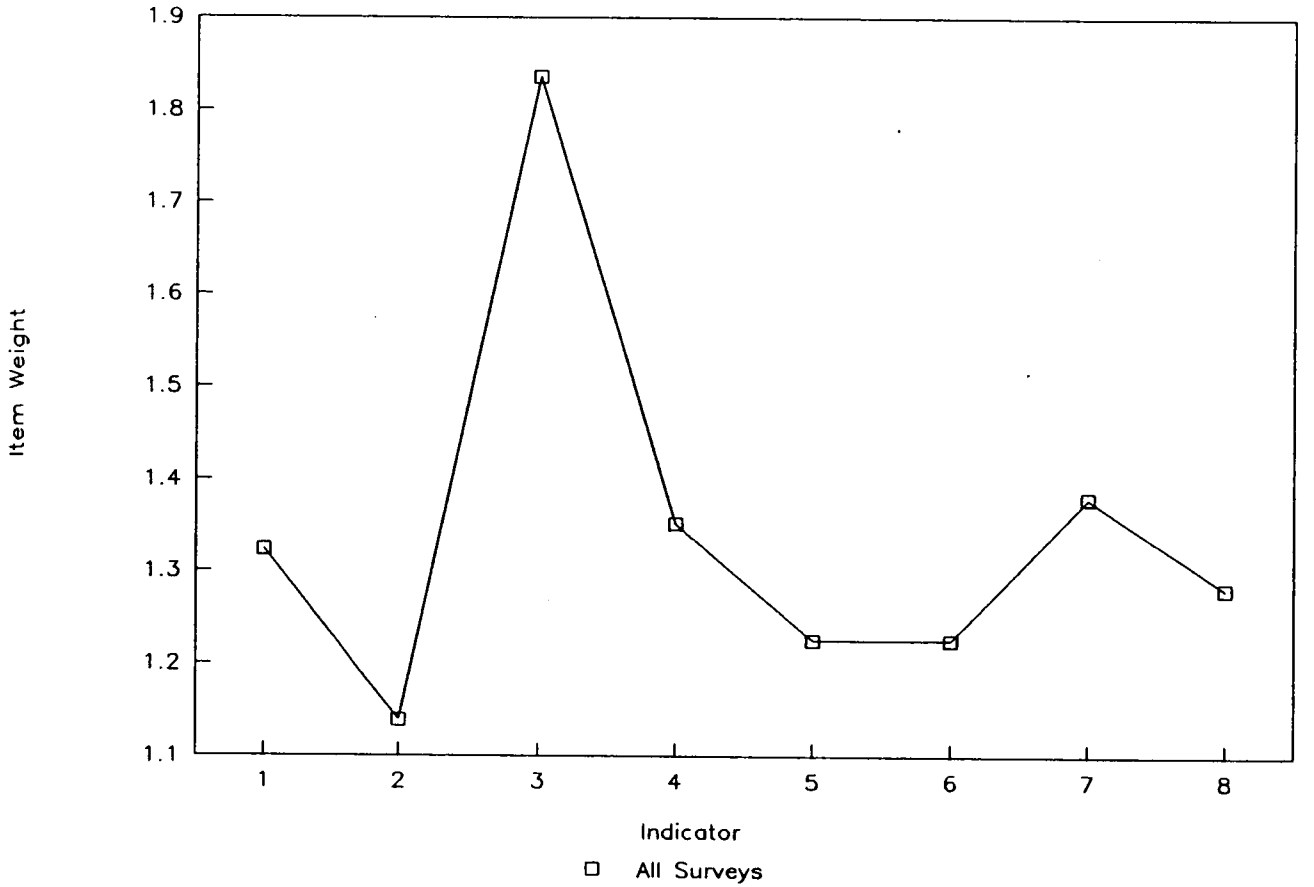


Figure 7. Average Item Weights for All Surveys
Parent Advisor Program Implementation Domain

only the most significant indicator in this domain but in the entire instrument. Philosophically, this weighting stands in contrast to the center-based emphasis on direct intervention with the child. It is apparent from this item weight that supervisors of home-based programs shared the belief that equipping the parent to intervene with their own child was more effective than spending the limited time available (1-2 hours per week) trying to intervene directly with the child.

Items 5, 6, and 8 were also some of the most highly valued items in the instrument. They emphasize tailoring the home visit to the unique needs and learning styles of the family and insuring that the parents are active participants in all decisions which affect their child. With regard to Indicator 3, it was interesting to note that some of the respondents circled the part about forwarding the lesson plans to the supervisor for review, indicating that they wrote lesson plans but did not forward them to their supervisors, since their supervisors did not involve themselves in the day to day operation of the program. Had this item been subdivided so that the individual could weight lesson planning without including the supervisory review, the weighting might have been different.

For programs using this instrument as an evaluation tool, the message is clear -- insure that the staff employed understand that their role is to equip the parent, not just provide home-bound services to the child. Attention must be

given to understanding the parents' needs while avoiding the pitfall of making all the decisions.

Domain 7: Staff Recruitment and Selection Domain

The items in this domain deal with identifying and screening potential staff members in order to have qualified personnel available to provide services to the families of young, handicapped children. Most services previously offered to special education children in the birth through three age category were not mandated; therefore, few guidelines existed regarding the qualifications needed by service providers. Responses varied greatly to the items in this domain, with item weights ranging from 1.431 (Item 1) to 2.662 (Item 12). As can be seen in Figure 8 (see Appendices E.7 and F.7 for actual indicators, means, standard deviations, and numbers of respondents), most program supervisors strongly agreed that having a plan which specified the credentials of the individuals who would provide home-based services (Item 1) was important. Other items in this domain which received heavy emphasis were Items 7 and 9, which related to adequately checking the references and credentials of an individual before sending them into homes to provide services, and Item 5, which related to clearly defining what was expected of persons providing home-based services. For some programs which only employ full-time staff, many personnel matters are

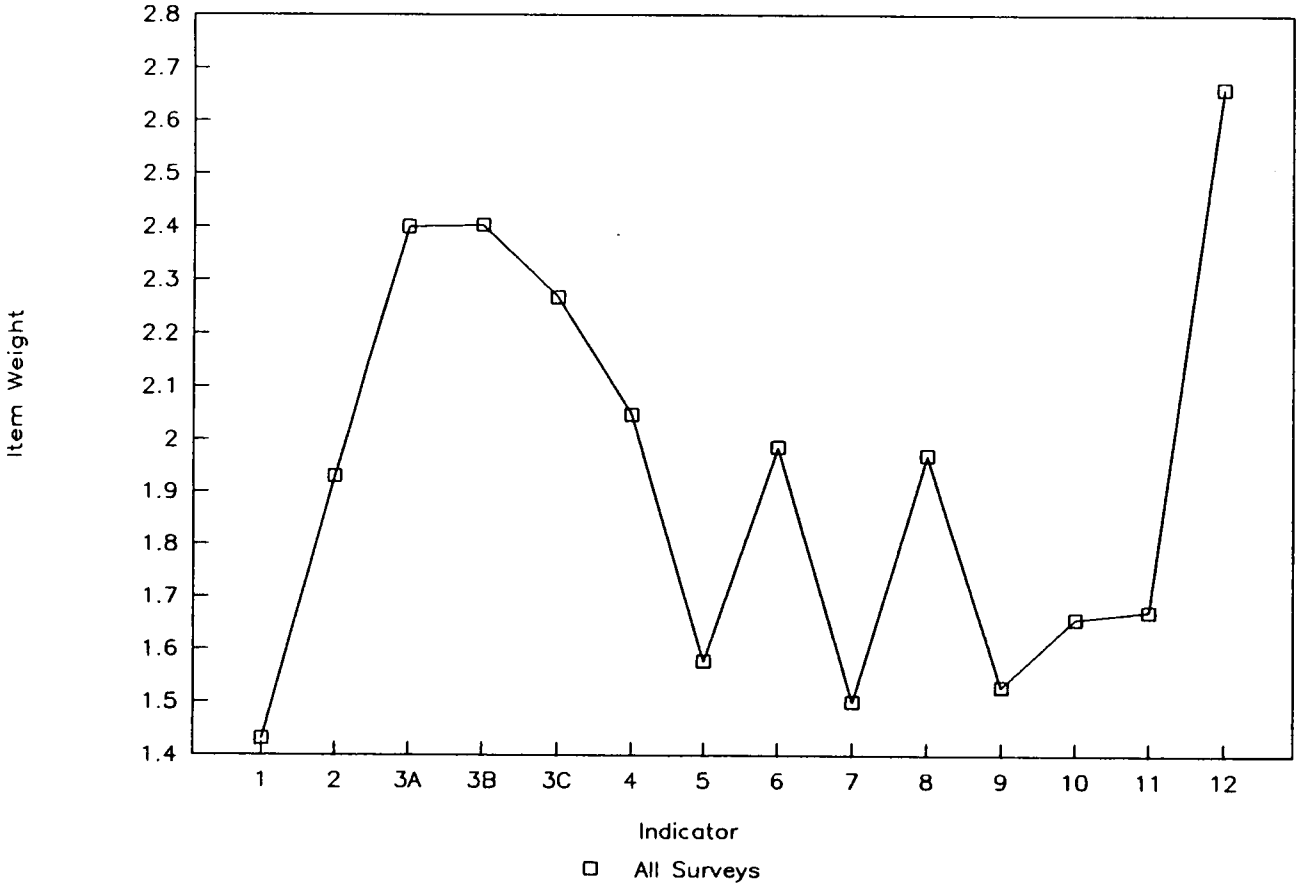


Figure 8. Average Item Weights for All Surveys
Staff Recruitment and Selection Domain

handled by central office staff rather than program staff. Some of the respondents commented that these items were not applicable to them, since personnel matters were managed elsewhere. Many of the items in this domain would be of little benefit to programs in this category, but for those programs which have to recruit and select staff, the items in this domain could serve as benchmarks, particularly those with weightings nearest 1. Unlike center-based programs where there are other professionals around to help insure staff accountability, home-based program services are likely to be delivered by one individual meeting with one or two family members. This creates opportunities for fraud. Programs which do not have policies and procedures in place to help recruit and select qualified staff might find the items in this domain useful, particularly those which were valued more highly.

Domain 8: Staff Development

The items in this domain have to do with equipping the staff with the skills needed to effectively intervene in the homes of young, handicapped children. As can be seen in Figure 9, the respondents highly valued the program quality indicators in this domain (see Appendices E.8 and F.8 for actual indicators, means, standard deviations, and numbers of respondents). Only one item, Indicator 14 which suggested a

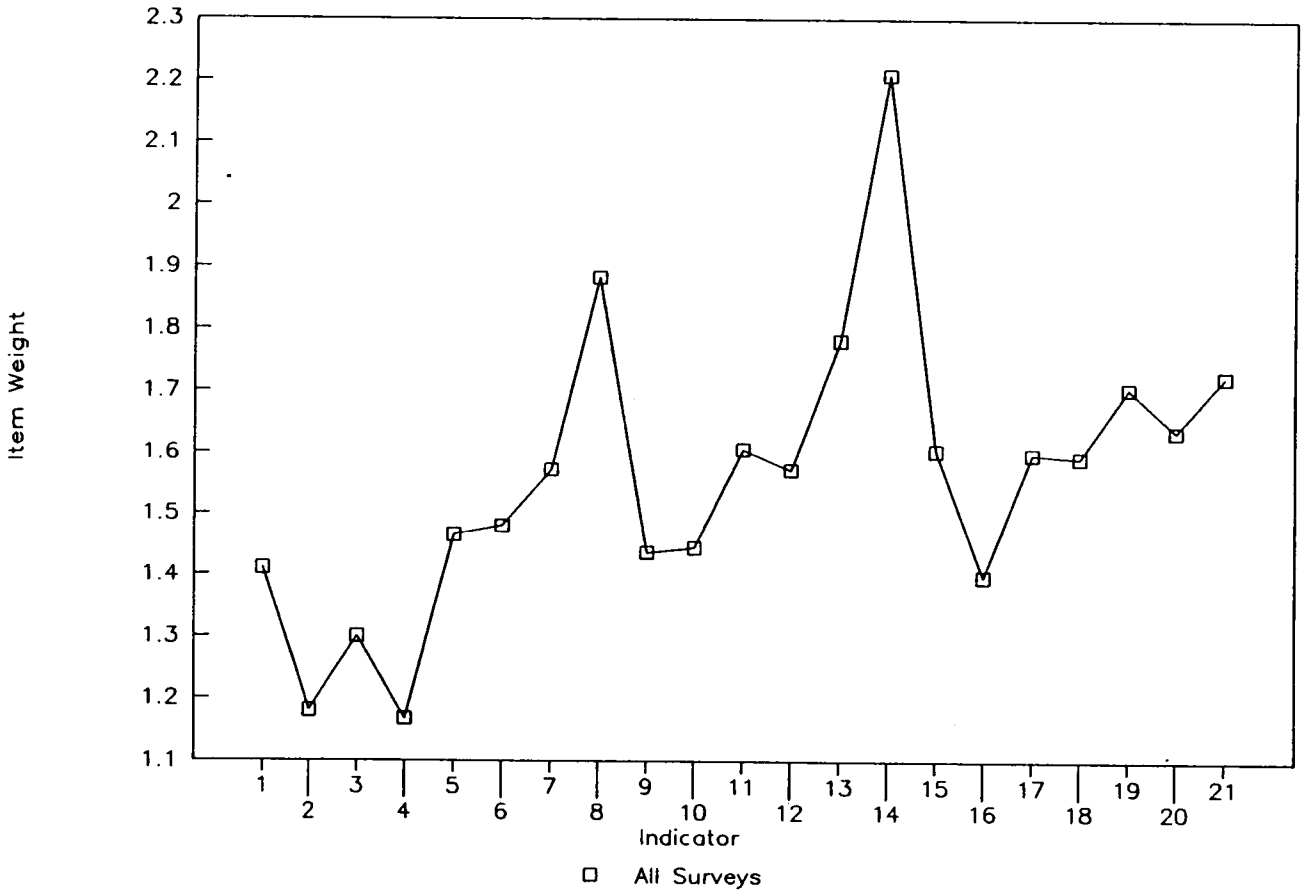


Figure 9. Average Item Weights for All Surveys
Staff Development Domain

method of targeting inservice needs which may have been unfamiliar to many of the respondents, received a weight of more than 2.0. Most items clustered in the 1.4 to 1.7 range. Three items in the domain were weighted as being highly related to quality home-based programming. Item 4, insuring that staff know how to plan and implement an individualized program, was one of the most valued items in the instrument. Item 2, which dealt with training staff in interactional skills so they could effectively communicate with parents, relates in content with the Parent Advisor Program Implementation items and received a weight commensurate with those items. The third indicator which received a highly valued weight, Item 3, speaks to the importance of recognizing that very young, handicapped children and their parents have rights which must be understood and considered. In a very real sense, the Parent Advisor who enters the family's home is an invited guest. This item, weighted at 1.300, agrees highly with Item 8 in the Parent Advisor Program Implementation domain, weighted at 1.282, which is concerned with involving parents in the entire process of educating their child.

The implications arising from these data are that programs wishing to implement program quality measures which were deemed most important would concentrate on equipping their staff with the skills needed to effectively implement an individualized program, keeping in mind that instruction is most effective when it is matched to the learning styles of

the recipients and is delivered in ways which demonstrate an appreciation for the rights of parents and their handicapped children.

Domain 9: Staff Supervision

Home-based programs present unique supervision challenges. Those programs which provide services to large geographic areas may be supervised from a central location far removed from the homes of the families being served. In addition, many programs employ contractual staff with diverse educational backgrounds. The items in this domain relate to providing quality supervision to those staff members who actually make home visits, not to other staff which may be employed by home-based programs. The program quality indicators in this domain and the means and standard deviations showing item weightings are presented in Appendix E.9. By looking at Figure 10, one can see that the 27 items in this domain have a great deal more scatter than in any of the other domains, with mean indicator weights varying from 1.667 (Indicator 1) to 2.968 (Indicator 26) (see Appendix F.9). Taken as a unit, the program supervisors placed less value on the items in this domain than on any other (see Figure 1). Indicators which were highly valued in this domain include the following: Item 1, the assignment of parent

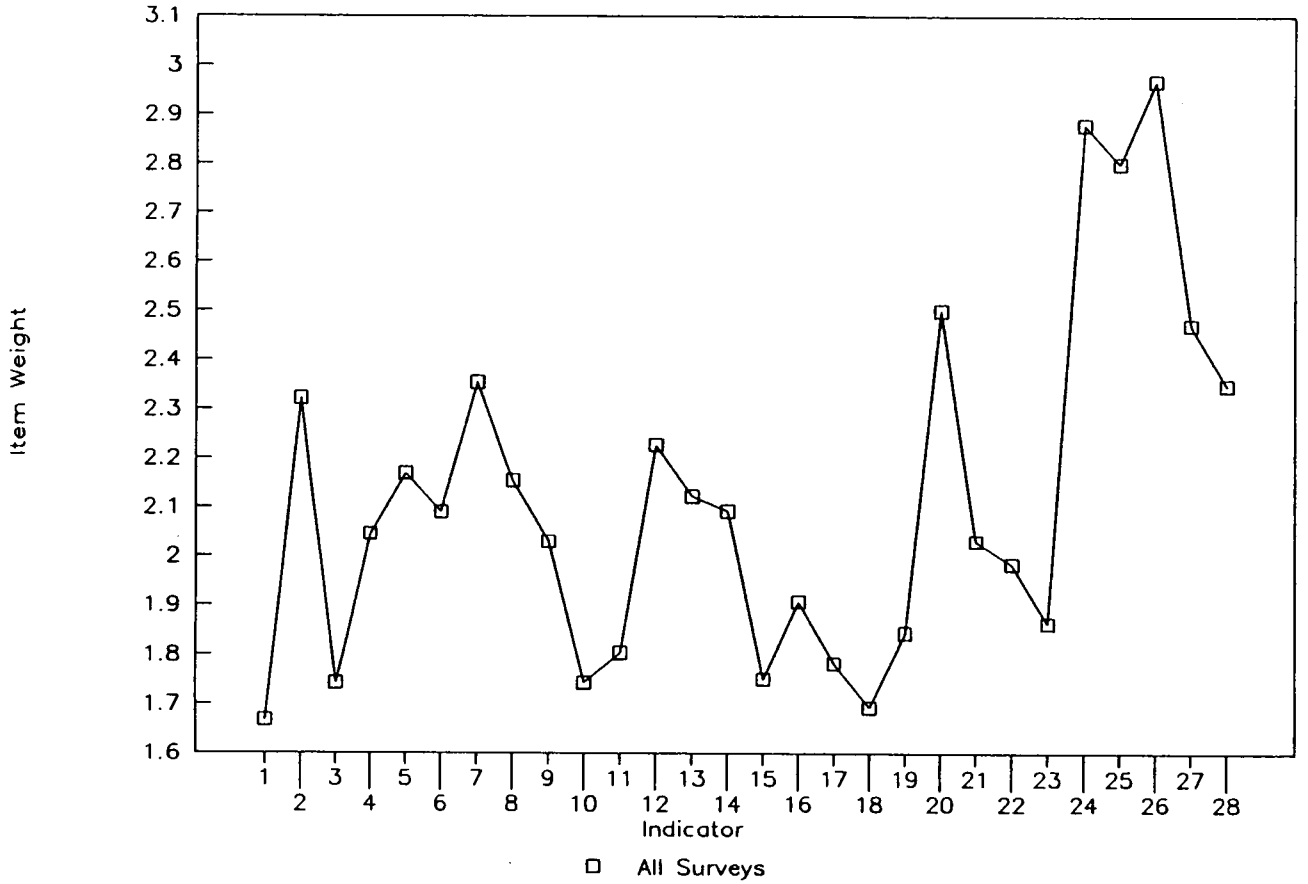


Figure 10. Average Item Weights for All Surveys
Staff Supervision Domain

advisors to supervisors who have thorough knowledge and experience in providing home-based instruction; Item 18, having a supervisor who requires accountability from staff; and Items 10 and 15, which relate to the supervisor taking time to both problem solve with the parent advisor and to do as many home visits as are necessary to insure that parent advisors are delivering quality services. The least valued items (Indicators 24, 25, 26, 27) relate to insuring that staff make the home visits they are being paid to make. The standard deviations on these items were large, indicating that responses varied greatly (see Appendix E.9). By further analyzing the data it was learned that these items were valued more by larger programs and by programs employing part-time parent advisors than by smaller programs and programs utilizing only full-time staff. It appears that as programs become larger, the risk of having staff who might claim to provide services which are not rendered tended to become a greater concern to supervisors. Obviously, if the number of supervisees increases without a corresponding increase in supervisory personnel, there is less opportunity for the supervisor to be directly involved with each supervisee.

Indicator 20 (item weight 2.500) in this domain and Indicator 17 (item weight 1.597) in the previous domain, both deal with collegial supervision; however, they are weighted quite differently. It would appear that while the program supervisors surveyed felt that collegial supervision was

important (Indicator 17, Staff Development domain), they placed less value on it when staff had to be compensated in order to create collegial opportunities.

As a planning tool, the responses in this domain suggest the importance of administratively lodging the home-based program with a supervisor who understands home-based instruction, is willing to be available to problem solve on a case by case basis and who will hold staff accountable for the outcomes of their efforts.

Domain 10: Funding and Financial Management

The items in this domain relate to securing and managing allocated funds. Quite a bit of variability was seen among the items in this domain, with item weights ranging from 1.217 (Indicator 16e) to 2.242 (Indicator 3) (see Figure 11; also see Appendices E.10 and F.10 for indicators, means, standard deviations and numbers of respondents). The emphasis on service delivery that was seen in some of the other domains can be clearly seen in this one, even though the stimulus statements were primarily designed to cause program supervisors to evaluate their procedures for fiscal accountability. The indicators which were valued as most important to quality home-based service were those dealing with the provision of support services (Indicators 16.1-16.5) and the avoidance of service interruptions due to funding

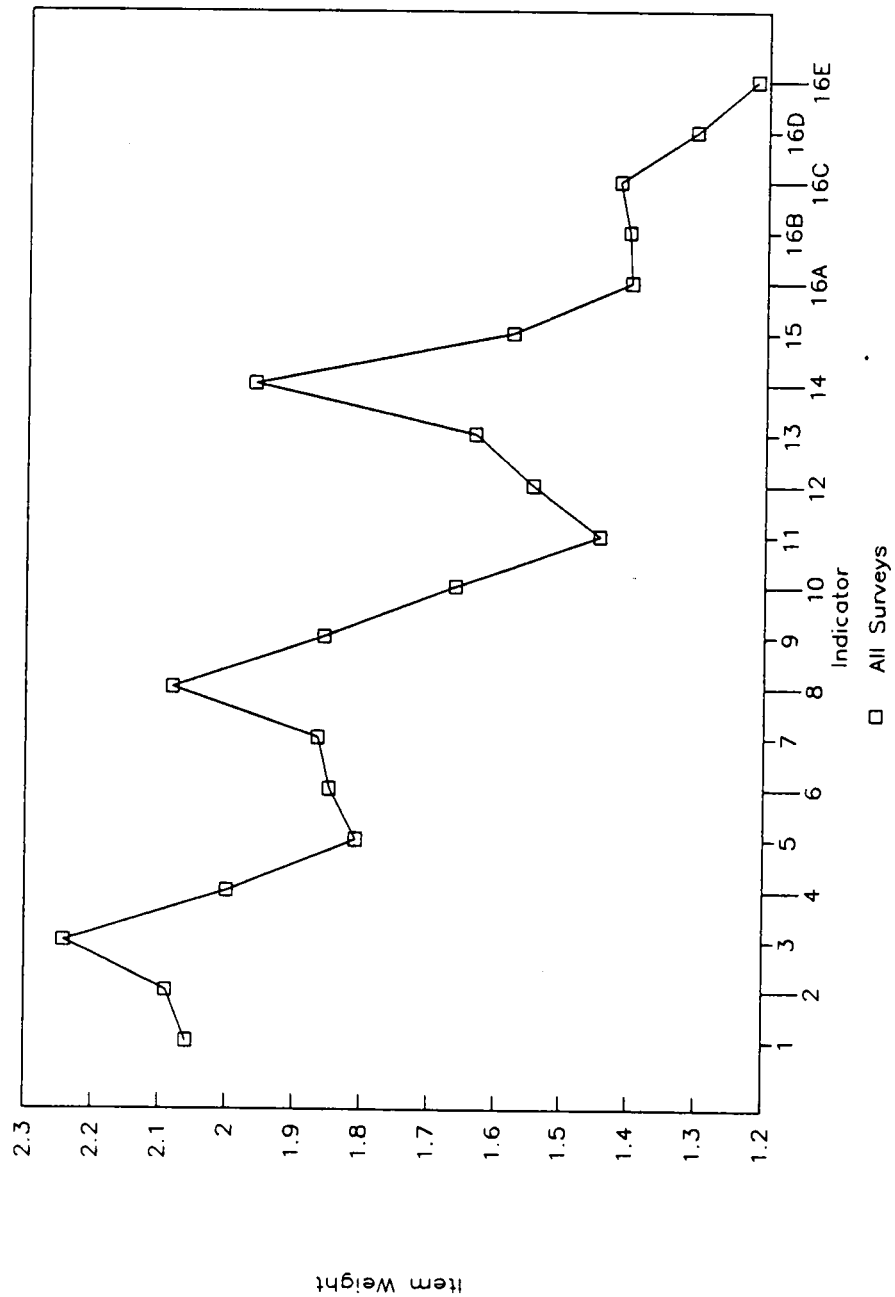


Figure 11. Average Item Weights for All Surveys
Funding and Financial Management Domain

limitations (Indicator 11). These data suggest that program planners need to make adequate allocation of funds for support services such as audiological, vision, psychological, physical and occupational therapy.

Domain 11: Support Services

The items in this domain relate to securing and coordinating the services of other professionals with special skills needed by handicapped children. Responses to the items in this domain were fairly consistent. As can be seen in Figure 12 (and Appendices E.11 and F.11, which include the indicators, means, standard deviations, and number of respondents), most of the items in this domain clustered in the 1.300 - 1.600 item weight range (Items 1, 2a, 2b, 2d-6, 8-10). Indicators 8 and 9, which have to do with empowering parents to be able to procure the services needed by their child, agree well with the weights assigned to content-related items (Indicators 2 and 8) in the Parent Advisor Program Implementation domain (Appendix E.6), demonstrating consistency in weighting. Most of the other items in this domain which were highly valued by the program supervisors were related to identifying and accessing other professionals who may need to be involved in assessment, consultation, or direct intervention. Weighting of these items (Indicators 1 - 6), was quite consistent, reflecting the perceived need to

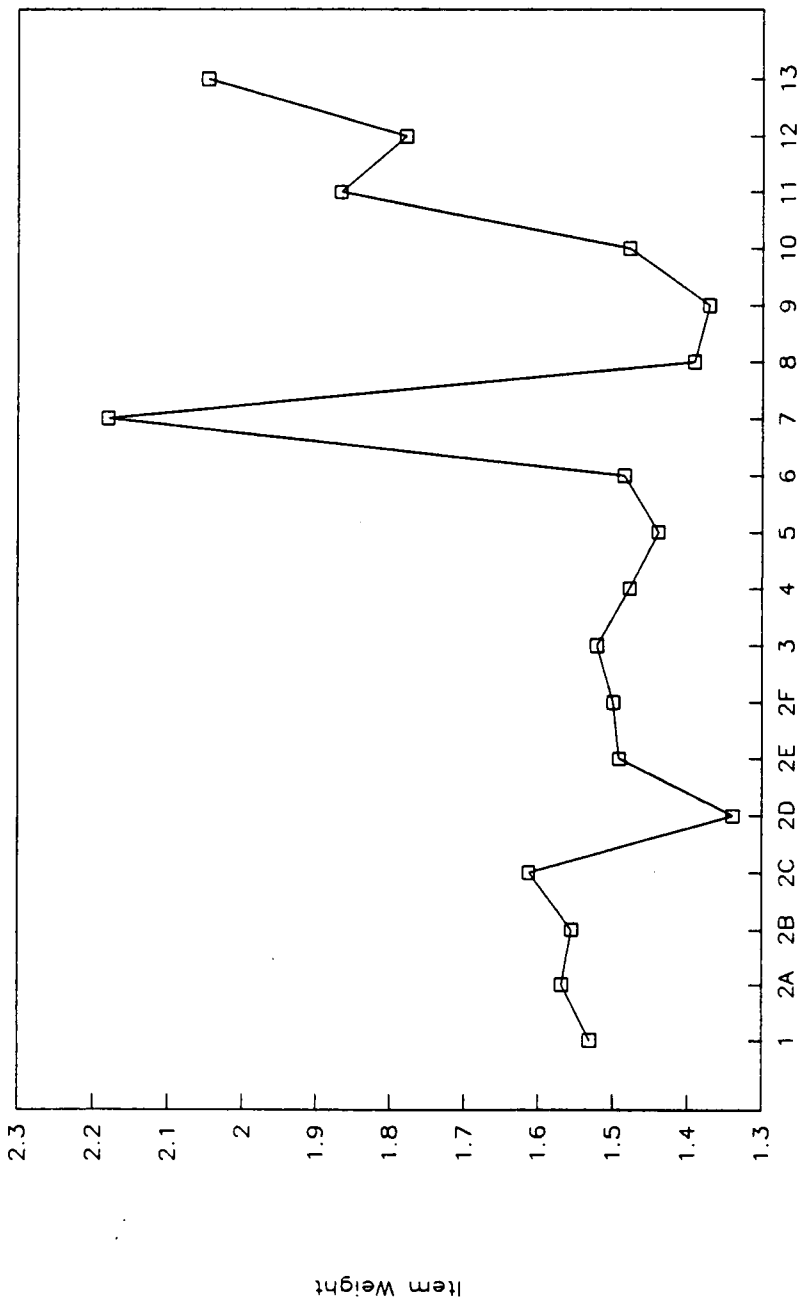


Figure 12. Average Item Weights for All Surveys
Support Services Domain

be able to call on other individuals with expertise to compliment the skills possessed by the program staff so that comprehensive services can be rendered. (The weighting of audiological services (Indicator 2.4 in this domain and Indicator 16.5 in the previous domain) as most important is understandable, since all persons completing the instrument work with hearing impaired children.)

Indicator 10, which stressed the need for parent support groups, was also a highly valued item. Its weighting indicated agreement with the literature concerning the stress that having a handicapped child places on families. The weight assigned to Indicator 5 may seem inordinately strong to persons unfamiliar with the problems faced by home interventionists in helping other professionals step outside of the clinic-based model of looking at children; however, it is in agreement with the literature on transdisciplinary programming.

The data in this domain suggest many benchmarks which are applicable to new home-based programs for families of young handicapped children. The implications for existing programs are that attention should be given to insuring that needed support services have been identified, that procedures have been developed for accessing them, and that staff understand how to access them.

Domain 12: Transitioning From Home-Based to Center-Based Program

The items in this domain relate to the area of transitioning the child being served in a home-based into a center-based program. Figure 13 (see also Appendix E.12 and F.12) depicts the weightings of the program quality indicators in the transition domain. A strong degree of consistency was found among the responses to the items in this domain, with item weights ranging from 1.26 (Indicator 3) to 1.58 (Indicator 11) and a domain weight which was lower than all others except parent advisor program implementation. It was obvious from the weights assigned that directors of quality home-based programs did not feel that their jobs were finished with families until the children had been successfully linked to their next educational placement.

The item most valued in this domain, Indicator 3 (1.261), stressed the need for thoroughly assessing the child prior to transitioning. This emphasis on assessment agrees strongly with the item in the Assessment and IFSP domain with the strongest weight (Indicator 4a, weighted at 1.143), which has to do with assessing the child in all developmental areas prior to developing the IFSP. It reflects the emphasis placed on using assessment data for programming decisions which SKI*HI underscores in its training programs.

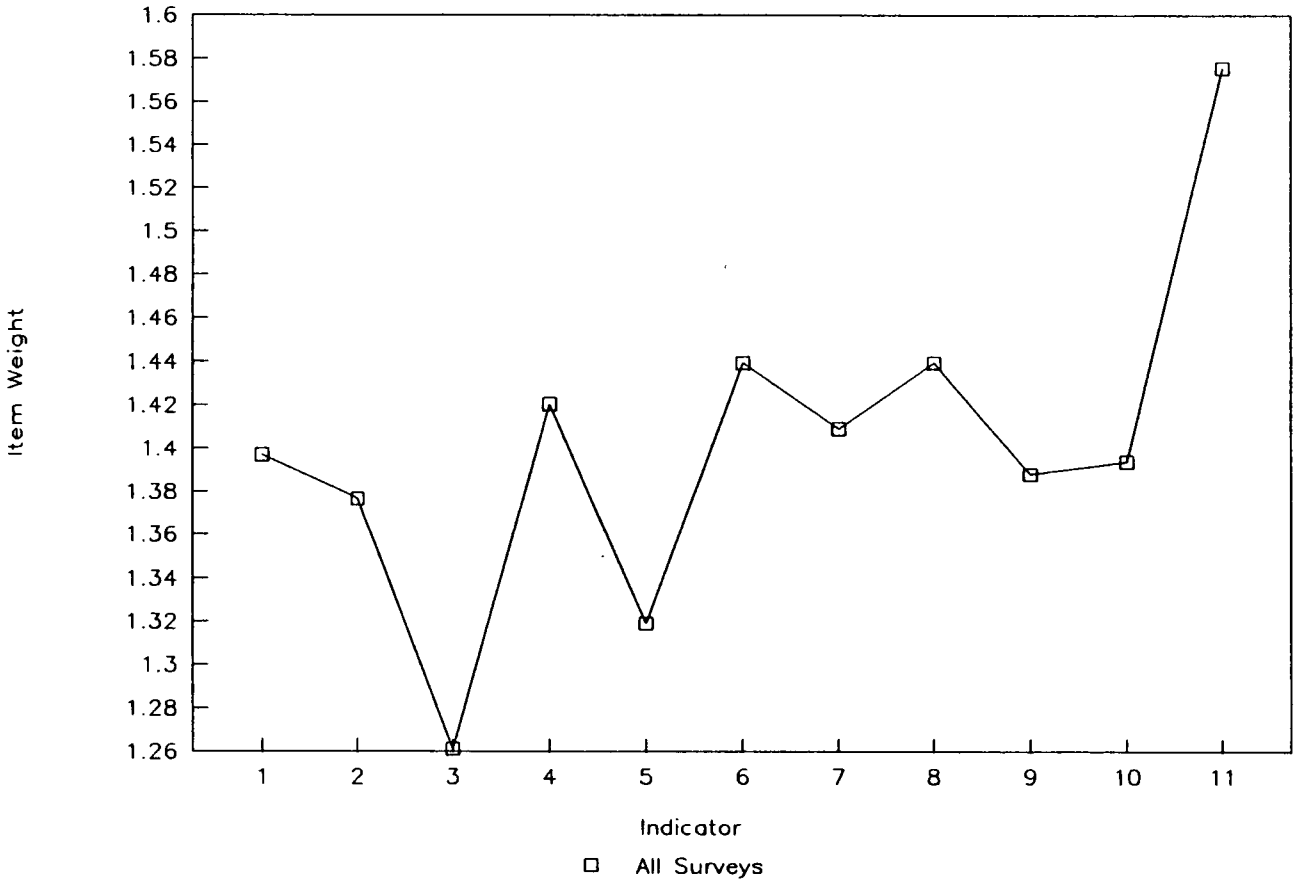


Figure 13. Average Item Weights for All Surveys Transitioning from Home-Based to Center-Based Program Domain

The directors surveyed emphasized the need (Indicator 5) for insuring that the program into which the child was transitioning be prepared to address the child's developmental needs. For many children, especially those in rural areas, there may only be one program available for them to enter; however, the emphasis placed on this item would suggest that attention be given to insuring the appropriateness of that placement. Ideas for facilitating this may found in Indicators 7, 8 and 9, which relate to communication between the two programs before, during, and after the change of placement has occurred. The value placed on the items in this domain by the program supervisors suggests that programs using this instrument carefully evaluate their policies and procedures to determine if they encourage intraprogram interchanges which promote smooth transition of handicapped children from the home-based program to the child's next placement.

Domain 13: Materials and Equipment Lending Library

Home-based programs do not have the luxury of having an on-site storeroom of equipment from which to draw. The tools at their disposal must either be available from the family or be taken to the home. Since the thrust of home-based programs is to equip the parent to effectively intervene with their child, having informational materials, educational toys, and

adaptive equipment available to loan to the parent and to the parent advisors working with each family enhances program effectiveness. Figure 14 (see also Appendices E.13 and F.13) presents the items in this domain, which ranged in value from 1.443 (Item 3) to 2.043 (Item 1). The program supervisors who rated the items in this domain strongly emphasized the need for making educational materials available for parents and professionals (Item 3). The weighting of this item was stronger than that of Indicator 1, which relates to adaptive equipment and educational toys; however, by looking at the standard deviation on Indicator 1, it is apparent that the item was of much more importance to some supervisors than to others. Those programs which have a large number of physically handicapped children and/or families unable to buy appropriate educational toys may have rated the item highly, while others did not see as much need. As one would expect, since all of the program supervisors surveyed work with hearing impaired children, Indicator 2, the hearing aid loaner bank, was highly valued. The implication from these data is that programs using this instrument may want to consider the families with whom they work to determine the type of lending equipment and materials needed to adequately address the needs which exist.

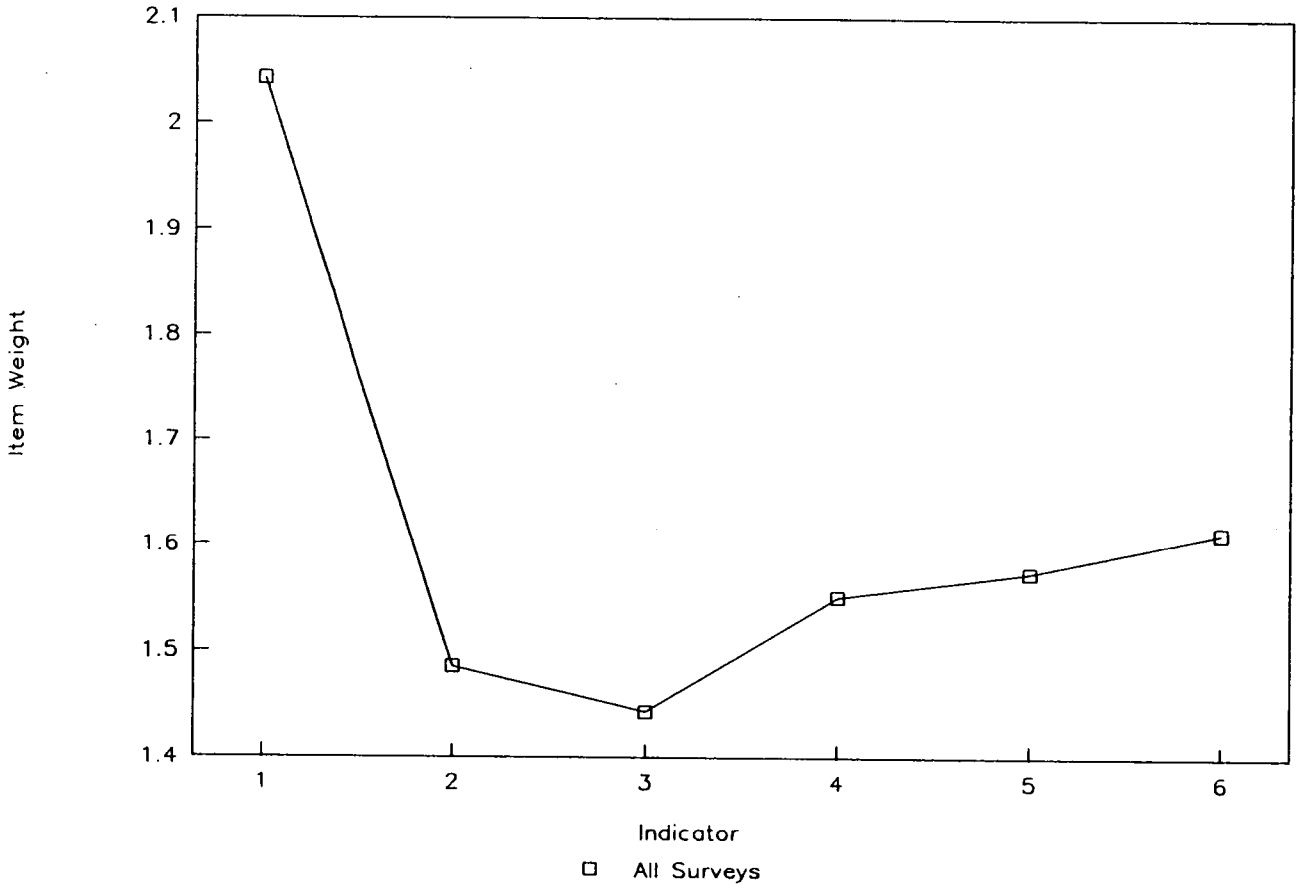


Figure 14. Average Item Weights for All Surveys
Materials and Equipment Lending Library Domain

Domain 14: Measurements of Achievement/Satisfaction

The final domain in the instrument is concerned with measuring program effectiveness. Items included in the domain present a variety of data sources for assessing program strengths and areas of need, ranging from securing the opinions of program staff, parents, and professionals from collaborating agencies, to studies of child achievement trends. Though all program quality indicators in this domain were weighted at less than 2.3, the mean domain weight was higher than all except two others. Figure 15 (see also Appendices E.14. and F.14) presents the data for this domain. Items 1 and 2, which deal with input from program staff, were valued more and had lower standard deviations than all other items in the domain. The indicator most valued after these was Indicator 4, the analysis of child and family progress data on a parent-advisor-by-parent-advisor basis to insure that all families are receiving quality services, regardless of which staff member is providing the service. While the item weights assigned to items in this domain were among the highest in the instrument, all were considered by program supervisors to be related to quality programming. These data imply that programs should strongly consider the extent to which present program staff, exiting program staff, and staff of programs into which children have been transitioned, are given opportunity for input. Further, they suggest that child

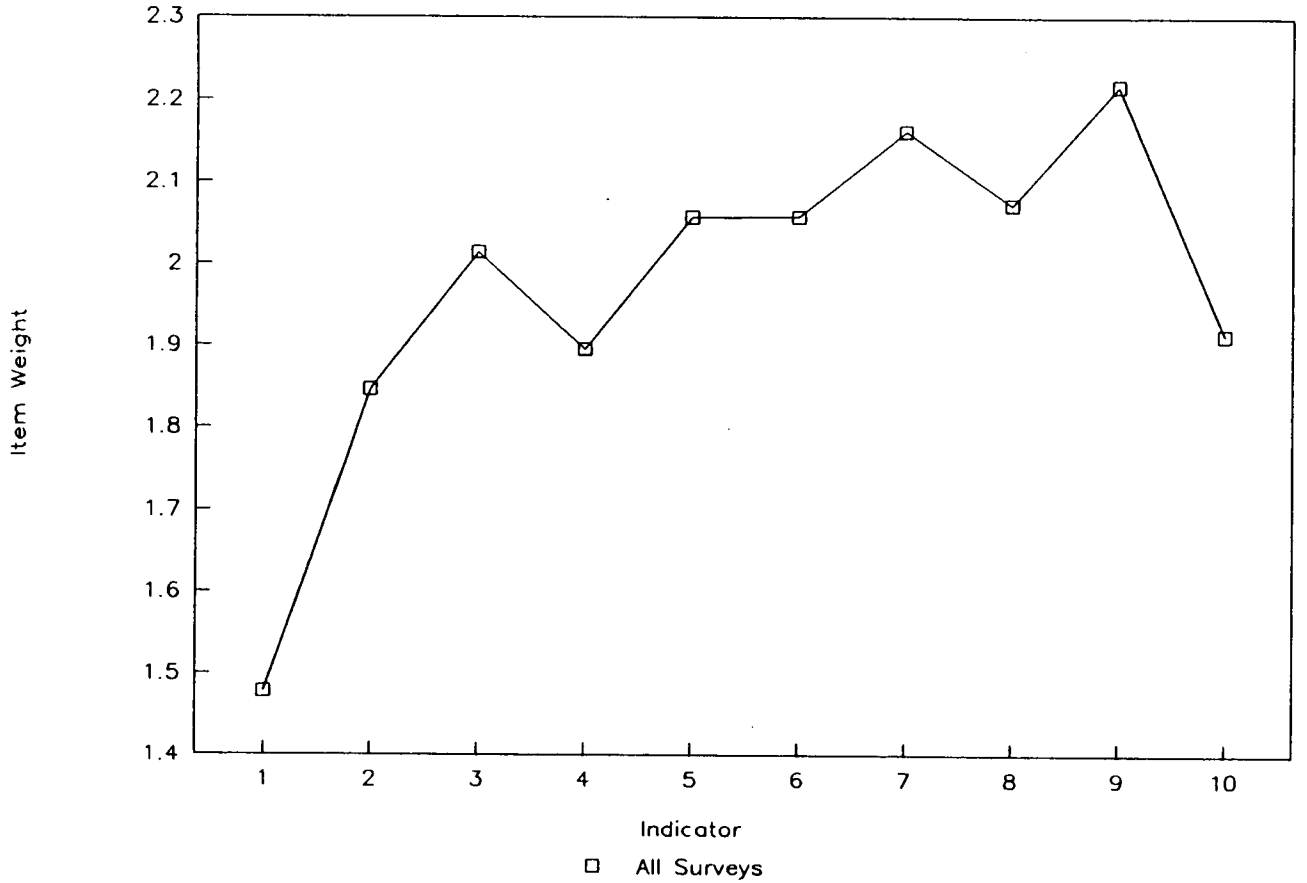


Figure 15. Average Item Weights for All Surveys Measurements of Achievement/Satisfaction Domain

and family progress be analyzed by parent advisor, rather than just for the total program.

Other Measures

The surveys received were stratified in a number of ways to determine whether certain demographic variables affected the item weights which were assigned. Data are presented in this section which show the relationships which were found. The areas of possible relationship which were explored included: program size, geographic region, length of time as an adoption site, and implementation status.

Table 4.2, shows the domain weights which were found when programs serving fewer than 20 children were contrasted with those serving 20 or more children. Column 1 contains the domain numbers which correspond to the 14 domains in the instrument. The second column contains the average item weights assigned by programs serving fewer than 20 children, while the third column contains the average of the item weights assigned by programs serving more than 20 children. The final column shows the degree of difference.

In all domains, the larger programs assigned more valued item weights than the smaller programs did. The smallest difference in weighting was in the assessment and IFSP domain (5), while the largest difference was in the staff supervision

Table 4.2 Average Domain Weight Stratified by Program Size

DOMAIN #	SIZE=<20	SIZE=20+	DIFFERENCE
1	2.277	1.864	0.412
2	1.681	1.329	0.352
3	1.553	1.222	0.331
4	2.010	1.620	0.390
5	1.510	1.344	0.166
6	1.417	1.139	0.278
7	1.991	1.782	0.209
8	1.621	1.397	0.224
9	2.307	1.688	0.619
10	1.836	1.474	0.362
11	1.696	1.357	0.339
12	1.467	1.243	0.224
13	1.702	1.420	0.282
14	2.106	1.639	0.467

domain (9). Other relatively large differences were found in the public awareness/child find domain (1) and in the measurements of achievement/satisfaction domain (14).

Interpreting these differences is difficult. Small programs, especially those which utilize only full-time staff and serve a limited geographic area, may need to rely less on mass media approaches to public awareness (1). The opposite could also be true--the need may exist, but if the staff perceive that they are serving all the children they can handle, no incentive exists to find more. The differences in staff supervision (9) domain weights may arise from the fact that larger programs have more people who need supervision; therefore, supervision takes on more importance. Conversely, supervisors of smaller programs may not perceive supervision as important because they are not as acutely aware of the benefits which may result from more emphasis on supervision issues. The fact that similar weights were found on the assessment domain (5) can probably be attributed to the fact that many of the indicators in that domain reflect legal requirements under the new law. In summary, differences were observed in relation to program size. The trend was that the items were perceived as being of more importance to the directors of larger programs.

In Table 4.3, the domain weights which were found when the data were stratified by geographic region are presented. Although the number of responses in some of the cells is too

Table 4.3 Average Item Weight by Domain
Stratified by Region of the Country

REGION	STAT.	DOMAIN 1	DOMAIN 2	DOMAIN 3	DOMAIN 4	DOMAIN 5	DOMAIN 6	DOMAIN 7	DOMAIN 8	DOMAIN 9	DOMAIN 10	DOMAIN 11	DOMAIN 12	DOMAIN 13	DOMAIN 14
		PUBLIC AWARE.	SCREEN	REFERRAL & DIAG.	CENSUS	ASSESS. & IFSP	PA PROG. IMPLEM.	STAFF RECRUIT	STAFF DEVEL.	STAFF SUPERV.	FUNDING	SUPPORT SERVICE	TRANSI- TION	LIBRARY	MEASURE MENT
NORTH EAST	S.D.	1.789	1.000	0.188	1.375	0.423	0.000	1.038	0.357	1.518	0.725	0.778	0.227	0.583	1.500
	AVG.	3.105	2.500	1.438	2.375	1.923	1.000	2.423	1.405	2.625	1.775	1.778	1.227	1.750	2.700
	N.	2	2	2	2	2	2	2	2	2	2	2	2	2	2
GREAT LAKES	S.D.	0.754	0.672	0.531	0.819	0.565	0.631	0.959	0.550	1.041	0.730	0.517	0.456	0.607	0.684
	AVG.	2.338	1.522	1.362	1.796	1.452	1.500	2.148	1.486	2.244	1.786	1.494	1.260	1.477	1.967
	N.	11	10	11	9	10	12	12	12	10	11	12	12	12	12
OIL STATES	S.D.	1.156	0.939	0.703	0.990	0.655	0.584	0.903	0.732	1.076	0.881	0.776	0.605	0.744	0.877
	AVG.	1.964	1.470	1.470	1.692	1.405	1.361	1.972	1.673	2.316	1.789	1.663	1.435	1.673	2.061
	N.	25	26	29	28	28	30	27	29	27	24	27	28	28	28
NORTH WEST	S.D.	0.474	0.500	0.250	0.750	0.404	0.000	0.462	0.286	0.679	0.475	0.444	0.318	0.333	0.850
	AVG.	2.711	1.600	1.250	3.250	1.442	1.125	2.231	1.524	2.750	1.775	1.500	1.318	1.333	2.550
	N.	2	2	2	2	2	2	2	2	2	2	2	2	2	2
MOUNT- AIN	S.D.	0.875	0.540	0.723	0.572	0.337	0.550	0.811	0.724	0.865	0.742	0.619	0.642	0.542	0.802
	AVG.	2.173	1.550	1.500	1.550	1.246	1.425	1.946	1.714	1.821	1.689	1.547	1.595	1.633	1.860
	N.	4	5	5	5	4	5	5	5	5	4	5	4	5	5
MID ATLANT.	S.D.	0.681	0.846	0.559	0.908	0.324	0.244	0.597	0.452	0.928	1.002	0.873	1.114	1.107	0.777
	AVG.	1.977	1.670	1.429	2.329	1.245	1.175	1.933	1.409	2.119	1.892	1.569	1.584	1.897	1.831
	N.	6	4	7	6	5	6	6	7	6	7	6	6	7	7
GRAIN	S.D.	0.949	0.513	0.707	0.697	0.572	0.427	0.752	0.526	0.713	0.692	0.536	0.436	0.512	0.641
	AVG.	2.075	1.443	1.654	1.713	1.652	1.267	1.781	1.563	1.829	1.570	1.497	1.418	1.367	1.860
	N.	6	6	6	5	4	5	5	5	5	5	5	5	5	5
SOUTH ATLANT.	S.D.	0.382	0.300	0.313	0.500	0.385	0.063	0.577	0.190	0.286	0.050	0.278	0.182	0.250	0.300
	AVG.	1.776	1.900	1.438	1.500	1.538	1.063	1.731	1.286	1.393	1.050	1.333	1.364	1.250	1.700
	N.	2	2	2	2	2	2	2	2	2	2	2	2	2	2
SOUTH CENTRAL	S.D.	0.760	0.760	0.678	0.970	0.573	0.521	0.713	0.389	0.592	0.773	0.710	0.501	0.642	0.709
	AVG.	1.942	1.533	1.500	1.883	1.499	1.333	1.628	1.357	1.452	1.525	1.704	1.333	1.778	1.607
	N.	6	6	6	6	6	6	6	6	6	6	6	6	6	6

small to allow many conclusions to be drawn, this depiction affords the opportunity to see that the items were significantly valued in all regions of the nation. Only two domain means were above 3.0, and these were in cells containing only two responses each (North East, Domain 1; and North West, Domain 4).

Items tended to be valued more in the South Atlantic, Mountain, and South Central regions. Programs in these regions were generally larger, entire state adoptions, while the programs in the North East, Great Lakes, North West, and Oil States tended to be smaller. The means for Domains 3, 5, 6, 8, 10, 11, 12, and 13 were less than 2.0 in all cells, indicating rather homogeneous item weightings in all regions of the nation. These data tend to indicate that region of the country did not exert much influence on the perceived importance of the program quality indicators.

Table 4.4 contains the domain means for all surveys, stratified by the length of time each program had been a replication site of Project SKI*HI. (Only one of the sites which responded to the survey had adopted since 1989.) Responses from those who adopted in 1986 or more recently can be found in the column labeled "AGE=<5 YEARS", while the responses of those adopting in 1985 or earlier are seen in the column labeled "AGE=5+". The final column displays the difference between the two sets of means. All of the observed differences are positive numbers, indicating that lower domain

Table 4.4 Average Item Weight by Domain Stratified by Length of Adoption

DOMAIN	#	AGE=<5 YEARS	AGE=5+	DIFFERENCE
	1	2.231	2.121	0.111
	2	1.614	1.560	0.054
	3	1.516	1.436	0.080
	4	1.921	1.888	0.033
	5	1.542	1.414	0.128
	6	1.534	1.411	0.123
	7	1.964	1.818	0.146
	8	1.520	1.397	0.123
	9	2.000	1.688	0.312
	10	1.836	1.474	0.362
	11	1.696	1.357	0.339
	12	1.467	1.243	0.224
	13	1.702	1.420	0.282
	14	2.106	1.639	0.467

means were registered by the programs who had adopted earlier. The greatest difference was in the measurements of achievement/satisfaction domain (14), followed by funding (10). None of the observed differences was greater than .50. These data suggest that while length of adoption was related to the item weights assigned, the difference in weight assigned was rather small, indicating that the effect was slight.

The final control variable to be explored was implementation status of the item being weighted. In addition to being asked to assign an item weight to each of the program quality indicators, each supervisor was also asked to indicate whether that particular indicator was being implemented in her program. Figure 16 depicts the item weights assigned by all programs when the implementation status of the program quality indicators was controlled. The blocks represent the domain means of all items which were reportedly being implemented by the program supervisors who responded. The plus signs (+) show the domain means for the items which were reported as not being implemented. A discrepancy of .5 or more was found for all domains except Domain 12, transitioning from home-based to center-based programs. The differences evident in the weights assigned to the items in the public awareness/child find (Domain 1), census (Domain 4), staff recruitment and selection (Domain 7), staff supervision (Domain 9), and measurements of

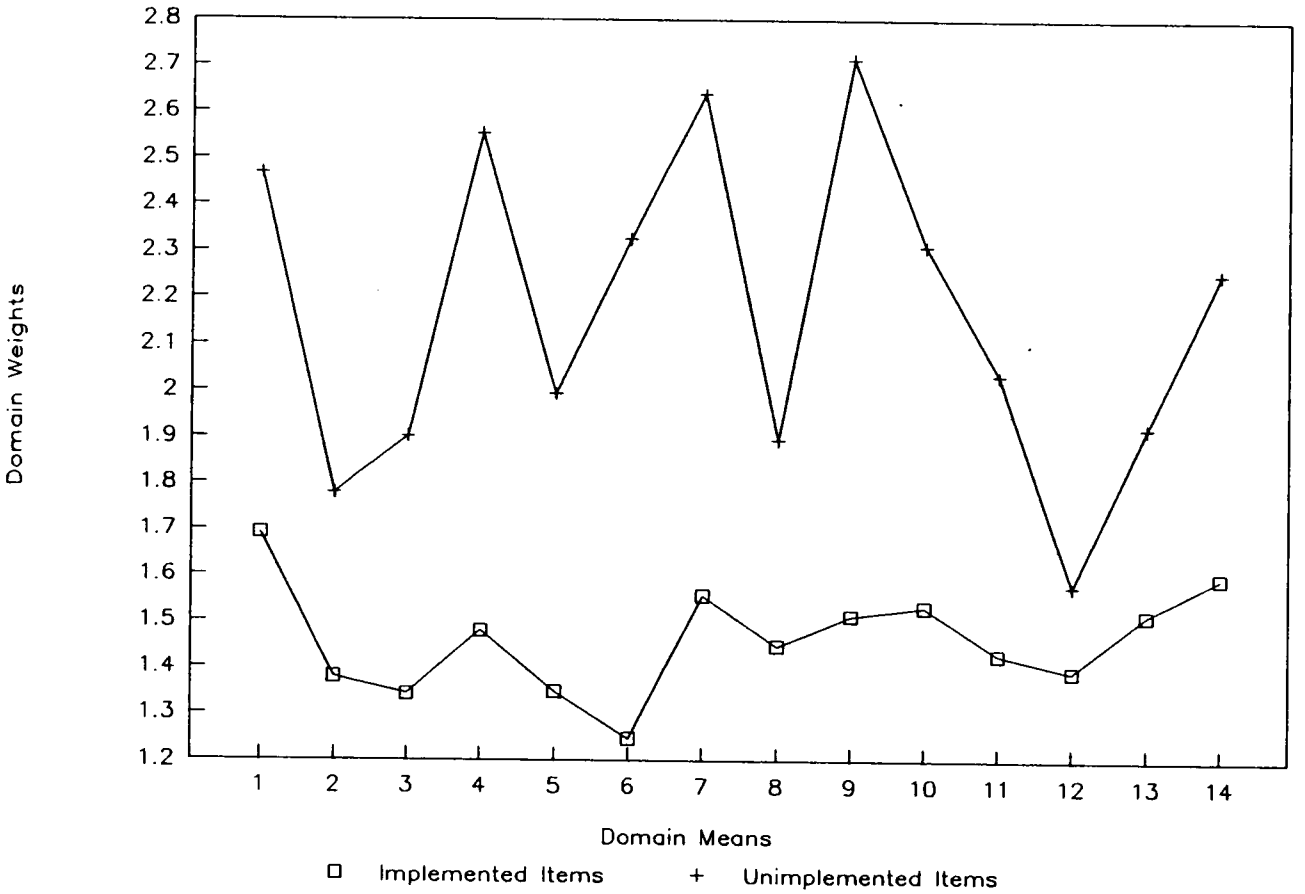


Figure 16. Average Item Weights for All Surveys Stratified by Implementation Status

achievement/satisfaction (Domain 14) were larger than any of the differences seen when program size was controlled.

The implication arising from these data is that items being implemented were held in much higher regard by program supervisors than those items which were not being implemented. It is interesting to note, though, that the average weight of the items not being implemented in each domain was still well below the predetermined 3.5 criterion level for remaining in the instrument.

Summary of Information Related to Research Question One

Before the data were collected in this study, a decision was made that all items which presented a mean score of 3.50 or less would be considered to be related to program quality and would be retained as a part of the validated instrument. All of the indicators in the Home-Based Program Evaluation Instrument were sufficiently valued by the program supervisors who weighted them to merit their retention. Therefore, all are considered significant indicators of quality home-based programming. The strength of each indicator's relationship to program quality is shown by the weight assigned it. The range of weights assigned to items varied from 1.139 to 2.968; however, most items were weighted in the 1.4 - 1.8 range. The variables of program size, geographic region, length of time as an adoption site, and implementation status were

explored in relation to their effect on the item weights assign. Larger programs tended to assign more value to the items than smaller programs did. Programs which had adopted Project SKI*HI five or more years ago assigned slightly more value to the items than those adopting more recently. Regional analysis revealed that most of the domains were highly valued in all areas of the nation. The greatest differences were observed in regard to whether the particular item was being implemented in the respondent's program. Items being implemented tended to be held in much higher regard than those not being implemented.

The validated instrument appears in Appendix E. The utility of the indicators it contains has been confirmed by the program supervisors who rated them. The benefit that programs may receive from using the instrument may vary, based on factors such as the structure of the program, whether the staff employed are full-time or part-time, the size of the geographic area served, and the handicapping conditions presented by the children for whom services are planned.

Analysis of Response by Instrument Form

Because of the length of the instrument (13 pages), two forms were used to try to determine if respondent fatigue affected the item weights assigned (Form A; Form B). The results were inconclusive due to a combination of factors.

First, the survey length had an adverse effect on the response rate. At the time of the original return request date, only a few surveys had trickled in. Phone calls were made to the sites to encourage a response. Several of the project directors indicated that the instrument length made the task too onerous to attempt. Twenty-one sites returned the demographic data sheet only, indicating a variety of reasons for not completing the survey.

After approximately 200 follow-up phone calls, which resulted in an insufficient number of completed surveys, a decision was made to send a second copy of the survey to the 26 sites which had submitted data to the SKI*HI Institute, but had not completed the instrument. Prior to mailing the survey, a phone call was made to each of the program sites, telling them about the survey and encouraging them to complete the instrument. When the follow-up surveys were mailed, all sites were inadvertently sent Form A. As a result, responses from programs registering high child achievement scores were over-represented in the Form A group. A total of 44 Form A surveys were returned. Of these, 14 were from High Child Achievement sites. In contrast, 35 Form B surveys were returned. Of these, only seven were from High Child Achievement sites. This over-representation of High Child Achievement sites precluded a meaningful analysis of the respondent fatigue question.

Research Question Number Two: Do those program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?

SKI*HI Child Achievement Data

All SKI*HI replication sites are encouraged to collect child progress data on each child at regular intervals. Language progress is measured by the SKI*HI Language Development Scale, a criterion referenced receptive and expressive language measure which has been normed for hearing impaired children. Directors are encouraged to submit child progress data to the SKI*HI Institute for analysis and feedback.

Unfortunately, not all sites choose to participate. The SKI*HI Institute annually receives data from approximately 30-40% of its adoption sites. The data from sites reporting to SKI*HI Institute in 1989-90 are shown in Appendix B. As can be seen, pretest and posttest means and standard deviations were computed for each site and the differences in means were analyzed to determine whether the changes were the result of accelerated progress as opposed to either maturation or chance. Of the 57 sites reporting data to the SKI*HI Institute for the 1989-90 school year, the children at 26 sites made statistically significant gains in both receptive

and expressive language. Of the remaining 30 sites, 10 had child achievement gains which were statistically significant on either expressive language or receptive language, but not on both; and 21 sites reported data which were not statistically significant on either language measure.

In order to answer research question two, the sites reporting child achievement data to the SKI*HI Institute were dichotomized into the High Child Achievement group and the Lower Child Achievement group, with the High Child Achievement group being defined as those sites having statistically significant results in both receptive and expressive language. Conversely, the Lower Child Achievement group arbitrarily included all sites reporting data whose child achievement results were not significant on BOTH receptive and expressive language.

A total of 79 usable surveys were received from directors of SKI*HI adoption site programs. Of this number, 40 were from sites which reported data to SKI*HI Institute; 39 were from sites not reporting child progress data. The responses from 40 of the 57 programs submitting child progress data to the SKI*HI Institute represented a 70 % response rate from this subset of the total population of adoption sites. Each survey received was assigned a single digit code which identified the category into which the survey was placed. The categories and the number of responses assigned to each were:

High Child Achievement - 21 surveys; Lower Child Achievement - 19 surveys; No Child Achievement Data Reported - 39 surveys.

Means and standard deviations were computed for each of the 222 instrument items for the High Child Achievement group, the Lower Child Achievement group, and the No Data Reported group. The general trend from the data was that all items were valued by all three groups. The High Child Achievement and the Lower Child Achievement groups tended to value the items more than the No Data Reported group. The items tended to be most valued by the High Child Achievement group. Lower mean scores were assigned to 189 of the items by the High Child Achievement group, compared to the 33 items assigned lower mean scores by the Lower Child Achievement group. Three items were rated equally by both groups. The figures which follow provide a visual depiction of the mean weightings for the High Child Achievement group and the Lower Child Achievement group. Actual means, standard deviations and numbers of respondents for all three groups can be found in the appendix which corresponds to each figure.

The data presented in relation to research question two were analyzed utilizing processes similar to those described in relation to the first research question. The data were stratified by group, then means and standard deviations were computed for each item and each domain. Figures containing these data are presented by domain using line graphs as a way of depicting the observed differences. The X-axis legend of

each graph identifies the program quality indicators in that particular domain, while the Y-axis legend contains computer-generated item weight categories which allow the differences in the way the items were rated to be seen. It is important to note that the Y-axis figures change from graph to graph, depending on the weights assigned to the indicators in that domain. **The lower the item weight, the more the item was valued by those who weighted it.** Supporting data for each line graph can be found in tabular form in the appendices as indicated. The program quality indicators by domain, along with their means and standard deviations, also appear in the appendices.

Prior to analyzing the item responses by achievement group, the demographic data gathered on each site were scrutinized to try to determine if differences existed in the characteristics of the two groups being studied. The profiles of the two groups differed in some important ways. The High Child Achievement sites tended to have been Project SKI*HI adoption sites for about two years longer than the Lower Child Achievement sites. The average High Child Achievement site served 58 children while the average Lower Child Achievement site served 10 children. The average High Child Achievement site had 1.2 full-time parent advisors and 15.6 part-time parent advisors, compared to .9 full-time parent advisors and 1.4 part-time parent advisors in the Lower Child Achievement sites. With regard to supervision, the High Child Achievement

programs had an average of .9 persons supervising full-time staff and .9 persons supervising part-time staff. This contrasted with .8 supervisors of full-time staff and .5 supervisors for part-time staff in the Lower Child Achievement sites. Five of the High Child Achievement sites assumed statewide program responsibility, compared to only 2 of the Lower Child Achievement sites. The information in the sections which follow should be considered with the understanding that these differences were present. Further, no attempt was made to control for the racial, ethnic or gender makeup of the sites submitting data.

Domain 1: Public Awareness/Child Find

Figure 17 displays the average item weights assigned by the High Child Achievement group and the Lower Child Achievement group to the items in the Public Awareness / Child Find domain (see Appendix G.1 for actual data). A great deal of variation was found in the weightings of the items in this domain, both between the two groups and within each group's ratings of the individual items. The High Child Achievement group valued 28 of the 38 items in this domain more than the Lower Child Achievement group did. The High Child Achievement group was more inclined to value mass media approaches to child find than was the Lower Child Achievement group, weighting the indicators related to newspaper articles (Items

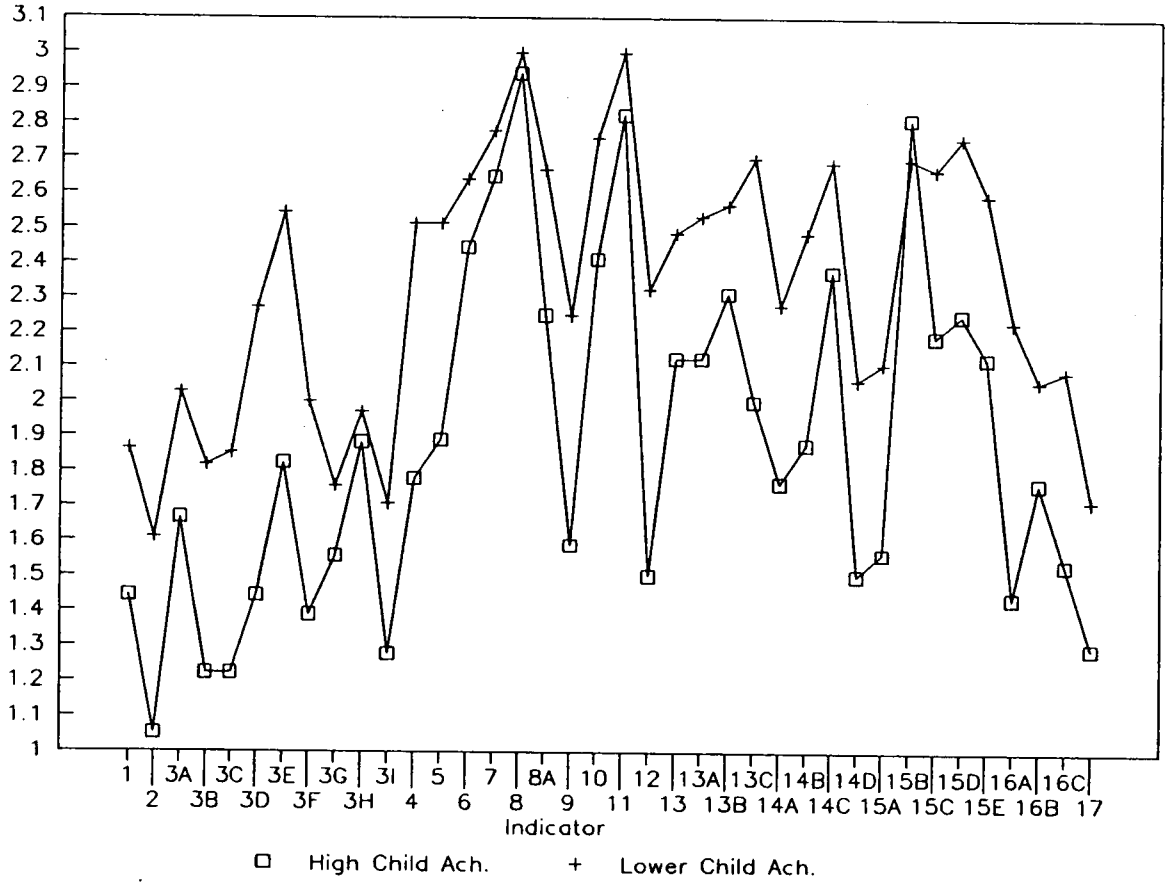


Figure 17. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Public Awareness/Child Find Domain

9 & 12), radio (Items 4-6) and TV (Items 13a-13c) public service announcements, and health fairs and conferences (Items 14a-14d), as more important, while the Lower Child Achievement group placed more value on newsletters for medical service providers and policy makers (Items 15b-e).

Domain 2: Screening

Figure 18 depicts the 10 indicators in this domain, plotted by the mean weights assigned by the two groups (see Appendix G.2 for item means, standard deviations, and numbers of respondents). All items were highly valued by both groups, with item weights ranging from a high of 1.8 (Indicator 1), to a low of 1.2 (Indicator 4). Five of the items were assigned lower weights by the High Child Achievement group and 5 received lower ratings by the Lower Child Achievement group. The High Child Achievement group assigned more significance to following up on families who failed to respond to the initial efforts to have their children brought in for testing (Item 4), and the development of hospital high risk screening procedures (Indicator 6). The Lower Child Achievement group placed more value on cribogram screenings (Indicator 9) than the High Child Achievement group did. Other rankings were similar.

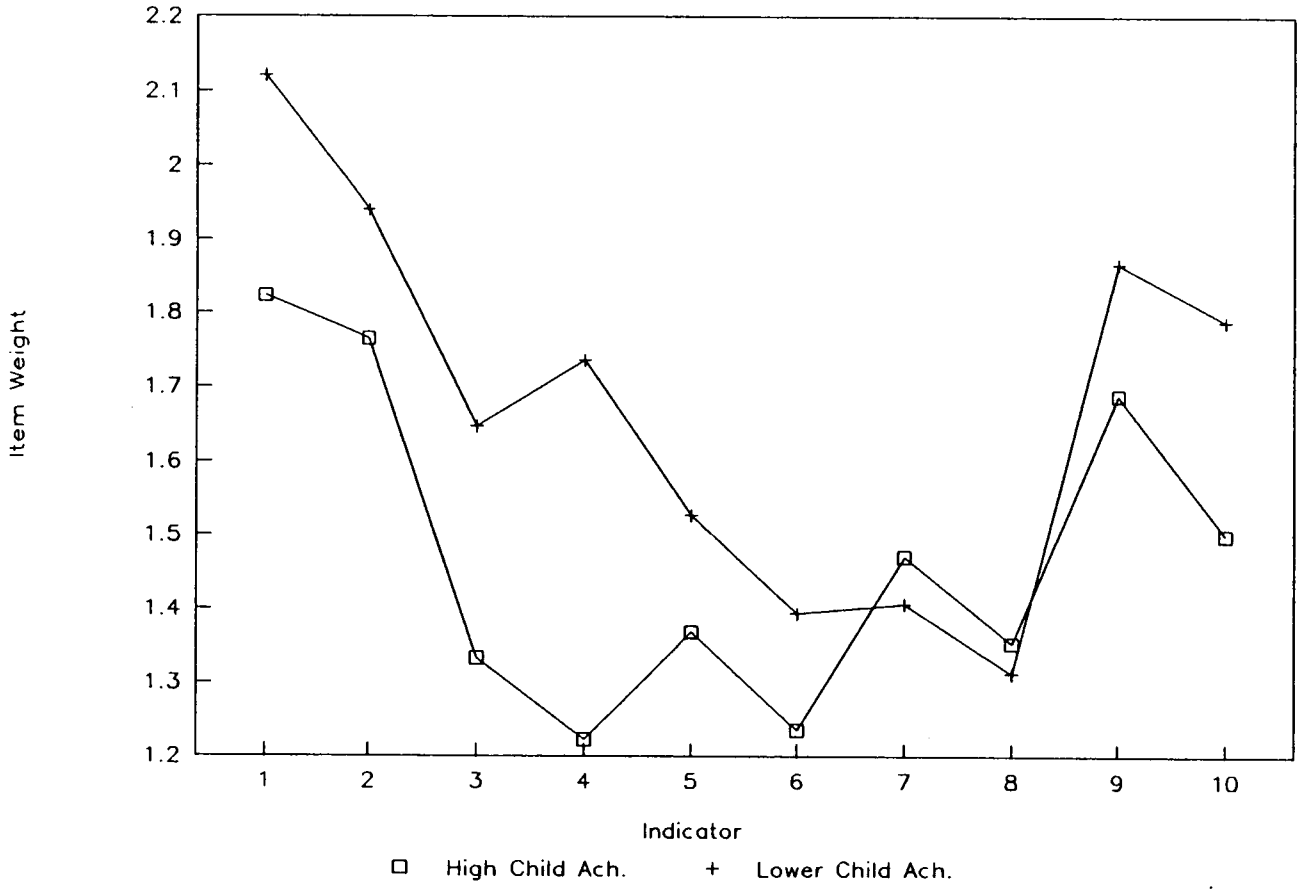


Figure 18. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Screening Domain

Domain 3: Referral and Diagnosis

All of the variables in this domain received item weightings of less than 2.0, but a great deal of variation was found in the way the items were weighted by the two groups. The High Child Achievement group placed more value on 6 of the 8 indicators, as is shown in Figure 19 (see also Appendix G.3). The greatest differences observed were in relation to referral procedures (Item 1), insuring that referring agencies understood those procedures (Item 2), feedback to referring agencies concerning the children they had referred (Item 6), and regular contact with professionals having initial contacts with handicapped children (Item 3).

Domain 4: Census

The weights assigned to the 4 items in this domain by the two groups can be seen in Figure 20 (see also Appendix G.4). Item weights vary from 1.5 to 2.4 within the domain. The High Child Achievement group assigned more value to all 4 items in this domain; however, differences between the two groups were slight. The most valued items related to insuring that the public school systems responsible for each child's next placement (Indicator 2B) and the lead agency responsible for implementing Public Law 99-457 (Indicator 2A), were informed of the child's presence.

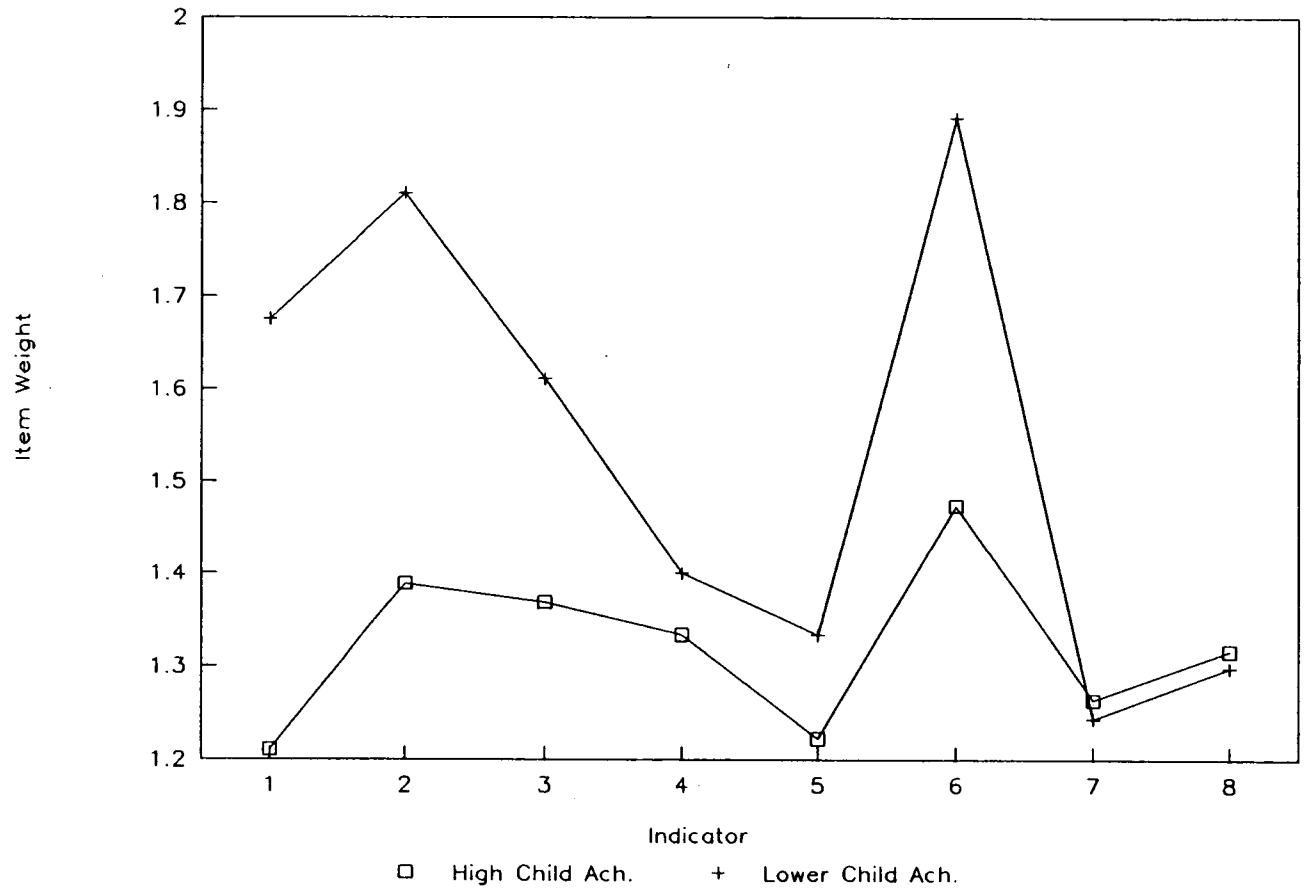


Figure 19. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Referral and Diagnosis Domain

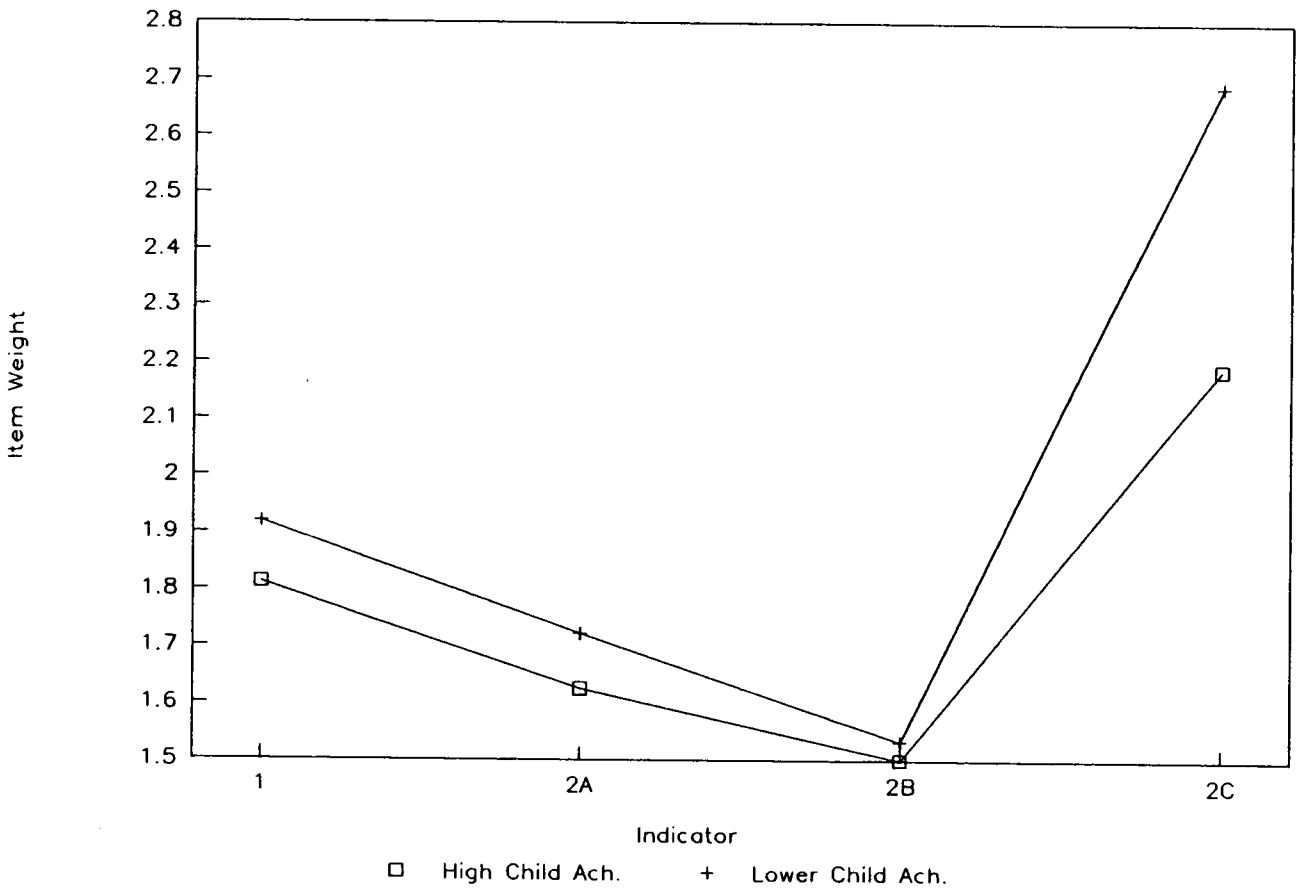


Figure 20. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Census Domain

Domain 5: Assessment and Individualized Family Service Plan

The weights assigned to the indicators in this domain varied from 1.2 on three indicators to 2.5 on one indicator. Twenty of the 24 indicators were more valued by the High Child Achievement group than the Lower Child Achievement group (see Figure 21 and Appendix G.5). The completion of ecological inventories (Item 6) and holding of multi-disciplinary team meetings at least twice per year (Item 18) were more valued by the Lower Child Achievement group. Greatest differences between the two groups were observed with the use of child progress data to assist in making communication modality decisions (Item 10), writing targeted skills as behavioral objectives in the IFSP (Item 14), and involving LEA personnel in all multi-disciplinary team meetings (Item 15), all of which were more valued by the High Child Achievement group.

Domain 6: Parent Advisor Program Implementation

Responses of the two groups to the items in this domain can be seen in Figure 22 (see also Appendix G.6). All items in this domain except Item 3, the writing of weekly lesson plans which are forwarded to the supervisor for analysis, were highly valued, with weights of less than 1.4 assigned by both groups. The Lower Child Achievement group placed more value on lesson plans (Item 3) than did the High Child Achievement

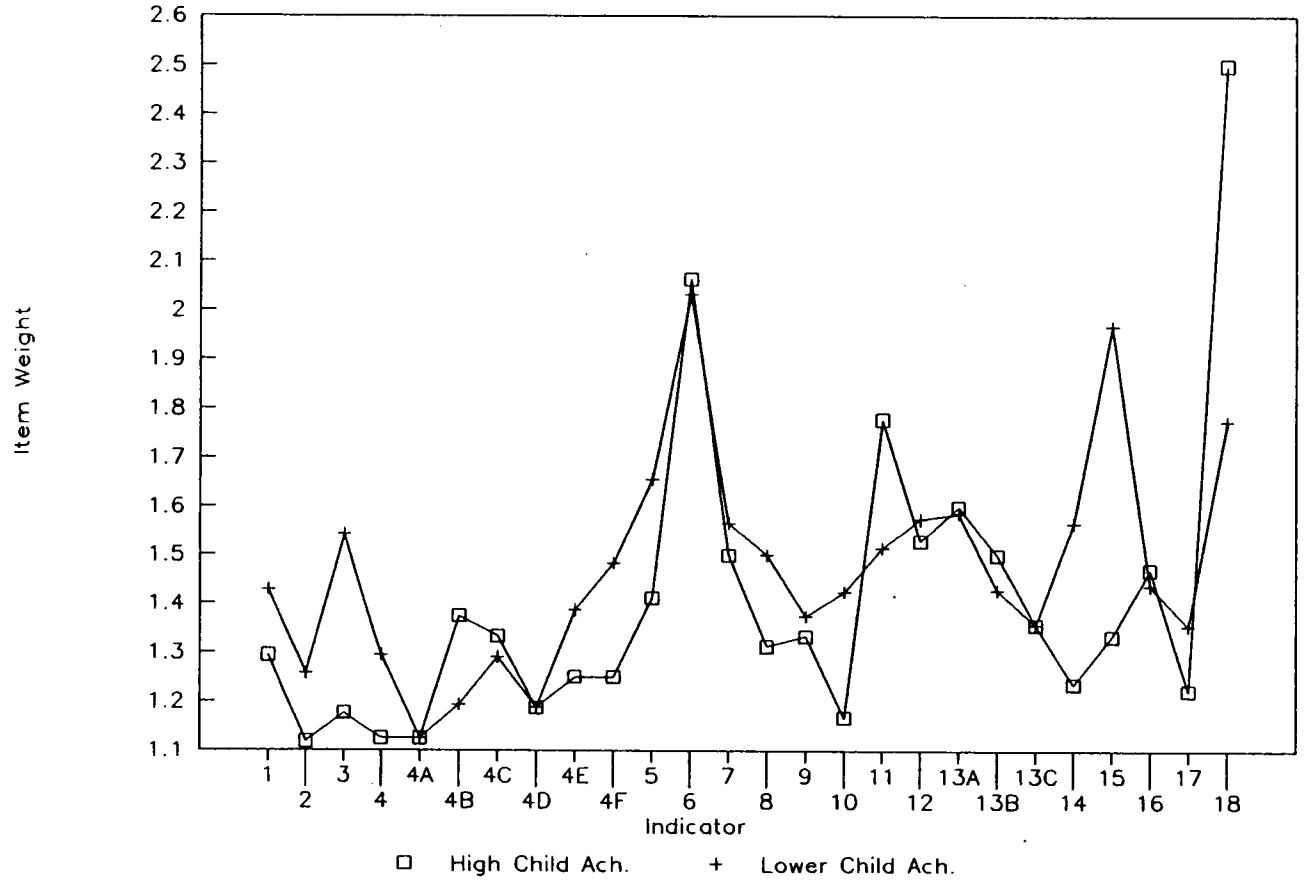


Figure 21. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Assessment and IFSP Domain

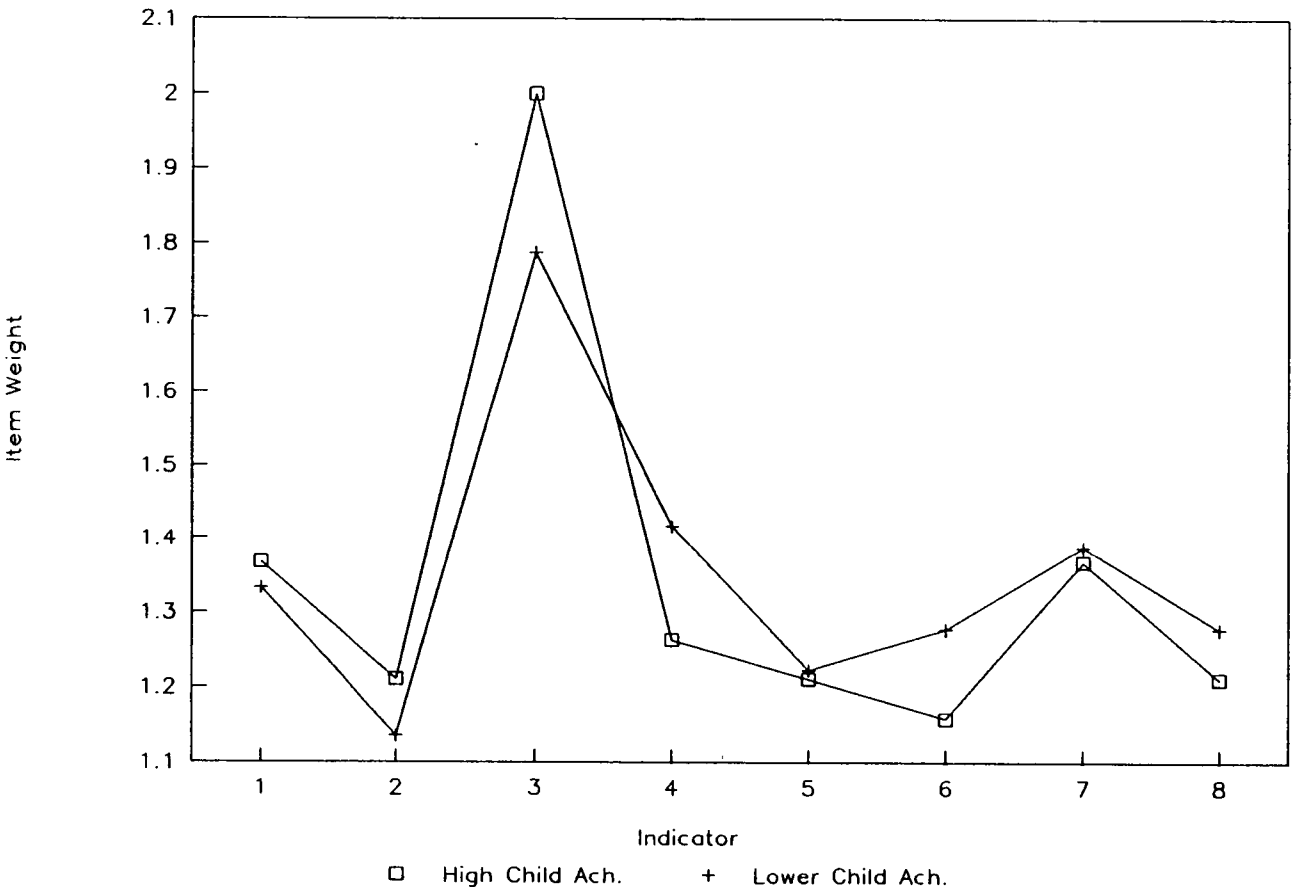


Figure 22. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Parent Advisor Program Implementation Domain

group. The High Child Achievement group placed more value on involving the parents in all aspects of the program (Item 8).

Domain 7: Staff Recruitment and Selection

The High Child Achievement group assigned lower item weights to 10 of the 12 indicators in this domain, as can be seen in Figure 23 (see also Appendix G.7). The greatest differences were on Items 4, 5, 6, 7, and 9, where the High Child Achievement group placed more value on contact with University programs (Item 4), clearly defined job descriptions (Item 5), a detailed employment application (Item 6), checking references (Item 7), and documentation of education (Item 9). These differences are noted, but must be considered carefully, remembering that the High Child Achievement sites tended to have more staff, most of whom were part-time.

Domain 8: Staff Development

Figure 24 shows the weights assigned by the two groups to the items in the staff development domain (see also Appendix G.8). The item weights within this domain varied from 1.1 to 2.5. Most of the High Child Achievement group weightings were in the 1.1 - 1.4 range. The High Child Achievement group assigned more valued item weights to 19 of the 21 items in this domain. Only on Items 14 and 15, which

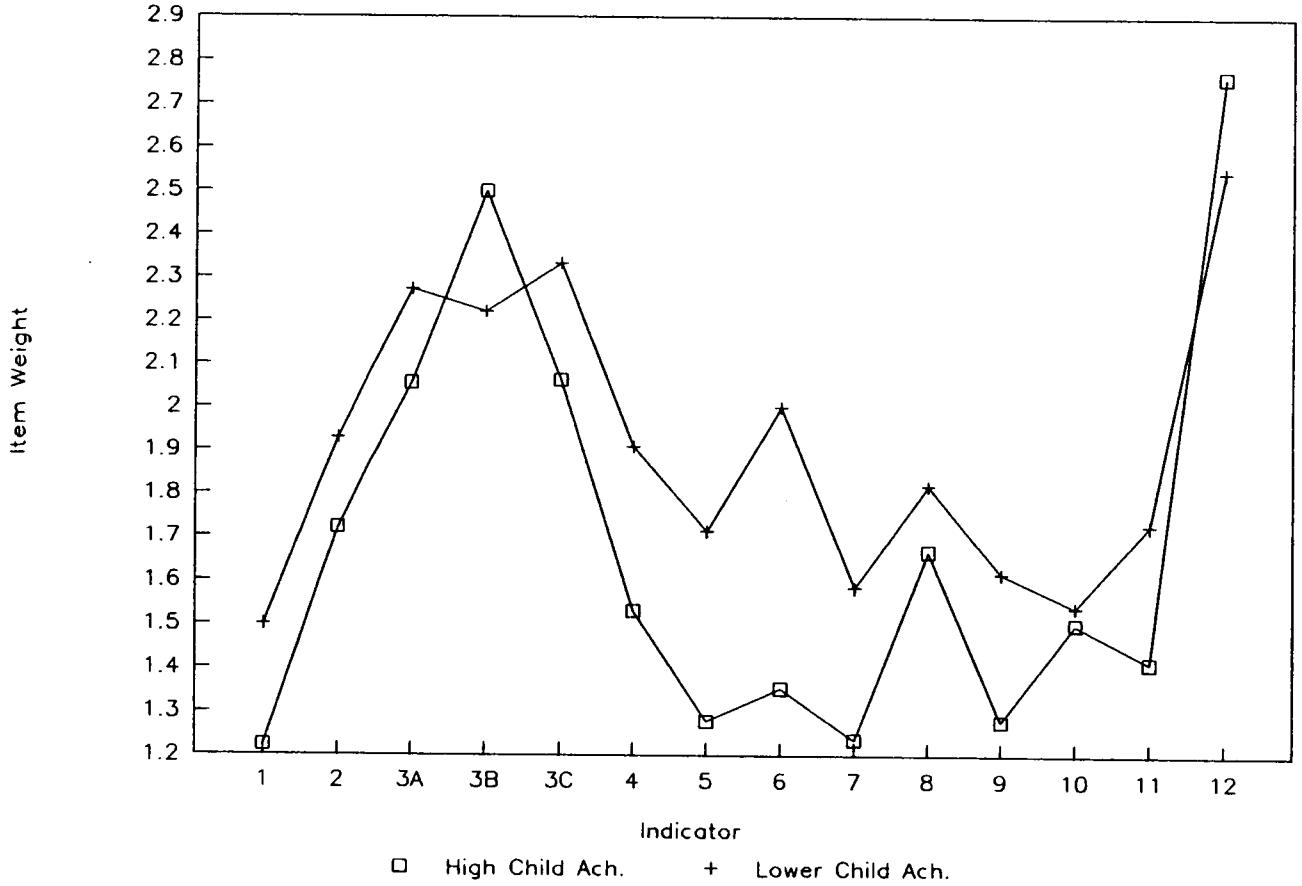


Figure 23. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Staff Recruitment and Selection Domain

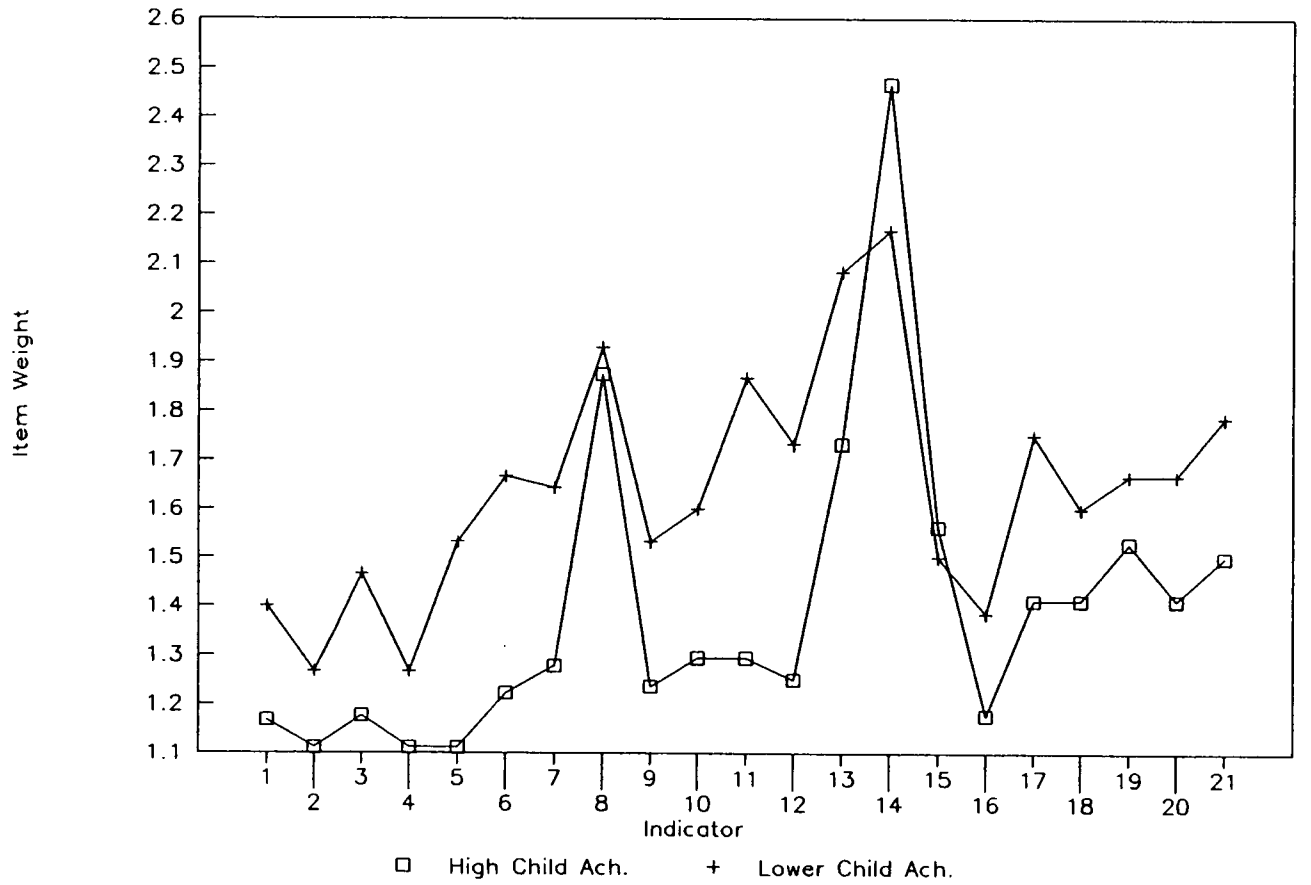


Figure 24. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Staff Development Domain

relate to the level of staff input considered when training is planned, were lower item weights assigned by the Lower Child Achievement group. The High Child Achievement group highly valued the training of staff to appropriately utilize assessment instruments (Item 1), the development of interactional / interpersonal skills needed to communicate with families (Item 2), understanding the rights of families (Item 3), planning and implementing the IFSP (Item 4), record-keeping (Item 5), and having a collegial atmosphere (Item 16). Indicators 9 -12, which deal with initial training of staff, were also highly valued by the High Child Achievement group. The Lower Child Achievement group tended to value the same items, but their responses reflected less enthusiasm for the items than was seen from the High Child Achievement group. The greatest single item difference was seen in the responses to Indicator 11, the offering of training at times and locations which allowed potential staff to participate. This, most likely, was a reflection of the fact that High Child Achievement group sites tended to employ large numbers of part-time staff, many of whom might not be available during "normal" work hours.

Domain 9: Staff Supervision

Great disparities existed in the item weights assigned by the 2 groups to the indicators in this domain, as can be seen

in Figure 25 (see also Appendix G.9). The range varies from 1.2 for the most valued item to 3.4 for the least valued item. The High Child Achievement group placed more value on 24 of the 28 indicators than the Lower Child Achievement group did. Seven of the items were assigned weights of less than 1.4 by the High Child Achievement group:

Item 1 - Supervision of parent advisors by a person knowledgeable of the curriculum and home intervention.

Item 3 - Giving the case manager/supervisor responsibility for all families in a targeted area, then holding that person responsible for seeing that services are rendered.

Item 15 - The case manager/supervisor making home visits with new parent advisors as frequently as necessary to insure that quality services are being rendered.

Item 16 - Clearly defined written duties for parent advisors.

Item 17 - Having the job duties clearly explained by the supervisor to the parent advisor.

Item 18 - Having the supervisor hold parent advisors accountable.

Item 19 - Supervisors giving parent advisors feedback on their progress via periodic review of performance.

High Child Achievement sites also placed great value on parent perceptions of parent advisor performance (Item 21), and on sharing this information with the parent advisor (Item 22).

Most of the Lower Child Achievement group weights clustered in the 2.0 - 2.6 range. Items 24, 25, and 26, which related to insuring that reported visits were actually made, received item weightings in the 3.2 - 3.5 range from the Lower Child Achievement group. Clearly, the supervision issues

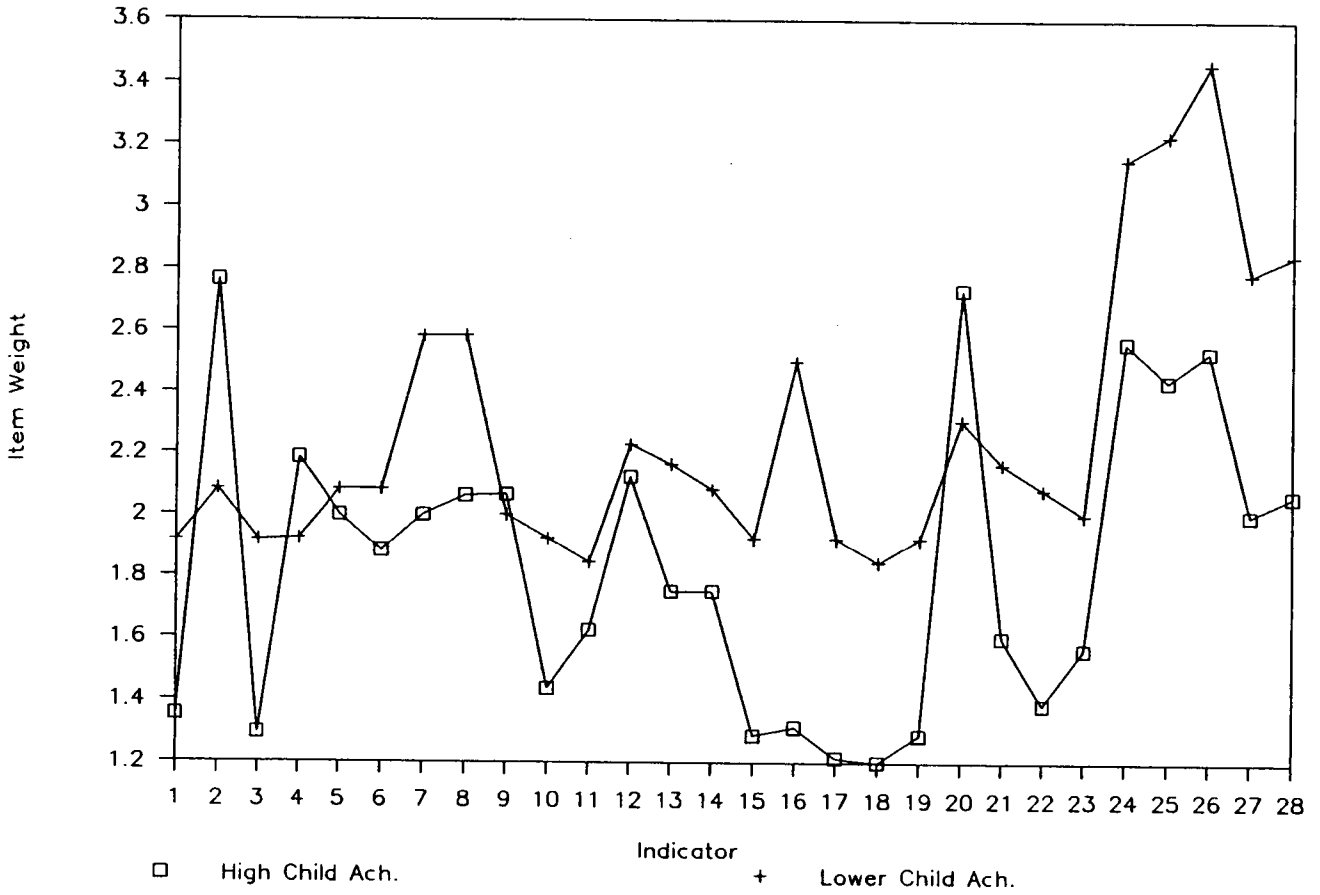


Figure 25. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Staff Supervision Domain

raised in the Home-Based Program Evaluation Instrument are more important to the High Child Achievement group than to the Lower Child Achievement group. While differences in numbers of staff and the size of the geographic region served may account for some of these differences, the data suggest that High Child Achievement sites view effective supervision as a much more critical component of quality home-based programming than the Lower Child Achievement sites do.

Domain 10: Funding and financial Management

Average responses to the items in this domain can be seen in Figure 26, which shows that High Child Achievement sites placed greater value on 19 of the 20 items (see also Appendix G.10). Assigned weights within the domain varied from less than 1.1 for the most valued item to 2.2 for the least valued item. The item of greatest importance to the High Child Achievement sites was the management of funds throughout the year so that service interruptions could be avoided (Item 11). This may be related to the high dependence on part-time staff. Programs rarely cut back full-time staff during the year, but contract funds can be depleted and create service interruptions if not managed carefully. The items most valued by the Lower Child Achievement sites related to the provision of adequate funding to purchase support services,

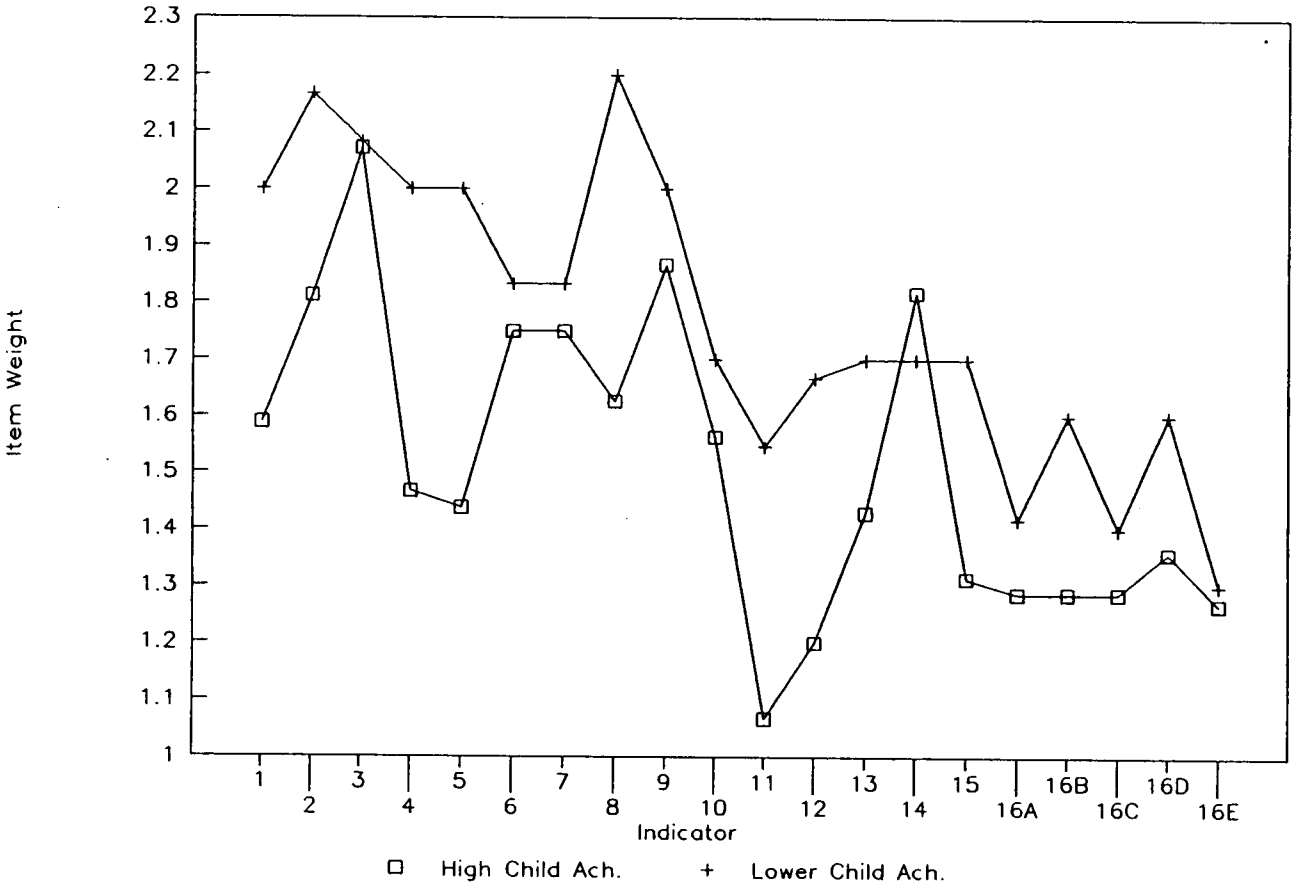


Figure 26. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Funding and Financial Management Domain

particularly physical therapy (Item 16A), vision services (Item 16C), and audiological services (Item 16E).

The weighting of Items 1, 2, 4, and 5, which dealt with project impact information and improvement plans being developed and submitted to funding authorities in a timely manner, may have been perceived as more important for the High Child Achievement sites because of their heavy dependence on contract staff.

Domain 11: Support Services

As can be seen in Figure 27, all of the items in this domain were weighted as more valued by the High Child Achievement sites (see also Appendix G.11). The range of weights assigned within the domain varied from 1.2 to 2.5. The item most valued in the domain was Item 6, the encouragement of support service providers to participate in multi-disciplinary team meetings. High Child Achievement sites placed more value on identifying support service providers (Items 2a-f), on insuring that parent advisors understood how to access those services (Item 3), and were using them appropriately (Item 4). Related items highly valued by High Child Achievement sites were: insuring that support service providers understood how their services related to the child's overall program (Item 5), and providing training for support service staff (Item 12). High Child

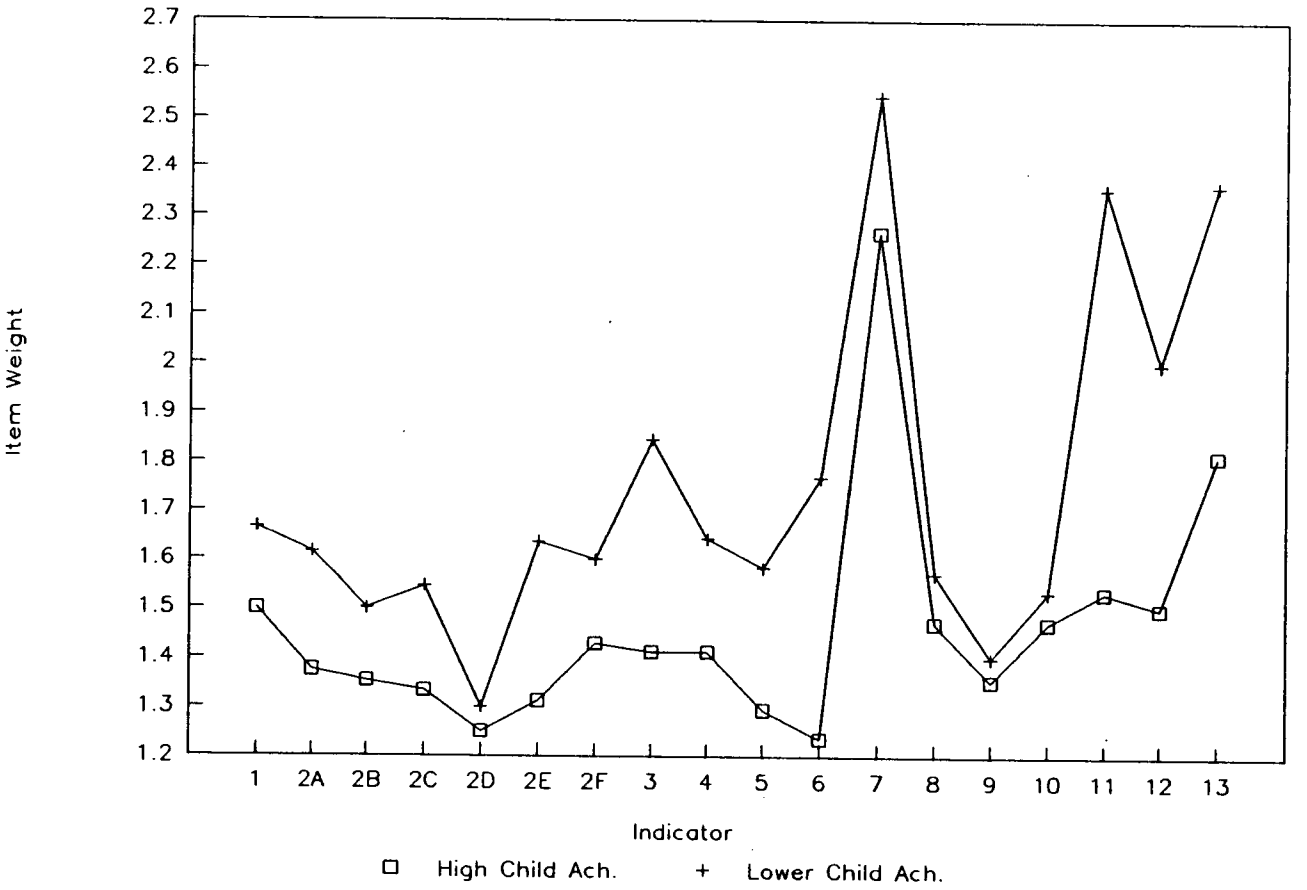


Figure 27. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Support Services Domain

Achievement sites also placed greater emphasis on parent support groups (Item 11).

The Lower Child Achievement sites placed greatest value on having support services available, particularly audiological services (Item 2D). This group also highly valued efforts aimed at helping parents become cooperative, facilitating child advocates (Item 9).

Domain 12: Transitioning From Home-Based to Center-Based Program

Figure 28 shows the average weights assigned by the two groups to the transition items (see also Appendix G.12). With the exception of the weighting assigned by the Lower Child Achievement group to Item 11, insuring that parents sense closure after their child has moved into a new program, all item weights for both groups fell below 1.7, indicating that all were highly valued. Lower mean scores were assigned by the High Child Achievement group to 10 of the 11 indicators within the domain, though the difference in assigned weights was slight on three indicators. All items were assigned weights of less than 1.6 by the High Child Achievement group. The greatest differences in assigned weights were observed on Items 1 and 2, which concern insuring that parent advisors were knowledgeable of all center-based programs in their area; Item 8, helping parents know what to expect from the new

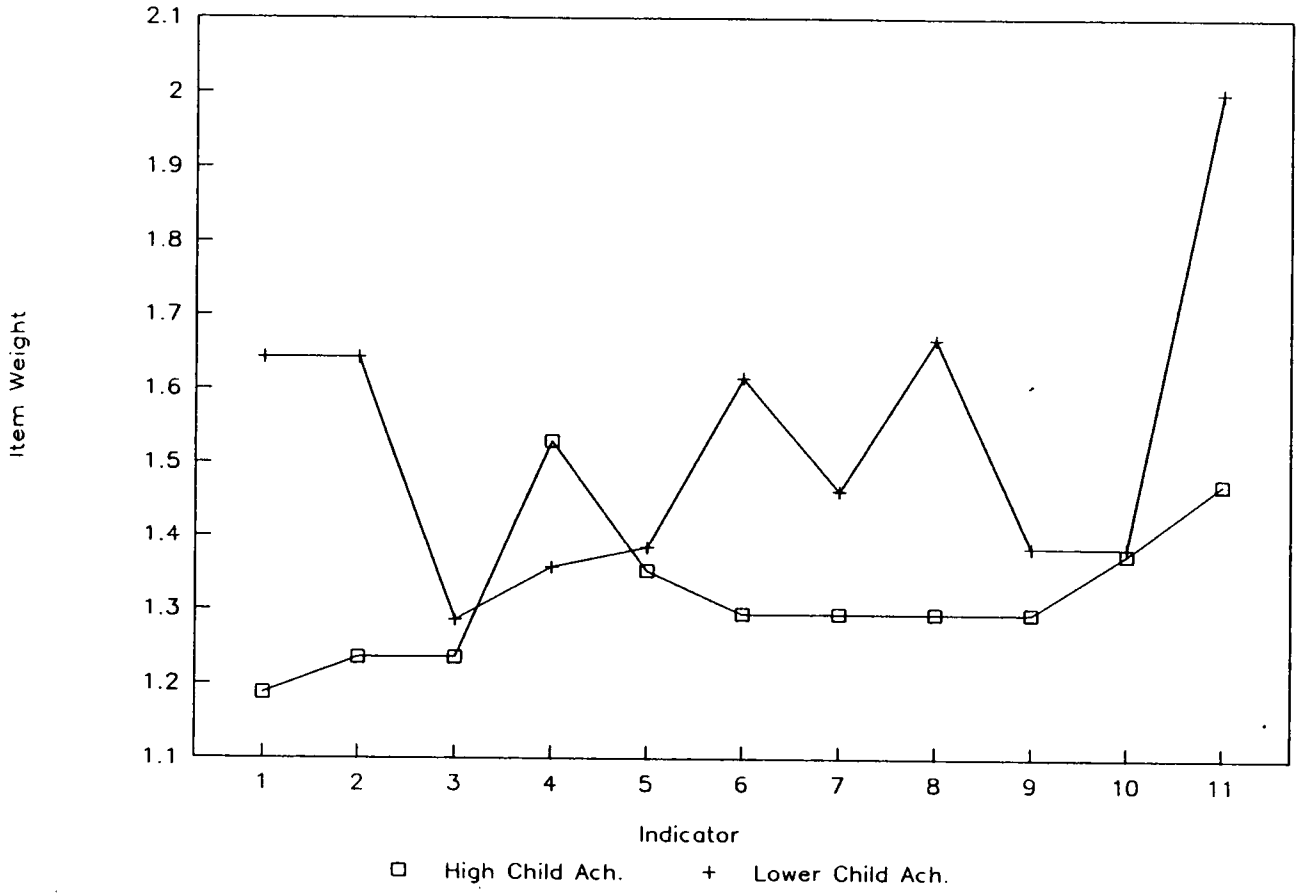


Figure 28. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Transitioning from Home-Based to Center-Based Program Domain

program; and Item 11, insuring that parents sense closure after the child has been transitioned into the new program.

Domain 13: Materials and Equipment Lending Library

Figure 29 shows the mean item weights assigned by the two groups to the indicators in the materials/equipment lending library domain (see also Appendix G.13). Item weights in this domain varied from 1.2 to 2.0. All items except the one dealing with the hearing aid loaner bank (Item 2) were weighted as more important by the High Child Achievement group. This group placed greatest value on having books, pamphlets, video and audio materials to loan to parents and professionals (Item 3), and on control procedures for these items (Item 4). These items were also highly valued by the Lower Child Achievement group, who assigned item weights of approximately 1.6 to each. The greatest difference in weights was on Item 6, parents and professionals utilizing the materials at appropriate rates, which was valued much more by the High Child Achievement group.

Domain 14: Measurements of Achievement/Satisfaction

Figure 30 shows the item weights assigned by the two groups to the items in this domain (see also Appendix G.14). Item weights within the domain varied from 1.35 for the most

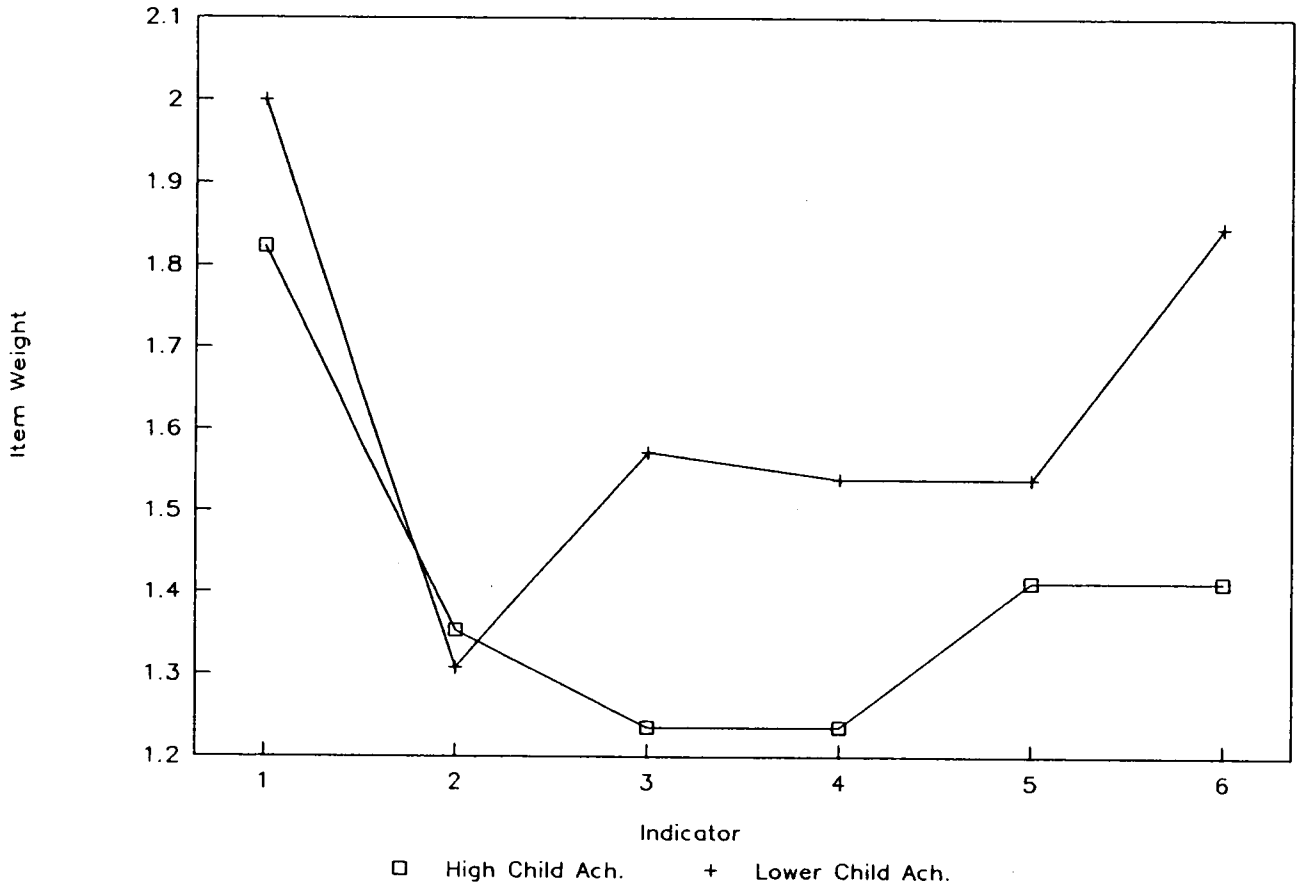


Figure 29. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Materials and Equipment Lending Library Domain

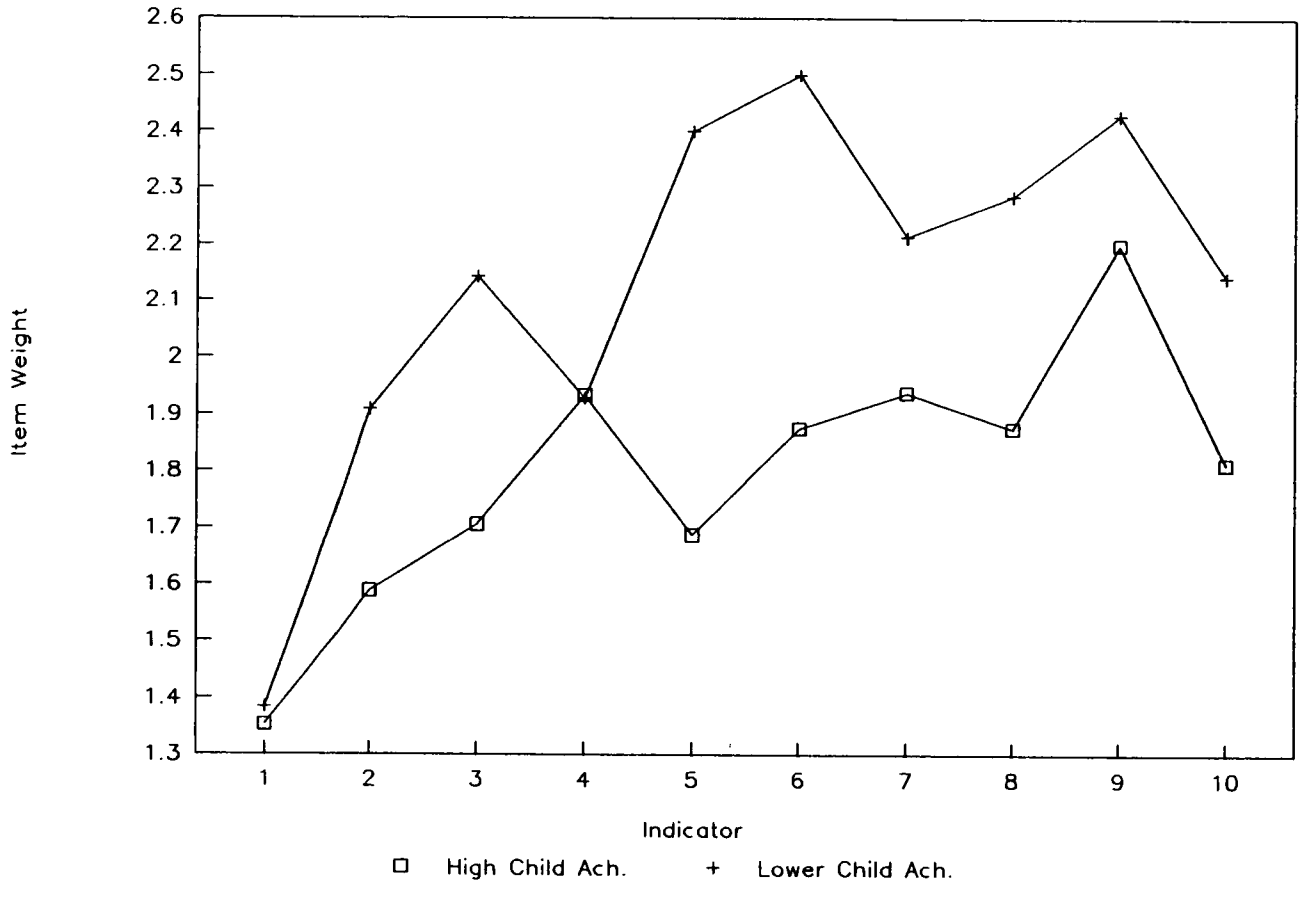


Figure 30. Average Item Weights for High Child Achievement and Lower Child Achievement Groups Measurements of Achievement/Satisfaction Domain

valued item, to 2.5 for the least valued item. On nine of the 10 items in this domain, lower means were assigned by the High Child Achievement group. Both groups placed strong emphasis on giving staff an opportunity to voice concerns and make recommendations (Indicator 1). Both groups placed similar emphasis on the analysis of child and family progress data on a parent advisor by parent advisor basis to insure that program quality is maintained by all staff (Item 4). High Child Achievement programs placed greater value on the analysis of home visit completion rates (Item 5) than the Lower Child Achievement sites did. High Child Achievement sites also assigned greater value to parent surveys to elicit satisfaction with the program.

Other Measures

In addition to asking each site to weight each item, each was also asked to specify whether that particular item was being implemented by their program. Figure 31 shows the percentage of items in each domain which were reportedly being implemented by the two groups. This graph differs from all of the others in that the Y-axis depicts the percentage of implemented items per domain; thus, the higher the score, the greater the number of implemented program quality indicators per domain. As can be seen, reported implementation rates varied greatly from domain to domain. The High Child

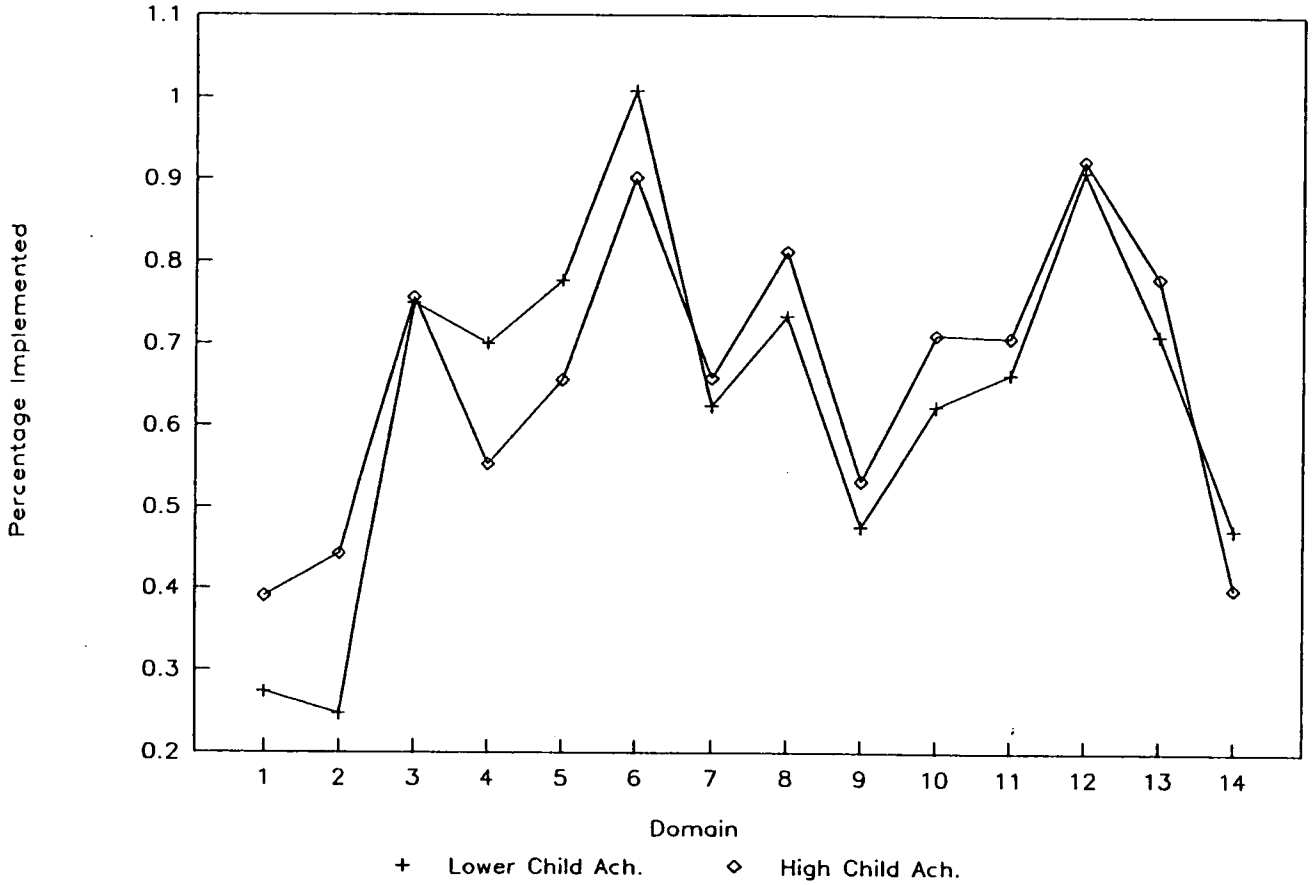


Figure 31. Percentage of Items Implemented by Domain for High Child Achievement and Lower Child Achievement Groups

Achievement sites reported higher rates of program quality indicator implementation in the following 10 domains:

Public Awareness/Child Find
Screening
Referral and Diagnosis
Staff Recruitment and Selection
Staff Development
Staff Supervision
Funding and Financial Management
Support Services
Transition from Home-Based to Center-Based Programs
Materials and Equipment Lending Library

The Lower Child Achievement group reported higher implementation rates for the following 4 domains:

Census
Assessment and Individualized Family Service Plan
Parent Advisor Program Implementation
Measurements of Achievement/Satisfaction

The trend observed from these data is that High Child Achievement group sites tended to be engaging in more of the activities which were related to program quality than the Lower Child Achievement sites were.

A trend reported in the Other Measures data presented in relation to research question one was that programs tended to place more value on the items which were being implemented by that program (see Figure 16). Figure 32 shows the average weight assigned by the High Child Achievement group and the Lower Child Achievement group to the implemented items in each domain. In 13 of the 14 domains, the High Child Achievement group assigned more value to the indicators of program quality it was implementing than the Lower Child Achievement group did. Only in the screening domain did the Lower Child

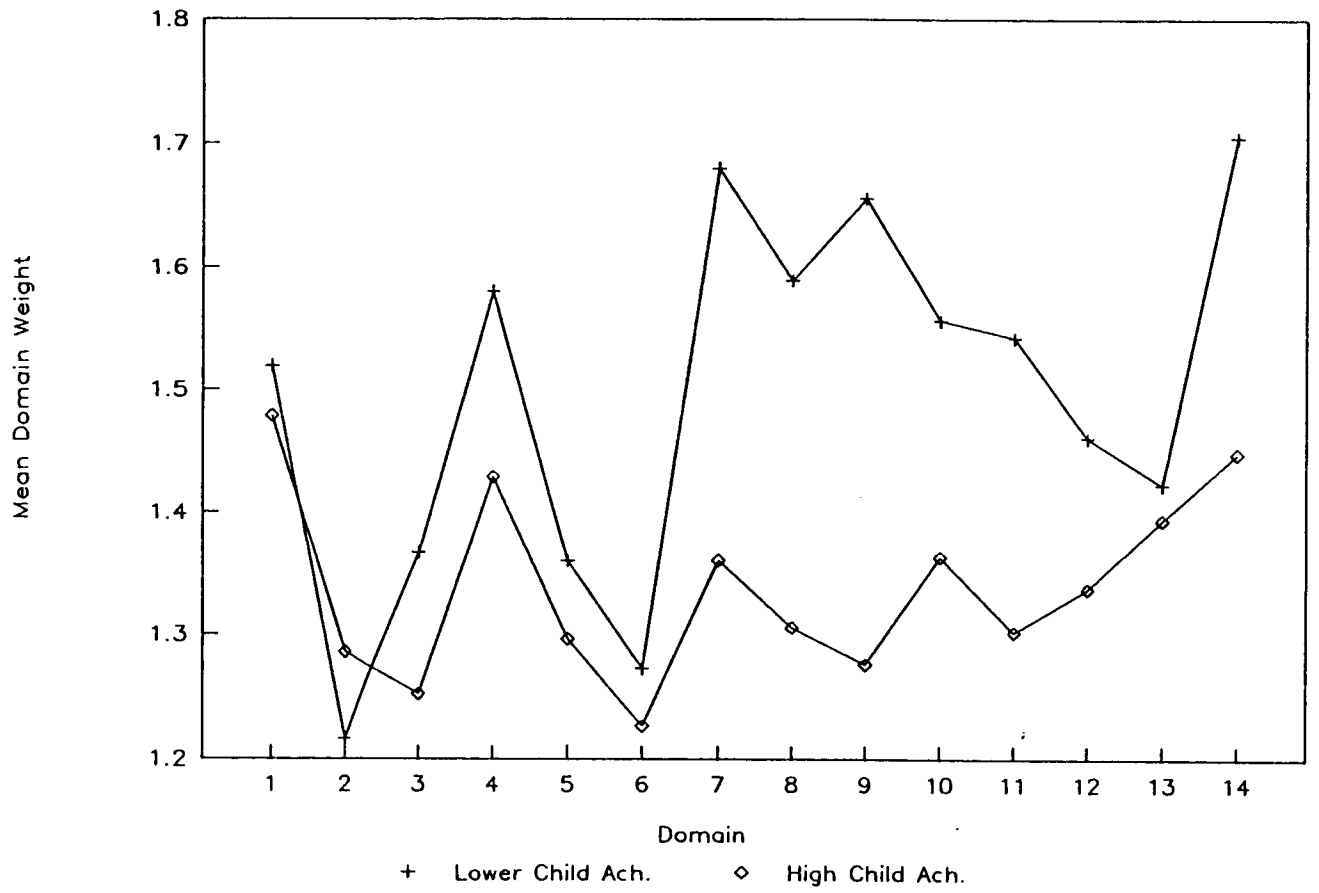


Figure 32. Average Weight of Implemented Items by Domain for High Child Achievement and Lower Child Achievement Groups

Achievement group assign more significance to the items it was implementing than the High Child Achievement group did.

An analysis of item weightings by group revealed that the High Child Achievement group placed more value on the majority of the items when compared to the Lower Child Achievement group. Of the 222 items in the instrument, the High Child Achievement group weighted 186 items as more important than did the Lower Child Achievement group, in contrast with only 33 items (3 items weighted the same) which were weighted as more important by the Lower Child Achievement group.

Summary of Information Related to Research Question Two

In response to research question two, it appears that the answer is "yes". Directors of programs demonstrating high child achievement perceive certain indicators of program quality as more important than do the directors of programs producing less notable child progress. In fact, it appears that they consider virtually all items as more important than do the directors of less successful programs.

The demographic differences in the two groups which were noted earlier may explain some of the variances between the two groups; however, attributing all the observed variances to demographic dissimilarities does not seem appropriate in light of the weight of the evidence. For example, one would expect sites with more staff to be more involved with supervision

issues. On the other hand, one would also expect to see programs which were having a greater impact on children placing more emphasis on hiring, training, and supervising staff. One would expect to find larger numbers of children being served by sites which were responsible for larger geographic areas. Conversely, one would also expect to see larger numbers of children being served by programs which place greater emphasis on child find and screening activities. Further research will be necessary before these issues can be clarified and resolved. The fact that the High Child Achievement group sites placed more value on almost all of the program quality indicators and were implementing a higher percentage of the indicators, leads one to suspect that these sites tended to put more emphasis on quality throughout their programs. This could account for some of the differences observed in numbers of children served, in the value associated with staff-related issues such as recruitment, development, and supervision, and in the achievement levels of the children who were served.

CHAPTER V

SUMMARY, CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

Introduction

This chapter contains a summary of the study and the conclusions drawn from the study, along with a discussion of the findings. Recommendations for using the validated, Home-Based Program Evaluation Instrument and for further research are also included. The chapter is organized into six sections. A summary of the study is presented in section one. The findings are summarized in section two. Conclusions are presented in section three. A discussion of the findings and conclusions follows in section four. Section five contains suggestions for utilizing the Home-Based Program Evaluation Instrument. The final section contains recommendations for further research.

Summary of the Study

The passage of Public Law 99-457 altered the population categories for whom special education and related services had to be provided. Part B of Public Law 99-457 mandated educational services to all handicapped children ages 3-5 by

July, 1991. Part H of Public Law 99-457 went even further. Section 671 stated:

> Congress finds an urgent and substantial need to enhance the development of handicapped infants and toddlers and minimize their potential for developmental delay; reduce the education costs to our society, including our schools; minimize the likelihood of institutionalization; and enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps.
>
> It is therefore the policy of the United States to provide financial assistance to states to develop and implement a statewide, comprehensive, coordinated, interdisciplinary program of early intervention services for handicapped infants and toddlers and their families; facilitate coordinat8ion of payments for early intervention services from various public and private sources; and enhance the capacity to provide quality early intervention services and expand and improve existing services.

In support of its findings and policy, Congress funded the Part H grant program enabling States to provide early intervention services to birth through two year old handicapped children and their families. Although Part H was discretionary, all States elected to participate.

Because of the age categories for whom services are targeted and because of the family service plan mandated in the law, many of the programs being planned nationwide to meet the needs of birth through five year old handicapped children will be delivering services in the home. A thorough search of the literature failed to reveal an instrument containing clear, validated, weighted items identifying best practices for delivering home-based services to young handicapped children and their families. In the absence of such an

instrument, program planners, developers, and supervisors lacked the information needed for making meaningful decisions related to establishing, implementing, and improving services to young handicapped children and their families.

The purpose of this study was to validate a program evaluation and program development instrument containing the essential elements or most promising practices related to identifying and serving young handicapped children utilizing a home-based service delivery model. It was intended to result in a useful, concise tool that would be advantageous to both program planners and those wishing to enhance an existing home-based, early childhood special education program, by incorporating those elements which had been deemed to be key components of quality, in-home services. The following research questions guided the study:

1. What are the program quality indicators for which there is national consensus among directors of home-based early intervention programs serving hearing impaired children?
2. Do those program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?

To collect the data, the Home-Based Program Evaluation Instrument, a tool containing 222 stimulus statements which had been drawn from early childhood special education literature or suggested by a panel of experts in home-based

early childhood special education, and which were perceived to be related to the provision of quality home-based services, was used as a survey tool. It was mailed to all of the United States replication sites of Project SKI*HI, a nationally validated home intervention program for hearing impaired young children, to ascertain the opinions of their program supervisors. A total of 79 useable surveys were returned, representing a 43 percent response rate. The responses of all persons completing surveys were utilized in addressing research question one. In order to address question two, the respondents were divided into three categories: a High Child Achievement group; a Lower Child Achievement group; and a No Child Achievement Data Reported group. Respondents were assigned to the first two groups based on the results of program data on achievement submitted to Project SKI*HI. Of the 57 sites submitting data to Project SKI*HI in 1989-90, 40 completed surveys, yielding a 71 % response rate from this subsample of the population. The responses of the High Child Achievement and Lower Child Achievement groups provided the information for addressing research question two.

Data were coded and analyzed, primarily using means and standard deviations computed via Lotus 1-2-3 software.

Summary of the Findings

Research Question Number One: What are the program quality indicators for which there is national consensus among directors of home-based early intervention programs serving hearing impaired children?

Prior to mailing the surveys to the program supervisors, a criterion was established for determining the item weight which had to be met in order for the item to be considered valid (3.50 or below). All 222 indicators in the Home-Based Program Evaluation Instrument (see Appendix E) were sufficiently valued by the program supervisors to be considered valid indicators of program quality for home-based programs, i. e., all were assigned mean weights of 3.5 or below. The strength of each indicator's relationship to program quality is reflected in the weight assigned to it--the lower the weight, the more the item was related to program quality. The utility of an indicator may vary from program to program, based on factors such as the structure of the program, whether the staff employed are full-time or part-time, the size of the geographic area served, and the handicapping conditions presented by the children for whom services are planned. The 14 domains into which the indicators were divided and a brief summary of the most valued indicators in each domain follows:

Domain 1: Public Awareness/Child Find

The development and dissemination of a program brochure targeting "at risk" clinics, public health departments, pediatricians' and general practitioners' offices, and hospital nurseries.

Domain 2: Screening

The development and implementation of hospital screening programs, especially in intensive care nurseries.

Domain 3: Referral and Diagnosis

Identifying qualified individuals to perform evaluations covering all areas of suspected disability.

Domain 4: Census

Keeping public school systems and the lead agency for implementing P. L. 99-457 informed of all handicapped children.

Domain 5: Assessment and Individualized Family Service Plan

Assessing present levels of performance in all developmental areas and addressing all deficit areas in the IFSP.

Domain 6: Parent Advisor Program Implementation

Equipping parents to help their child reach targeted goals, matching the instruction to the learning style of the parent, and involving the parent in all decisions affecting their child.

Domain 7: Staff Recruitment and Selection

Having a plan which specifies the acceptable credentials of those to be considered for home-based service provider positions; thoroughly doing background and reference checks.

Domain 8: Staff Development

Equipping staff with the skills needed to effectively implement an individualized program, to match instruction to the learning styles of the parents, and to demonstrate appreciation for the rights of parents and their handicapped children.

Domain 9: Staff Supervision

Placing the program under the supervision of a person who understands home-based instruction, is willing to be available to problem solve on a case by case basis with staff, and who holds staff accountable for child and family outcomes.

Domain 10: Funding and Financial Management

Adequate funds for support services such as PT/OT, audiological, psychological, and vision services; management of funds so that service interruptions are avoided.

Domain 11: Support Services

Giving parents both the knowledge and the interpersonal skills needed to access the support services their child needs; helping support service providers understand their

discipline's role in relation to the child's total program.

Domain 12: Transition from Home-Based to Center-Based Program

Thoroughly assessing the child's present levels in all developmental areas prior to transitioning; insuring that the new program addresses all deficit areas.

Domain 13: Materials and Equipment Lending Library

Making printed and audio-visual materials available to both parents and professionals having contact with the child.

Domain 14: Measurements of Achievement/Satisfaction

Gleaning input from program staff concerning ways of enhancing the program policies and procedures; analyzing child and family progress in relation to the staff members providing the service in order to insure consistent provision of high quality services.

Research Question Number Two: Do those program directors whose programs register high child achievement perceive certain items as more indicative of program quality than do directors of programs which have lower child achievement?

Careful analysis of the demographic data submitted by each program revealed that the High Child Achievement sites and the Lower Child Achievement sites differed in several respects. High Child Achievement sites had been in existence

an average of 2 years longer, served an average of 48 more children, relied more heavily on part-time parent advisors, and were more likely to have statewide responsibility. All differences found in the item weights assigned by the two groups had to be considered with these demographic variations in mind. Differences may have existed in the ethnic, racial, or gender characteristics of the students served at different sites; however, no attempt was made to control for these variables.

When compared to the Lower Child Achievement group, the High Child Achievement programs placed more value on the majority of the items . Of the 222 items in the Home-Based Program Evaluation Instrument, the High Child Achievement group weighted 186 items as more important, in contrast with only 33 items (3 items weighted the same) which were weighted as more important by the Lower Child Achievement group. The greatest differences in weighting were observed in the Staff Recruitment and Selection, Staff Development, and Staff Supervision domains.

A general trend observed in the data was that the item weight assigned related to whether the particular item was being implemented by the program. Program supervisors tended to assign more importance to the items which were being implemented in their programs. An analysis of the weights assigned to items being implemented by both the High Child Achievement and the Lower Child Achievement programs revealed

that High Child Achievement programs assigned more significance to the items in 13 of the 14 domains.

High Child Achievement programs were also more likely to be implementing more of the program quality indicators than the Lower Child Achievement programs. Higher implementation percentages were reported by the High Child Achievement group in 10 of the 14 domains covered by the Home-Based Program Evaluation Instrument.

High Child Achievement program supervisors tended to attach great value to most of the program quality indicators. One hundred thirty of the program quality indicators were assigned item weights of 1.5 or less, while only 30 were assigned weights of 2.0 or greater. Lower Child Achievement program supervisors tended to highly value the items, too, but to a smaller degree. They weighted 63 items at 1.5 or less and 63 items at 2.0 or greater.

To sum up, directors of programs demonstrating high child achievement perceived certain indicators of program quality as more important than did directors of programs with lower child achievement. While demographic differences may account for some of the observed differences, the weight of the evidence seems to indicate that directors of programs producing high child achievement results place more importance to almost all aspects of program quality.

Conclusions

This study was initiated in order to identify the indicators of program quality for home-based, early childhood, special education programs, and to assign weights to those indicators so that program planners and those who supervise home-based programs would have a tool which could be used to evaluate present program practices and to guide future program development. In addition, the study was designed to compare the perceptions of supervisors of high child achievement programs and lower child achievement programs to determine whether differences existed in the relative value each attached to the program quality indicators. Based on the analysis of the data and the findings which emerged, the following conclusions can reasonably be drawn:

1. There was consensus among the supervisors of Project SKI*HI replication sites that the items included in the Home-Based Program Evaluation Instrument were, in fact, valid indicators of program quality.
2. Although all items were sufficiently valued by the respondents for inclusion in the instrument, some were considered more important indicators of program quality than others.
3. The items in the Parent Advisor Program Implementation domain were weighted consistently lower than those in the

other domains, indicating consensus among program supervisors that the services which were delivered in the home during the weekly home visit were most important to overall program quality.

4. The item weightings within domains, when ranked from low to high, can be viewed as rank ordered steps for future program enhancement.

5. Program supervisors tended to place more value on program quality indicators which were being implemented by their programs.

7. High Child Achievement program supervisors were more likely to more highly value the program quality indicators than the Lower Child Achievement program supervisors were.

8. High Child Achievement programs were more likely to be implementing more items from the Home-Based Program Evaluation Instrument than were being implemented by the Lower Child Achievement programs.

9. Even in regard to indicators being implemented by both the High Child Achievement and the Lower Child Achievement groups, High Child Achievement supervisors tended to assign item weights indicating that they placed more value on the items.

10. High Child Achievement program supervisors were more likely to value the program quality indicators in the Staff Recruitment and Selection, Staff Development, and

Staff Supervision domains than the supervisors of Lower Child Achievement program supervisors were.

11. High Child Achievement program supervisors tended to place high priority on all program quality indicators.

Discussion

Based on the findings and conclusions, it appears that the task which was undertaken, to validate an instrument containing program quality indicators which are statements of best practice for providing in-home services to young, handicapped children, has been accomplished. At the outset of this project, three types of validity were identified: content validity, criterion-related validity, and construct validity. At least two of these have been met, and the third has been partially addressed by the process which has been completed.

First, content validity, which concerns the scrutiny of an instrument to determine if it contains a representative sample of the behavior domains that it purports to measure, has been satisfied. This was done in the following ways:

1. The supervisors of all of the replication sites of a nationally validated home intervention program were asked to evaluate each item's relationship to home-based program quality by scrutinizing the item's content and assigning it a weight which reflected that person's perception of the item's importance.

2. Each person completing a survey was asked to review the wording of each item and make suggestions for clarification.
3. Each person was also asked to suggest new items which were not included in the instrument.

Each item was assigned the mean weight derived from the collective responses received from the program supervisors polled. All items met the criterion for inclusion in the instrument. Wording changes were suggested by four of the respondents. All recommended changes were in regard to the use of the term "case manager" in the Staff Supervision domain. These changes were noted and have been made. One new item was recommended. Since it was recommended by only one person and since there was no valid way of assigning it an item weight without sending it to a panel of experts to consider, it is being held for future development.

Second, criterion-related validity, which has to do with the effectiveness of an instrument in predicting an outcome in specified situations, has been addressed. This was done by using a second data source, the 1989-90 child achievement data from Project SKI*HI's national database, to stratify the respondents into three groups: the High Child Achievement group, the Lower Child Achievement group, and the No Data Reported group. It was assumed that if the instrument items met criterion-related validity, the program supervisors from the High Child Achievement group sites would rate the items as

more important than the Lower Child Achievement group. This, indeed, was demonstrated. The High Child Achievement programs assigned more valued item weights to 186 of the 222 items in the instrument.

Finally, construct validity, which is related to determining whether certain measures actually depict a specified conceptual idea, was at least partially addressed. Construct validity is usually determined by the accumulation of information over time from a variety of sources. The degree to which this research effort has satisfied construct validity will eventually be seen in the extent to which programs which adopt this instrument benefit from it. In this research effort, it was addressed by checking to see if the actual practices of the High Child Achievement group differed from those of the Lower Child Achievement group. It was posited that if the items in the instrument met construct validity, more of the program quality indicators would be being implemented by the High Child Achievement group than by the Lower Child Achievement group. This, too, was reported in the data, as High Child Achievement sites reported higher implementation rates on 10 of the 14 domains.

The ultimate test of the validity of this instrument can only be seen in the effect that its use has on the programs which decide to put it into practice. If it gives those charged with planning, developing and implementing home-based

programs the information they need to make meaningful decisions, it is valid.

Recommendations for Use

Data, findings, and conclusions presented in this study support the assertion that the items in the Home-Based Program Evaluation Instrument are valid indicators of program quality. What is needed at this point is for the instrument to be used by both established programs and new programs in order to determine how well it functions as a program evaluation tool and a program planning document. In order to use the instrument, program staff should:

1. Read each item in the Home-Based Program Evaluation Instrument and indicate whether their program is performing that particular program quality indicator.
2. Order the items in each domain which are not already being implemented, using the item means to determine which items are most important.
3. Formulate a program development plan using the most important items from each domain as targets.
4. Establish implementation time lines for those items which seem to hold the most potential for aiding their particular program.
5. Record progress toward implementing the program quality indicators.

Recommendations for Further Research

With the proliferation of home-based programs spawned by the implementation of P. L. 99-457, opportunities for research on the effectiveness of the Revised Home-Based Program Evaluation Instrument will be numerous. Suggested studies include the following:

1. A matched pairs study of sites using the same curriculum and serving similar student populations could be undertaken. Contrasting the outcomes observed in programs using the instrument with those not using it would provide a measure of its utility.
2. Surveys could be done of the opinions of supervisors of programs serving different populations of young, handicapped children in order to determine whether the instrument is of more value to programs serving certain disability groups than to others. Stratifying these data by student characteristics, such as race, ethnic background, and gender, would provide a test of the viability of the instrument for enhancing programs serving diverse student populations.
3. Some of the Lower Child Achievement sites could be encouraged to begin using the Home-Based Program Evaluation Instrument in order to see if meaningful changes in their programs emerge as a result of implementing the items in the instrument.

4. Further research needs to be done with the High Child Achievement sites to determine if factors other than those included on the Home-Based Program Evaluation Instrument can be found which identify reasons for the performance of these programs. Interviews with High Child Achievement site supervisors would be helpful to determine the factors which contribute to their high degree of enthusiasm for the various aspects of program quality.
5. Interviews with the staff of the Lower Child Achievement programs could be conducted to provide a more complete picture of the activities occurring at these sites.
6. Parents of children served by both the High Child Achievement and the Lower Child Achievement programs could be interviewed to determine whether differences exist in their perceptions of program effectiveness.
7. The academic backgrounds of program supervisors and parent advisors from the High Child Achievement and the Lower Child Achievement programs could be compared to determine whether differences exist in either the levels of education or the fields of study.
8. The data from High Child Achievement programs seemed to suggest that supervisors of High Child Achievement programs made everything a priority. Gathering data on the personality types of the supervisors of both High Child Achievement and Lower Child Achievement sites would

be quite interesting. These data might reveal that persons with certain personality traits were more likely to be found in leadership positions in more successful programs.

9. The Home-Based Program Evaluation Instrument needs to be updated and revalidated at least every 5 years in order to insure that the items maintain their salience. This could be accomplished by replicating the present study.

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APPENDICES

APPENDIX A

HOME-BASED PROGRAM EVALUATION INSTRUMENT INSTRUCTIONS

Introduction

The Home-Based Program Evaluation Instrument is a compilation of 228 program quality indicators gleaned form early childhood special education literature and input from a panel of 11 SKI*HI adoption site personnel. Three columns follow each item and are describe below.

Instructions

A. | YES | NO | Columns

The two columns labeled | YES | NO | at the end of each item are for you to use to record whether or not that particular indicator is being done by the SKI*HI program which you supervise. If the item is being done by your program, place a check (✓) in the "YES" column. If that item is not being done in your program, place a check a (✓) in the "NO" column. If you feel that your program is doing an exemplary job of implementing a particular indicator, place a plus (+) in the "YES" column.

B. | WEIGHT | Column

The final column is labeled |WEIGHT|. Please use the following plan to weight each item.

1. Read each program quality indicator.

2. Read the following statement to yourself: "This item relates to program quality or program effectiveness."

3. Rate each item using the following Likert-type scale:
   1 - Strongly Agree
   2 - Agree
   3 - Undecided, but probably Agree
   4 - Undecided, but probably Disagree
   5 - Disagree
   6 - Strongly Disagree

4. If you think of items that you would like to add to the instrument or if you have wording changes that you wish to recommend, add your suggestions on the back of the appropriate page and reference the item number.

5. Copy the completed instrument if you wish to use it to assist in pinpointing areas for future development.

6. Complete the attached data sheet so that I can contact you if I need to do so. I am interested in seeing if responses vary by program size, geographic region, etc.

7. Return the completed instrument and data sheet in the envelope provided.

Thank you for your cooperation and assistance.

Sincerely,

Don Thompson

Don Thompson

Public Awareness/Child Find

	YES	NO	WEIGHT
1. The agency has a written plan for promoting public awareness and child find in order to children residing within the agency's jurisdiction who are in need of early intervention services are identified.			
2. A brochure describing the agency's services has been developed.			
3. The brochure is being disseminated to all agencies/organizations serving infants and young children, including the following:			
a. day care centers			
b. public health departments			
c. pediatricians' and general practitioners' offices			
d. state departments of education			
e. state legislators			
f. school systems			
g. hospital nurseries			
h. college programs which train medical personnel			
i. "at risk" clinics			
4. Radio public service announcements (PSAs) have been developed.			
5. Radio PSAs have been disseminated to all radio stations in the agency's geographic region.			
6. Radio PSAs are updated and radio stations are sent new PSAs three or more times per year.			
7. A system for monitoring radio PSA use by each station has been developed and station managers are given positive feedback for airing the PSAs.			
8. A 24-hour call-in service has been established so that persons responding to PSAs can do so at any time.			
a. If yes, is it toll free?			
9. News release articles have been developed for newspaper distribution.			
10. Staff members have been trained on how to enlist newspaper support.			
11. Staff members are compensated for public service announcement activities (radio, TV, newspaper, health fairs).			
12. News articles regarding the agency's services appear at least annually in every newspaper in the agency's service delivery area.			
13. Television public service announcements (PSAs) have been developed:			
a) all stations in service delivery area have received copies.			
b) spotchecks are made to insure that PSAs are being aired.			
c) station managers are praised for airing the PSAs.			

	YES	NO	WEIGHT
14. The agency has developed the following materials for use at health fairs and organization conferences:			
a) video or slide program description	___	___	_____
b) posters	___	___	_____
c) scrapbook	___	___	_____
d) brochures	___	___	_____
15. The agency has a newsletter that is mailed at least quarterly to the following:			
a) parents of enrolled children	___	___	_____
b) hospital	___	___	_____
c) medical service providers (physicians, audiologists, PT/OTs, etc.)	___	___	_____
d) policy makers (legislators, local judges, state agency staff)	___	___	_____
e) school systems	___	___	_____
16. The agency provides speakers for the following:			
a) university medical school classes	___	___	_____
b) physicians/nurses professional associations	___	___	_____
c) civic organizations	___	___	_____
17. The agency encourages visits from personnel of other agencies which serve infants and young children.	___	___	_____

Screening

	YES	NO	WEIGHT
1. The state birth certificate application contains information about family history of impairment.	___	___	_____
2. A procedure has been established so that "at risk" indicators on the birth certificate are monitored and children who are "at risk" are being referred for screening.	___	___	_____
3. A directory of appropriate places to refer families of "at risk" children has been developed and disseminated.	___	___	_____
4. A follow-up system is used for families who fail to respond to the initial efforts to have their children brought for testing.	___	___	_____
5. Screening of children is provided at no cost to families.	___	___	_____
6. Hospital high risk screening procedures have been developed.	___	___	_____
7. Hospitals are following the screening procedures.	___	___	_____
8. Intensive care nursery babies are all screened for various handicapping conditions.	___	___	_____
9. Cribogram screenings are being conducted on all newborns in the service delivery area.	___	___	_____
10. Hospitals outside the service delivery area which may serve families within your service delivery area are included in your efforts to locate all impaired infants.	___	___	_____

Referral and Diagnosis

	YES	NO	WEIGHT
1. Procedures have been developed to clearly identify the path that agencies doing the screening of newborns must take in order to refer a child to your agency.			
2. A plan has been developed for determining which agencies understand how to refer a child to your agency?			
3. Regular contact is made with public and private agencies, including audiologists, physicians, etc., who have initial contact with handicapped children, to insure that they always remember to refer children.			
4. Contact is made within ten calendar days with the family of each child referred.			
5. Acknowledgements are made on all referrals.			
6. Those agencies/professionals who refer a child to your program are given ongoing information about the child referred.			
7. Initial diagnostic evaluations are performed by qualified individuals in order to confirm the child's sensory impairment/s.			
8. All areas of suspected impairment are examined by qualified diagnosticians.			

Census

	YES	NO	WEIGHT
1. An accurate census is maintained on all children in the agency's service delivery area.			
2. All appropriate individuals/agencies are notified, including the following:			
a. lead agency for implementing P. L. 99-457. (State Dept. of Education; Dept. of Public Health; Dept.of Human Resources, etc.)			
b. local school district where family resides.			
c. legislators			

Assessment and Individualized Family Service Plan

	YES	NO	WEIGHT
1. Written policies and procedures have been established and implemented to appropriately assess children who are suspected of needing early intervention services.			
2. All children enrolled have been determined eligible for services.			
3. Objective data gained from standardized instruments are being gathered on all children enrolled.			

	YES	NO	WEIGHT
4. An Individualized Family Service Plan (IFSP) has been developed with each family and includes the following mandated components:			
a. An objective assessment of the child's present levels of performance in physical development, cognition, speech and language skills, psychosocial development and self-help skills.			
b. The family's strengths and areas of need as they relate to the child's development.			
c. Child and family outcomes that are anticipated, along with criteria, timelines and procedures used for determining progress.			
d. The specific early intervention services needed to meet the unique child and family needs including frequency, intensity and method of service delivery.			
e. The designation of a case manager responsible for implementing the IFSP and coordinating with other agencies and individuals.			
f. A plan for transitioning the child from the infant and toddler (0-2) programs of Part H into the services provided to older children under Part B.			
5. The multi-disciplinary team that is called to develop the IFSP includes individuals who provide related services.			
6. Ecological inventories are used to determine the demands of the current environments on the child (home, school, etc.) as well as those of the next educational placement. (An ecological inventory is an identification of specific skills needed for minimum functioning in various environments, including the home, workplace, leisure/recreation, and community. Expectations are based on the skills of non-handicapped age peers. Specific goals are then established, such as "To dress without assistance." The process for reaching this goal is then task analyzed and a discrepancy model is used for teaching any missing steps.)			
7. Data from the child's formal assessments and ecological inventories are considered in setting IFSP goals.			
8. Child and family progress are formally reassessed at least quarterly, or in compliance with state guidelines.			
9. Parents are apprised in writing of child progress in compliance with state guidelines and have all assessment results explained soon after data are gathered.			
10. Child progress data are used in making decisions such as that of determining communication modality.			
11. Child staffings are held at least semi-annually.			
12. Child progress data are kept and aggregated for determining program impact.			

	YES	NO	WEIGHT
13. Training needs are prioritized with respect to:			
a. their usability across settings	___	___	_____
b. their immediate applicability	___	___	_____
c. their appropriateness for the child	___	___	_____
14. Targeted skills are stated as behavioral objectives and incorporated into the IFSP.	___	___	_____
15. Local education agency special education personnel are invited to all multi-disciplinary team meetings.	___	___	_____
16. Educational decisions on each child are based on evaluation data.	___	___	_____
17. The child's present levels of performance are assessed regularly using appropriate instruments.	___	___	_____
18. Multi-disciplinary team meetings are held on each child at least twice annually.	___	___	_____

Parent Advisor Program Implementation

	YES	NO	WEIGHT
1. Each family receives a weekly home visit of 1-2 hours duration provided by a trained parent advisor.	___	___	_____
2. The major thrust of the home visit is to equip the parent with the skills necessary for helping their handicapped child reach targeted goals.	___	___	_____
3. Each parent advisor writes weekly lesson plans for each family and forwards them to their case manager/supervisor for review and feedback.	___	___	_____
4. Each parent advisor is using the home visit curriculum/s and other curriculums materials appropriately.	___	___	_____
5. Each parent advisor varies the activities and approaches utilized to suit the unique needs of the families receiving services.	___	___	_____
6. Each parent advisor is following the home visit format while at the same time is tailoring the presentations to the learning styles of the parents.	___	___	_____
7. Each parent advisor is attempting to involve in the home visit all of the significant individuals in the child's life.	___	___	_____
8. Each parent advisor is involving the parents effectively in decision-making, planning, and conducting of home visits.	___	___	_____

Staff Recruitment and Selection

	YES	NO	WEIGHT
1. The agency has developed a plan which specifies the academic credentials and backgrounds required of staff to be hired.	___	___	_____
2. The agency disseminates information about training opportunities to agencies which potentially have contact with individuals with the desired backgrounds.	___	___	_____

	YES	NO	WEIGHT
3. Lists of individuals within the state with desired credentials have been secured, including the following, if applicable:			
a. state Teacher Certification lists	___	___	_____
b. state Speech, Language, Hearing Association membership lists	___	___	_____
c. LEA Special Education personnel lists	___	___	_____
4. University training programs are contacted and apprised of your program and its employment opportunities.	___	___	_____
5. Job descriptions have been developed which clearly outline the duties to be performed.	___	___	_____
6. An application has been developed or adopted on which pertinent work history, educational information, and demographic information can be recorded.	___	___	_____
7. Each applicant's references are checked before employment is offered.	___	___	_____
8. A reference response form is being utilized to record the impressions of persons knowledgeable of each applicant's skills and abilities.	___	___	_____
9. Documentation of education is secured on each applicant before employment is begun.	___	___	_____
10. State-mandated health requirements are met by each staff member prior to beginning employment.	___	___	_____
11. Each applicant's level of interest and level of mastery during pre-employment training are considered.	___	___	_____
12. Each applicant submits a letter of intent/contract, specifying acceptable compensation rates for home visits and training.	___	___	_____

Staff Development

	YES	NO	WEIGHT
1. Staff have been taught to appropriately utilize the assessment instruments used by the program.	___	___	_____
2. Staff have developed the interactional/interpersonal skills needed to communicate program information effectively to parents and professionals by matching the instructional strategies used in presentation with the learning style of the recipients of the instruction.	___	___	_____
3. Staff understand the rights of children and their parents and have been trained to deal with procedural safeguards and due process.	___	___	_____
4. Staff know how to plan and implement an individualized educational program.	___	___	_____
5. Staff have been trained on how to complete the necessary record-keeping documents used by the program.	___	___	_____
6. On-going staff development activities are planned.	___	___	_____
7. A needs assessment is used in determining the staff development activities offered.	___	___	_____

	YES	NO	WEIGHT
8. Staff completing the needs assessment are given the opportunity to give input on both their perceived level of skill and the skill level required for the specific topic on which training is being considered.			
9. Training programs have been developed to give program staff the initial training needed to begin program implementation.			
10. The initial training program is of sufficient scope to equip individuals with the academic and experience backgrounds accepted by the program to begin program implementation.			
11. Staff training is offered at times and locations which allow potential staff to participate.			
12. Training objectives have been categorized and training activities have been developed to give each staff member the necessary level of theoretical knowledge and practice needed to perform the task.			
13. The needs assessment instrument used to determine staff training includes statements of knowledge and competencies which represent "most promising educational practices."			
14. The persons completing the needs assessment are asked to rate the need for training with regard to these "most promising practices" along two dimensions: 1) the level of knowledge or skill required for the job at hand; and 2) the individual's current level of skill on that competency.			
15. Staff's expressed training needs are an important consideration in the programs planned.			
16. A collegial atmosphere exists among program staff so that needs and alternatives are freely shared.			
17. Collegial supervision experiences are encouraged to promote skill enhancement.			
18. Inservice training involves sufficient demonstration, practice and feedback to accomplish the desired level of mastery.			
19. A follow-up plan has been designed to reinforce learning.			
20. Inservice programs are evaluated and the results are used to aid in planning future programs.			
21. In-service training is provided which is designed to shore up weaknesses noted in the parent advisors performance.			

Staff Supervision

	YES	NO	WEIGHT
1. Each parent advosor (person providing direct services to families in their homes) has been assigned to a case manager/supervisor (person who has had special training in the use of the curriculum being followed and has demonstrated skill in providing direct servies to families, and who directly surervises the parent advisor).			

	YES	NO	WEIGHT
2. Each case manager/supervisor personally provides direct services to one or more families of handicapped children in order to keep the supervisory staff person in touch with the "real world" of service provision.			
3. Case managers are assigned responsibility for all the families within a particular geographic region and are held accountable for insuring that services are provided to their targeted families.			
4. Case managers assign cases to parent advisors in their regions and assist in the initial meeting of each family and the parent advisor by introducing the parent advisor, giving a program overview, gathering case history information, and planning the assessments to be done.			
5. The case manager assists the new parent advisor with assessing each child and and family and in writing the Individualized Family Service Plan to be followed.			
6. The case manager requires weekly lesson plans on each child from each parent advisor. Parent advisors write lesson plans for each child each week and forward them to the case manager for review and feedback.			
7. The case manager reviews the lesson plans, provides written comments, and returns a copy to the parent advisor.			
8. Each parent advisor records the results of each home visit and submits monthly reports to the case manager.			
9. Case managers maintain weekly telephone contact with each parent advisor.			
10. The case manager schedules time for face to face contact with each parent advisor to problem solve and answer questions.			
11. The case manager and/or other person knowledgeable of best practices does formal observations on each parent advisor at least twice yearly and provides feedback on performance and suggestions for better serving the family.			
12. Prior to each observational home visit, a preobservation conference is held with each parent advisor.			
13. During the observational home visit, the case manager rates the parent advisor on the previously agreed upon components of the successful home visit.			
14. A post observational conference is held and an improvement plan is written.			
15. Case managers make visits with each new parent advisor as frequently as necessary to insure that quality services are being provided.			
16. Each parent advisor has a written job plan which details major job responsiblities and identifies indicators of exceptional job performance in each category of responsibility.			

	YES	NO	WEIGHT
17. Each parent advisor has the job plan explained by the case manager so that understanding is assured.			
18. Each parent advisor is held responsible for performing duties as outlined in the job plan.			
19. The job plan is reviewed periodically with each parent advisor and progress toward meeting the targeted objectives is discussed and documented.			
20. Parent advisors are afforded the opportunity to do collegial supervision and receive compensation for doing so.			
21. Parent satisfaction questionnaires are mailed annually to each family receiving services, giving them opportunity to provide input regarding parent advisor performance.			
22. The parent survey results are scrutinized by the case manager and shared with the parent advisor when appropriate.			
23. The program has developed ways for documenting that scheduled visits are actually made.			
24. The parent signs a home visit log at the completion of each home visit.			
25. Home visit logs are forwarded monthly to each case manager for scrutiny.			
26. The case manager compares the home visit log with the invoice submitted by the parent advisor.			
27. The case manager approves all home visits and training/consultation hours prior to their performance by the parent advisor.			
28. Travel claims are monitored by the case manager and compared with the home visit logs to insure accuracy.			

Funding and Financial Management

	YES	NO	WEIGHT
1. The program annually develops a written summary of program impact student achievement gains, per child costs, and total program costs.			
2. The program annually develops a program improvement plan which targets additional families and/or geographic regions to be served during the following funding year.			
3. The improvement plan includes information concerning the impact that failure to provide requested program will have upon the families.			
4. The project impact information and the improvement plan request are submitted in a timely fashion to the appropriate funding authorities.			
5. Individuals who make funding decisions are kept apprised of the program's merit throughout the year.			

	YES	NO	WEIGHT
6. A workable system has been established and implemented for contracting services with part-time and or full-time staff.			
7. Management procedures have been implemented for authorizing home visits, consultation/training hours, and travel prior to their performance by the contract staff.			
8. Control procedures have been implemented to document that the services billed have actually been provided.			
9. Contract staff are required to submit invoices for services and reimbursement for travel so that an accurate paper trail can be maintained.			
10. Contract staff receive payment for services in a timely manner.			
11. Allocated funds are budgeted and managed throughout the project year so that service interruptions are avoided.			
12. Accurate records are maintained on each disbursement.			
13. Compensation and reimbursement records are maintained on each contract parent advisor.			
14. Each contract parent advisor receives a Form 1099 at the completion of each calendar year to document payments received.			
15. Accurate census information is maintained to document children served.			
16. Management strategies have been designed to provide for the purchase of the following support services in all sections of the service delivery region:			
1. Physical Therapy			
2. Occupational Therapy			
3. Vision Services			
4. Psychological Support			
5. Audiological Services			

Support Services

	YES	NO	WEIGHT
1. Adequate funding has been allocated for the purchase of the various support services needed by each child in the program.			
2. Persons qualified to provide the following support services have been identified in each geographic section of the service delivery area:			
1. Physical Therapy			
2. Occupational Therapy			
3. Vision Services			
4. Audiological Services			
5. Psychological Support Services			
6. Medical/opthalmological Services			
3. Parent advisors understand how to access needed support services.			
4. Parent advisors are utilizing support services appropriately.			

	YES	NO	WEIGHT
5. Persons providing support services understand the child's total program and the part that their particular area of expertise plays in the child's overall program.			
6. Support service providers are encouraged to participate in the multi-disciplinary team meetings held on children who are receiving their services.			
7. Support service providers are compensated for participating in M-Team meetings.			
8. Parent advisors are endeavoring to empower parents with the skills to access needed support services without parent advisor assistance so that the child's needs can continue to be met after formal intervention and parent advisor assistance have ceased.			
9. Parent advisors are seeking to help parents become cooperative, facilitating, child supporters as opposed to being demanding child advocates.			
10. Parent support groups are available to every parent enrolled in the program.			
11. Ongoing evaluation of parent support groups is done to insure that groups remain vibrant and meet targeted needs.			
12. Training activities are developed to assist support service providers in tailoring their services to the needs of a preschool handicapped child.			
13.Support service providers are compensated for participating in in-service training opportunities.			

Transitioning From Home-Based to Center-Based Program

	YES	NO	WEIGHT
1. Each parent advisor is familiar with all center-based program options available in their locale.			
2. Each parent advisor of a child nearing transition to a center-based program has visited the center-based options available.			
3. Accurate assessment of the child's needs and competencies is made prior to transitioning in order to insure that an appropriate program is planned.			
4. The parents are assisted in visiting all center-based options prior to a placement decision being made.			
5. Placement in a particular center-based program is recommended because the program is believed to best meet the child's needs at that particular developmental level, and not just because the child has reached a specific age level.			
6. Provisions have been made for the family to continue receiving home visits as needed until the program is completed.			

	YES	NO	WEIGHT
7. Teachers from both the home-based program and the center-based program into which the child is transitioning are fully aware of the services provided by the other, have regular contact, and respect each other professionally.			
8. Parents know what to expect from the new program.			
9. Both the home-based program and the center-based program are willing to make modifications as needed to help the child adjust to the new setting.			
10. Ongoing communication and consultation between the home-based program and the center-based program occurs after placement in the center-based program in order to insure satisfactory adjustment.			
11. Steps are taken to insure that parents sense closure after a reasonable period of transition time has elapsed.			

Materials and Equipment Lending Library

	YES	NO	WEIGHT
1. An adaptive equipment/toy lending service is available to the children enrolled in the program.			
2. A Hearing Aid Loaner Bank service is available for trial periods and during times when personal aids require repair.			
3. A materials lending service which includes books, pamphlets, video and audio tapes is available to parents and professionals.			
4. Control procedures have been established which allow for adequate accounting of items loaned.			
5. Procedures are being followed to keep loaner items in good repair.			
6. Parents and professionals are utilizing these lending services at an appropriate rate.			

Measurements of Achievement/Satisfaction

	YES	NO	WEIGHT
1. All staff are given at least annual opportunities to voice concerns about program policies and procedures and to make recommendations for program improvement.			
2. Exit interviews are conducted with all staff who leave the program in order to discover areas of dissatisfaction and weakness and to discuss strategies for remediating these problem areas.			
3. Child and family progress data are aggregated and analyzed to insure that the rate of progress of families in the program parallels that of other similar programs.			
4. Child and family progress data are analyzed by parent advisor to determine if program quality is being maintained by all staff.			
5. Home visit completion rates are analyzed to insure that all families are receiving an adequate quantity of service.			

	YES	NO	WEIGHT
6. Parent surveys are mailed annually to each family receiving services to determine satisfaction with the program and to elicit input for program enhancement.			
7. Longitudinal studies are done on children who have completed the program in order to assess the sustained effects of the program.			
8. Parents of children who have exited the program are surveyed at appropriate intervals to get their ideas/input for program enhancement.			
9. Collaborating agencies/individuals are surveyed annually to determine their satisfaction with the program and to glean ideas from them about ways to improve the program.			
10. Programs into which children who have completed the home-based program are transitioned are surveyed regarding the unattended needs of entering children which should have been addressed in the home-based program.			

THANK YOU FOR COMPLETING THIS INSTRUMENT. PLEASE RETURN IT ALONG WITH THE PROGRAM DATA SHEET AS SOON AS POSSIBLE. I GREATLY APPRECIATE YOUR HELP.

Don Thompson, Director
Comprehensive Educational Resource Center
Tennessee School for the Deaf
2725 Island Home Boulevard
Knoxville, TN 37920

APPENDIX A

Program Data Sheet

Program Name_____

Program Address_____
Street

_____ _____ _____
City State Zip

Program Supervisor_____

Person Completing Survey_____

Title of Person Completing Survey_____

Phone No. of Person Completing Survey (___) ____ - _____

Number of years you have worked in a SKI*HI type program_____

Number of SKI*HI cases you directly serve now_____

Year Program Adopted Project SKI*HI _____

Geographic Region Served (circle one of the following)
1. Immediate county 2. Surrounding Locale
3. Region of the State 4. Entire State

Are the services that your agency provides to families free?
(circle one) Yes No

Number of full-time parent advisors _____

Number of part-time parent advisors_____

Number of persons providing supervision to full-time staff____

Number of persons providing supervision to part-time staff____

Number of hearing impaired children your program served last year using the SKI*HI model_____

APPENDIX B

SKI*HI INSTITUTE

809 North 800 East
Utah State University
Logan, Utah 84322-1900 Phone (801) 752-4601

Project SKI*HI, INSITE, REAP, VIP, Tactile Signing, NDN Developer Demonstrator, Early Intervention Inservice

NOTE: Numbers were substituted for site prefixes to protect the anonymity of individual sites.

February 19, 1991

Don Thompson
Tennessee School for the Deaf
2725 Island Home Blvd.
Knoxville, Tennessee 37920

Dear Don:

Here are the data that you requested. Included are all sites for which data were submitted for 1989-90. This is the most recent that we have.

Site Prefix	LDS Receptive					LDS Expressive					Sample Size
	Pretest		Posttest		Effect	Pretest		Posttest		Effect	
	Mean	(sd)	Mean	(sd)	Size	Mean	(sd)	Mean	(sd)	Size	
ALL SITES	18.27	(11.38)	26.43	(13.35)	.72*	16.74	(10.75)	24.08	(13.00)	.68*	597
1	29.00	(26.87)	42.00	(25.46)	1.14*	26.00	(19.80)	38.00	(22.63)	1.12	2
2	16.00	(NA)	28.00	(NA)	.NA	16.00	(NA)	28.00	(NA)	.NA	1
3	23.83	(14.71)	31.50	(15.61)	.67	21.67	(11.37)	30.00	(13.56)	.67*	12
4	18.22	(12.95)	25.41	(14.84)	.63*	16.44	(12.55)	22.89	(14.34)	.63*	99
5	17.83	(10.46)	32.17	(13.82)	1.26*	16.67	(8.37)	29.00	(14.61)	1.26*	12
6	15.00	(12.73)	24.00	(22.63)	.79	15.00	(12.73)	23.00	(24.04)	.74	2
7	10.00	(2.83)	15.00	(7.07)	.44	9.00	(1.41)	14.00	(5.66)	.46	2
8	12.29	(6.87)	20.29	(11.34)	.70*	10.29	(5.82)	17.71	(11.22)	.69*	7
9	22.00	(14.97)	30.80	(18.14)	.77*	21.60	(17.05)	30.40	(20.12)	.82*	5
10	14.00	(NA)	32.00	(NA)	.NA	20.00	(NA)	32.00	(NA)	.NA	1
11	18.46	(12.76)	27.08	(12.82)	.76*	16.77	(11.76)	24.15	(11.59)	.69*	13
12	14.45	(8.35)	24.45	(12.50)	.88*	14.18	(6.76)	21.45	(10.51)	.68*	22
13	25.42	(15.99)	33.08	(17.20)	.67*	24.26	(15.47)	31.04	(16.30)	.63*	23
14	17.82	(12.76)	25.64	(14.31)	.69*	17.09	(12.28)	24.18	(15.27)	.66*	11
15	16.00	(NA)	28.00	(NA)	.NA	12.00	(NA)	20.00	(NA)	.NA	1
16	36.75	(13.05)	45.00	(13.52)	.73*	32.50	(12.13)	41.62	(14.81)	.85*	8
17	20.67	(12.94)	24.33	(16.51)	.32	20.33	(11.34)	26.00	(17.62)	.53	6
18	18.00	(15.68)	27.60	(13.14)	.84	16.00	(18.06)	27.20	(16.71)	1.04*	5
19	10.00	(6.53)	14.50	(5.00)	.40	8.50	(5.00)	12.50	(3.79)	.37	4
20	19.50	(13.10)	30.50	(5.97)	.97	19.00	(13.71)	27.00	(10.00)	.74*	4
21	13.69	(5.22)	20.62	(7.76)	.61*	12.77	(5.69)	19.38	(9.78)	.62*	13
22	14.50	(6.99)	19.25	(7.78)	.42*	13.25	(6.84)	17.75	(7.21)	.42*	8
23	13.20	(6.42)	28.80	(7.16)	1.37*	11.20	(7.16)	26.40	(7.67)	1.41*	5
24	10.00	(3.46)	17.33	(6.43)	.64	10.00	(4.00)	16.67	(5.77)	.62	3
25	14.80	(12.38)	22.40	(15.19)	.67*	14.00	(10.39)	24.40	(17.34)	.97*	5
26	16.00	(4.90)	26.00	(7.83)	.88*	17.00	(6.22)	25.00	(10.13)	.74	4
27	13.14	(3.44)	19.71	(5.09)	.58*	11.71	(3.73)	16.57	(3.60)	.45*	7
28	24.50	(14.50)	33.33	(11.89)	.78*	22.83	(14.93)	29.00	(13.00)	.57*	12
29	18.00	(12.49)	33.33	(26.03)	1.35	17.33	(12.22)	28.00	(24.25)	.99	3
30	15.25	(6.84)	28.75	(11.90)	1.19*	13.75	(5.60)	25.75	(11.13)	1.12*	8

31	16.00	(NA)	20.00	(NA)	.NA	16.00	(NA)	22.00	(NA)	.NA	1
32	16.00	(NA)	16.00	(NA)	.NA	14.00	(NA)	14.00	(NA)	.NA	1
33	14.91	(5.54)	27.45	(11.49)	1.10*	14.36	(6.31)	22.73	(10.56)	.78*	11
34	13.33	(1.16)	20.00	(3.46)	.59	13.33	(1.16)	20.00	(3.46)	.62	3
35	21.50	(10.76)	34.00	(12.00)	1.10	19.50	(6.61)	29.50	(11.00)	.93*	4
36	21.51	(10.75)	29.18	(12.83)	.67*	20.14	(10.50)	27.16	(12.58)	.65*	103
37	11.50	(3.00)	18.50	(5.26)	.62*	10.00	(5.16)	18.50	(6.40)	.79*	4
38	9.60	(7.67)	16.80	(13.68)	.63	7.60	(6.69)	17.20	(12.54)	.89*	5
39	10.00	(NA)	40.00	(NA)	.NA	10.00	(NA)	36.00	(NA)	.NA	1
40	16.00	(3.46)	18.67	(1.16)	.23	13.33	(2.31)	16.00	(0.00)	.25	3
41	6.00	(NA)	10.00	(NA)	.NA	8.00	(NA)	12.00	(NA)	.37	1
42	15.00	(7.93)	22.50	(9.24)	.66*	14.50	(6.48)	22.00	(8.48)	.70*	8
43	15.00	(7.07)	24.00	(16.97)	.79	15.00	(9.90)	19.00	(12.73)	.37	2
44	18.71	(7.00)	21.29	(6.82)	.23	16.43	(6.57)	17.86	(6.58)	.13	14
45	16.00	(5.66)	23.00	(7.07)	.62	19.00	(7.07)	23.00	(7.07)	.37*	2
46	12.00	(NA)	28.00	(NA)	.NA	8.00	(NA)	22.00	(NA)	.NA	1
47	12.00	(NA)	20.00	(NA)	.NA	10.00	(NA)	20.00	(NA)	.NA	1
48	16.40	(8.10)	22.40	(9.18)	.53*	11.20	(6.48)	19.80	(9.06)	.80*	10
49	20.67	(12.56)	29.00	(15.27)	.73	17.00	(12.88)	27.67	(18.95)	.99*	6
50	19.33	(16.43)	29.00	(18.01)	.85*	18.67	(15.58)	26.00	(16.30)	.68*	6
51	14.60	(10.46)	23.60	(11.54)	.79*	13.00	(10.72)	21.60	(10.58)	.80*	10
52	32.00	(0.00)	36.00	(0.00)	.NA	24.00	(0.00)	36.00	(0.00)	.NA	2
53	14.00	(7.57)	29.14	(10.19)	1.33*	13.43	(8.38)	23.86	(10.68)	.97*	7
54	9.00	(1.41)	14.00	(0.00)	.44	8.00	(2.83)	10.00	(2.83)	.19*	2
55	12.00	(7.21)	16.00	(6.93)	.35	12.00	(4.00)	16.00	(5.29)	.37	3
56	7.00	(2.10)	13.67	(5.57)	.59*	7.00	(2.10)	13.33	(4.68)	.59*	6
57	16.92	(9.56)	25.31	(12.80)	.74*	14.94	(8.13)	22.28	(12.31)	.68*	72

Note: Effect sizes were computed by subtracting the pretest mean from the posttest mean and dividing by the overall pretest standard deviation. *=Associated mean score differences were statistically significant, $p \leq .05$.

Sincerely,

Carol

Carol Strong, Research Director
Project REAP

APPENDIX C

SKI*HI REPLICATION SITE LIST

10/89

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
ALABAMA			
Alabama Institute for Deaf/Blind P.O. Box 698 Talladega, Ala. 35160	ALX	Terry Graham Phyllis Mayfield, Coor'd	(205) 362-1500
ALASKA			
Alaska State Prog. for Deaf Russian Jack School 4420 East 20th Ave. Anchorage, Alaska 99508	AKA	Edy Bosworth Jim Rich, Dir. Carolyn Coe (Data)	(907) 333-5536
ARIZONA			
Arizona State Sch. for Deaf 1200 West Speedway Blvd. P.O. 55445 Tucson, Arizona 85703-0545	AZX	Barry Griffing Joni Kiser-Dunn Linda Meiners Peggy Kile	(602) 628-5261 628-5271
ARKANSAS			
Arkansas Presch. Network Arkansas Sch. for Deaf 2400 West Markham P.O. Box 3811 Little Rock, Ark. 72203	AKX	Jerrie Finch St. Coor'd Gillis Ward	(501) 371-2554
ARKANSAS NETWORK SITES:			
St. Francis County Ctr. Route 2, Box 45A Forest City, Ark. 72335	AKC	Doreen Craig	(501) 633-2566
Price Elementary 809 West 12th St. Crossett, Ark. 71635	AKD	Jana Bailey	(501) 382-2616
Bates Elementary School 601 Buchanan Fayetteville, Ark. 72701	AKF	Ann Newman	(501) 521-1455
Teacher Center 1111 Spring St. Hot Springs, Ark. 71901	AKH		(501) 624-2582

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Brookland Elementary P.O. Box 35 Brookland, Ark. 72417	AKJ	Kitty Crews	(501) 624-2582
Jenkins Memorial Children's Ctr. 2410 Rike Dr. Pine Bluff, Ark. 71603	AKP	Karla Johnson	(501) 534-2035
Friendship School P.O. Box 928 Russellville, Ark. 72801	AKR	Anna Marie Eitenmiller	(501) 967-1460
Kilpatrick Elementary 904 East 35th Street Texarkana, Ark. 75502	AKT	Pat Reese	(501) 776-6719
Van Buren Hearing Impaired Presch. St. Paul United Methodist Church 4100 Grand Ave. Fort Smith, Ark. 72904	AKV	Anita Riley	(501) 783-5908
COLORADO			
Colorado Dept. of Health Handicapped Children's Home Intervention Prog. 4210 East 11th Ave. Denver, CO 80220	COX	Kathy Watters	(303) 331-8412
CONNECTICUT			
American School for the Deaf Parent-Child Counseling Program 139 North Main St. West Hartford, Conn. 06107	CTA	Karen Stockton Supvr, P-CCP	(203) 727-1339 (203) 727-1334
Capital Region Education Council (CREC) Hearing Impaired Prog. Stillman School 129 Hartford Ave. Wethersfield, Conn. 06109	CTC	Jennifer Kolzak	(203) 529-4260
DELAWARE			
Margaret S. Streck School for Deaf 620 East Chestnut Hill Rd. Newark, Delaware 19713	DLN	George Shellem	(302) 454-2097

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
FLORIDA			
Brevard County School Dist. 1450 Martin Blvd. Merritt Island, FL 32952	FLB	Patsy Day	(305) 631-1911
Dade County Public Schools Home Hospital Prog. 47 Zamora Ave. Coral Gables, FL 33134	FLD	Michael Exelbert Supt.	(305) 445-5188
Early Interv. Prog. for HI Sch. Dist. of Escambia County ESE 30 East Texas Dr. Pensacola, FL 32503	FLP	Jan Destafney Vicki Kelley	(904) 432-6121 Ext. 5456
Easter Seal Society 1475 Northwest 14th Ave. Miami, FL 33125	FLM	Patti Jo Larghi Joan Bornstein, Dir. Education	(305) 325-1626
Florida Sch. for Deaf/Blind 207 North San Marco St. Augustine, FL 32084	FLS Dir.	Nancy Stavropulos JoEllen Murchison, (SKI*HI Coor'd)	(904) 824-1654
Pinellas County Schools Special Education 1916 Druid Road Clearwater, FL 34624	FLC	Marilyn Scharbaugh	(813) 462-9641
GEORGIA			
Atlanta Area School for the Deaf Georgia PINES 890 North Indian Creek Dri. Clarkston, GA 30021	GAA	Charlene Frick Director Mona McCubbin Supt.	(404) 296-7101
HAWAII			
Kapiolani Women's and Children's Medical Ctr. 1319 Punahou St. Honolulu, Hawaii 96826	HWI	Deborah A. Larkins Gabe Richard Dave, Pres.	(808) 947-8511

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
IDAHO			
Idaho School for the Deaf Idaho Preschool Satellite Prog. 202 14th Avenue East Gooding, Idaho 83330	IDX	Ron Darcy Reg. Dir.	(208) 934-4457
INDIANA			
Indiana School for the Deaf Home Intervention Prog. 1200 East 42 Street Indianapolis, IN 46205	INA	Lee Murphy, Supt. Jess Smith	(317) 924-4374 Ext. 195
IOWA			
Heartand Education 6500 Pioneer Parkway Johnston, Iowa 50131-1603	IAH	Jim Doyle, Suprv. Jerilyn Thiel Data Person	(515) 964-2550 Ext. 60
Mississippi Bend AEA Catch Clinic Bettendorf, Iowa 52722	IAM	Les Schmeltz	(319) 355-4644
KANSAS			
Early Childhood Developmental Ctr. 94 Lewis Dr. Hays, Kansas 67601	KSH	Sheryl Lorance Theda Webster	(913) 625-3257
High Plains Education Coop. 621 East Oklahoma Ulysses, Kansas 67880	KSG	Steve Mosler Chris Squier	(316) 356-5577
Northwest Kansas Ed. Serv. Ctr. 135 West Sixth Colby, Kansas 67701	KSN	Jim Wheeler Sharon Bixson	(316) 462-8282
Southeast Kansas Reg. Ed. Serv. Ctr. P.O. Box 189 Girard, Kansas 66743	KSS	David DeMoss Lauren Riffle	(316) 724-6281
Southwest Kansas Area Coop. 1000 2nd Ave. P.O. Box 460 Dodge City, Kansas 67801	KSD	Gary Bishop, Dir. Kathy Cortise	(316) 227-8002

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Unified School Dist. #489 West Central Kansas Spec. Ed. Coop. 230 West 11th St. Hays, Kansas 67601	KSH	Myra Lawrence	(913) 625-7321
Wichita Public Schools 640 North Emporia Wichita, Kansas 67214	KSW	James Dyk, Dir. Mary Purtee Allen Elementary School 4814 East Mt. Vernon Wichita, Kansas 67218	(316) 268-7754
KENTUCKY			
KIPDS 131 Porter Building Human Development Inst. (HDI) University of Kentucky Lexington, KY 40506-0205		Andy Hensley	(606) 257-7939
Kentucky Sch. for the Deaf South 2nd St. Danville, Kentucky 40422		William A. Melton Jr.	(606) 236-5132
LOUISIANA			
Louisiana School for the Deaf Educational & Support Services P.O. Box 3074 Baton Rouge, Louisiana 70821	LSD	Karen DeVille	(504) 769-8160
MAINE			
Governor Baxter School for the Deaf P.O. Box 799 Portland, ME 04104-0799	MAG	Angela Bruno	(207) 781-3165
Pine Tree Society P.O. Box 518 Bath, ME 04530	MAP	Marlene Ouellette	(207) 443-3341
York County Counseling Services 23 Water St. Saco, ME 04072	MAY	Janet Michaud Bernard Henry, Dir.	(207) 282-7504

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Bangor Regional Speech/Hearing Ctr. 103 Texas Ave. Bangor, ME 04401	MAB	Jean Heath, Dir. Barbara Roscoe	(207) 941-2850
York Hospital Speech & Language Prog. 15 Hospital Dr. York, ME 03909	MAH	Jan Steffan	(207) 363-4321
Northeast Hearing and Speech Prog. 43 Baxter Blvd. Portland, ME 04101	MAN	Debbi Wolfenden Director	(207) 626-1774
Avis W. Purdy Speech & Hearing Ctr. Kennebec Valley Medical Center P.O. Box 1101 Gardiner, ME 04345	MAA	Linda Snow, Aud.	(207) 626-1774
Susan Gould-Lieghton, Audiologist 570 Main St. P.O. Box 1247 Presque Isle, Maine 04769	MAI		(207) 764-8401
Debra Zulofsky, Therapist P.O. Box 10201 Portland, ME 04104	MAO		(207) 774-4440
Caroline Hyde, Audiologist Yarmouth Audiology and Hearing 18 Main St. Yarmouth, ME 04096	MAR		(207) 846-3308
Sue Haley, Therapist 4 Tall Pines Scarborough, ME 04074	MAS		(207) 883-5285
MICHIGAN			
Port Huron Area Schools Exceptional Children H.I. Prog 2720 Riverside Dr. Port Huron, MI 84060	MCP	Susan Kamischke	(313) 984-3101
Midland Interm. Sch. Dist 3917 Jefferson Midland, MI 48640	MCJ	Paula Renker Adelle Pugh	(517) 839-0720

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Clare-Gladwin ISD 4041 East Mansiding Rd. Clare, Michigan 48617	MCC	Jack Raymond	(517) 386-3851
Grand Rapids Hearing Impaired Prog. 2036 Chesaning Southeast Grand Rapids, Michigan 49506	MCG	Mary Ann Deane	(616) 246-5104
Hillsdale County ISD 3471 Beck Road Hillsdale, Michigan 49242	MCH	Clara Packard Ann Parzych	(517) 439-1515
Dearborn Public Schools Total Communication Prog. 4824 Lois Avenue Dearborn, Michigan 48126	MCD	Ann Schroeder	(313) 582-6232
Michigan School for the Deaf Court at Miller Rd. Flint, Michigan 48502	MCF	David Updegraf Margaret Lewis	(313) 767-6111
Redford Union Oral Prog. Hear Imp. 18499 Beech Daly Rd. Redford, Michigan 48240	MCR	Sandy North	(313) 592-3332
Washtenaw Interm. Sch. Dist. 1819 South Wayne Rd. Ann Arbor, Michigan 48106-1406	MCW	Peggy Singer	(313) 994-8168
Detroit Public Schools EIDC/Couzens 3550 John C. Lodge Detroit, Michigan 48201	MCE	Elizabeth Grassi	(313) 494-2240
Special Education Services Flint Community Schools 923 East Kearsley St. Flint, Michigan 48502	MCK	Sally Creech Sherry A. Goodwin Dir.	(313) 762-1557 (313) 762-1097
Saginaw School District 550 Millard Street Saginaw, Michigan 48601	MCS	Debra Lively	(517) 776-0200
Huron Interm. Sch. Dist. 711 East Soper Rd. Bad Axe, Michigan 48413	MCX	Janet Richard Kris Kalis	(517) 269-9216

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Macomb Interm. Sch. Dist. Education Services Ctr. 44001 Garfield Rd. Mt. Clemens, Michigan 48044-1497	MCO	Joyce Sheehy	(313) 286-8800
Trenton Program for Hearing Impaired Trenton Public Schools 3700 Benson Trenton, Michigan 48183	MCT	Neil Van Riper Supt. Shirley Lamp	(313) 676-3515
AMA Inter. Sch. Dist. 1692 West M 32 Alpena, Michigan 49707	MCA	Pat Stark Tom Miller, Dir.	(517) 356-6161
Northview Total Communication Prog. Highlands Middle School 4644 Chandy Northwest Grand Rapids, Michigan 49505		Lu Ann Sheridan	
Van Buren ISD Special Education Center 701 South Paw Paw St. Lawrence, Michigan 49007	MCL	Kathleen Corstange	(616) 647-8091
Sinai Hospital Hear. Imp. Prog. 15440 W. McNichols Detroit, MI 48235-2899		Keith Lepard	(313) 493-6274
Kalamazoo Public Schools 218 Schuring Rd. Portage, Michigan 49081	MCP	Sandy Van Erkyl	(616) 384-0491
Bay Arenac ISD Trombley Infant/Preschool Ctr. 401 Bangor St. Bay City, Michigan 48706	MCB	Jay Crane, Princ. Lindsay Liedke, PA	(517) 684-1643
Charlevoix-Emmett ISD P.O. Box 318 08568 Mercer Blvd. Charlevoix, Michigan 49720		Suzanna Felt Thomas E. Caldwell	(616) 536-7957 (616) 547-9947
MINNESOTA			
Kathy Steffens 11614 Sunset Trail Plymouth, MN 5441		Statewide Coordinator (work)	(612) 546-9160 627-4616

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Region 1 and 2			
Northwest ECSU 114 West First St. P.O. Box 390 Thief River Falls, Minnesota 56701	MNH	Linda Ruberto	(218) 681-8005
Region 3			
Northeast ECSU Special Ed. Off. 820 North Pokegama Ave. Grand Rapids, Minnesota 55744		Linda Forsberg	(218) 740-0750 Ext. 257
Boundary Waters Special Ed. Coop. 600 East Harvey Ely, Minnesota 55720	MNY	Gene Zabinski	(218) 365-6312
Cloquet Area Spec. Ed. Coop. 509 Carlton Ave. Cloquet, Minnesota 55720	MNQ	Gus Kohlts	(218) 879-1283
Duluth ISD #709 2nd Street & Lake Ave. Duluth, Minnessota 55802	MNU	John Freeman Marilyn March	(218) 723-4111
Northland Spec. Ed. Coop. Technical Bldg. Virginia, Minnesota 55744	MNV	Fran Spender LaVonne See	(218) 741-4772
International Falls Public Sch. Holler Elementary School South International Falls, Minnesota 56649	MNI	John Langenbrunner Mike Erikson	(218) 283-9976
Mid-Range Spec. Ed. Coop. First Avenue & 4th St. Southwest Chisholm, Minnesota 55744	MNM	Ken Malkovich Sue Dobsen	(218) 254-2164
Tri-County Cooperative Center #946 P.O. Box 657 Grand Rapids, Minnesota 55744	MNZ	Ron Rubado Sue Bounds	(218) 326-0521
Region 4			
Fergus Falls Area Spec. Ed. Coop. 600 Friberg Fergus Falls, Minnesota 56537	MNF	Orrie Leabo Linda Matter	(218) 736-7576

Runestone Special Ed. Coop. 7th and Fillmore Alexandria, Minnesota 56308	MNA	Robert Halvorson	(612) 762-3602
West Central ECSU 1001 East Mt. Faith Fergus Falls, Minnesota 56537	MNX	Vicki Bowe	(218) 739-3273

Region 5

Mid-State Educational Coop. 11th Street 100 SE Little Falls, Minnesota 56345	MNL	Tom Schoepf	(612) 632-2921
Paul Bunyon Spec. Ed. Coop. 804 Oak Street Brainerd, Minnesota 56401	MND	Pat Wright	(218) 828-5225

Regions 6 & 8

Southwest/West Central ECSU Southwest State University P.O. Box 547 Marshall, Minnesota 56258	MNS	Bruce Drackley	(507) 537-1481
Crow River Special Ed. Coop. 30 Glen Street North Hutchinson, Minnesota 55350	MNG	Lori Schulstad	(612) 587-2860

Region 7

Central Minnesota ECSU 3337 West Germain, Suite 105 St. Cloud, Minnesota 56301	MNO	Dixie W. Anderson	(612) 255-3236
St. Francis ISD #15 3325 Bridge St. P.O. Box 128 St. Francis, Minnesota 55070	MNT	Susan J. Butler	(612) 753-2241

Region 9

Riverbend Spec. Ed. Coop. 400 South Payne New Ulm, Minnesota 56073	MNN	Nicole Halabi	(507) 359-2057

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
St. Peter Spec. Ed. Coop. Highway 22 North St. Peter, Minnesota 56082	MNP	Gary Lee, Dir.	(507) 931-5420
South Central ECSU 1610 Commerce Dr. North Mankato, Minnesota 56001	MNK	Kathi Malone, Supr.	(507) 389-1425
<u>Region 10</u>			
Region 10 Special Education Prog. 1200 S. Broadway Rm 160 Rochester, Minnesota 55904		Annette Kirchhoff	(507) 285-7340
<u>Region 11</u>			
Anoka-Hennepin ISD #11 11299 Hanson Blvd. Coon Rapids, Minnesota 55433	MNC	Bea LaRock Jim Kornov	(612) 755-8220 422-5236
Special Interm. Sch. Dist. #916 3300 Century Avenue North White Bear Lake, Minnesota 55110	MNW	Jean Bentley 916 EARS Prog. 1130 West County Road B Roseville, Minnesota 55115	(612) 487-1500
St. Paul Sch. Dist. #625 Como Park Elementary 780 West Wheelock Parkway St. Paul, Minnesota 55117		Jean Snowden	
MISSISSIPPI			
Mississippi School for Deaf 1253 Eastover Dr. Jackson, MS 39211	MSS	Ed Broome	(601) 987-3934
University of Mississippi Medical Ctr. Communicative Disorders Lab 2500 North State Street Jackson, MS 39216	MIU	Ojus Malphurs Jane Malphurs	(601) 984-4550
MISSOURI			
Missouri School for the Deaf 505 East 5th St. Fulton, Missouri 65251	MOX	Ruth Ann Dodd	(314) 642-3301 Ext. 16

AGENCY NAME/ADDRESS	PREFIXQ	CONTACT PERSON	TELEPHONE
Children's Mercy Hospital 24th and Gillham Kansas City, Missouri 64108	MOK	Sally Wendler	(816) 234-3677
Gallaudet School for the Deaf Project Hll 1616 South Grand Boulevard St. Louis, Missouri 63104	MOS	Geneva Shearburn	(314) 771-2894
MONTANA			
Montana School for the Deaf 3911 Central Avenue Great Falls, Montana 59401	MTX	Ernie Bateman	(406) 453-1401
NEBRASKA			
ESU #9 Services for the Hear. Imp. P.O. Box 2047 Hastings, Nebraska 68901	NEH	Gayle Van Patten Barbara Elliot	(402) 463-5611
ESU #10 Services for the Hearing Imp. West Highway #30 Kearney, Nebraska 68847	NEK	Deb Rosewinkel	(308) 237-3020
School Dist. of Grand Island Central Nebraska Support Service 318 South Clark Grand Island, Nebraska 68801	NEG	Kathy McFarland Cheri Roberts	(308) 381-5929
AGENCY NAME/ADDRESS	**PREFIX**	**CONTACT PERSON**	**TELEPHONE**
Lexington City Schools 1610 Washington Lexington, Nebraska 68850	NEL	Jim White, Dir.	(308) 324-4681
NEW JERSEY			
Marie H. Katzenbach Sch. for Deaf 320 Sullivan Way West Trenton, New Jersey 08628		Ann Fajgier	(609) 883-2600
Shirley Eves Center/UCP of Cumberland Co. 10th and Vine Street P.O. Box 787 Millville, New Jersey 08332-0787		Joan Pienta	(609) 825-5840

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
NEW MEXICO			
New Mexico School for the Deaf 1060 Cerrillos Road Santa Fe, New Mexico 87501	NMX	Larry O'Connor Suzanne Pope - STEP-HI New Mexico Sch. for Deaf 124 Richmond Southeast Albuquerque, NM 87106	(505) 827-6711 (505) 266-7344 (505) 268-7072
NEW YORK			
Fayette School 1057 Merrick Avenue Merrick, New York 11566	NYN	Susan Martello Angelo Vespe William Clark Nassau BOCES Salisbury Center Valentines Rd. & the Plain Rd. Westbury, New York 11590	(516) 486-7711 (516) 486-5626 (516) 997-8700
Rehabilitaiton Services, Inc. 204 Court St. P.O. Box 310 Binghamton, New York 13902		Catherine P. Burnett	(607) 722-5308
St. Francis de Sales Sch. for Deaf 260 Eastern Parkway Brooklyn New York 11225		Nancy Springer	(212) 636-4573
St. Lawrence-Lewis BOCES Outer State Street P.O. Box 231 Canton, New York 13617	NYL	Pamela Whittet	(315) 386-4505
Jefferson-Lewis-Hamilton-Herkimer-Oneida BOCES Arsenal Street Rd. R.D. #1 Watertown, New York 13601	NYJ	Gary McDermott	(315) 788-0400
Rochester School for the Deaf 1545 St. Paul St. Rochester, New York 14621	NYC	Leonard Zwick Lorrie Pasetto	(716) 544-1240
Special Children's Center, Inc. 21 Wilkins Road Ithaca, New York 14850	NYI	Judy Kugelmass, Dir	(607) 272-1240
Syracuse City Schools 345 Jamesville Avenue Syracuse, New York 13210	NYS	Ellen Donigan	(315) 425-4084

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
North Syracuse Early Ed. Prog. Riordan Elemantary School 205 South Main St. North Syracuse, New York 13212-3169	NYR	Amy Gooh	(315) 470-3196
Onandage BOCES Preschool Program 303 Roby Avenue East Syracuse, New York 13057	NYO	Susanne Fitzgerald	(315) 433-2600
Early Learning Ctr. Madison County ARC 588 Broad St. Oneida, New York 13421	NYE	Ann Winslow, Dir.	(315) 363-3397
United Cerebral Palsy & Handicapped Children's Ass'n of Syracuse 1603 Court St. Syracuse, New York 13208	NYU	Katy Franz	(315) 455-5726
Suffolk County BOCES III Speech and Hearing Prog. 507 Deer Park Road Dix Hills, New York 11746	NYD	Mary Margaret Weiss	(516) 549-4900 Ext. 288
New York School for the Deaf 555 Knollwood Rd. White Plains, New York 10603	NYW	Karen Liede	(914) 949-7310 Ext. 266
Mill Neck Manor School for the Deaf Frost Mill Road Mill Neck, New York 11765	NYM	Eileen Toomey	(516) 922-4100
Lexington Sch. for Deaf Infant Ctr. 75th St. & 30th Ave. Jackson Heights, NY 11370		Carol Whalen	(718) 899-8800
Junior High School 47 Sch. for the Deaf 225 East 23rd St. New York, NY 10010		Elisabeth Grunig	(212) 481-0300
New York Sch for Deaf-Rome 401 Turin St. Rome, NY 13440		Joan Fargnoli	(315) 337-8400

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
NORTH CAROLINA			
North Carolina School for the Deaf Rutherfordton Rd. Morganton, NC 28655	NCX	Lucy Peterson	(714) 433-2955
NORTH DAKOTA			
North Dakota School for the Deaf 14th Street & College Dr. Devil's Lake, ND 58301	NDX	Kathleen Burr Alan Mealka	(701) 662-5031 662-8784
OHIO			
Ohio Dept. of Education Early Childhood Section 65 South Front Street, Room 202 Columbus, Ohio 43266-0308		Jane Weichel (Info copies only)	(614) 466-0224
Akron Public Schools Special Education - Miller Bldg. 65 Steiner Ave. Akron, Ohio 44301	OHA	Mary Beth Kluge Kim Schreckenberger	(216) 434-1661
Canton City Schools 4336 Cleveland Ave. SE Canton, Ohio 44707	OHN	Phyllis Ashbolt	(216) 452-6521
Champion Dist. Hear. Imp. Ctr. 5976 Mahoning Ave NW Warren, Ohio 44483	OHW	Donna Zuga Cathy Anderson	(216) 847-8644
Cincinnati City Schools 230 East 9th St. Cincinnati, Ohio 45202	OHI	Sharyn Albright	
Cleveland City Schools Alexander Graham Bell Sch. 11815 Woodland Ave. Cleveland, Ohio 44120	OHC	Juanethel Newsom Sue Manross	(216) 299-6966
Columbiana County Brd/Ed. 339 East Lincoln Way Lisbon, Ohio 44432	OHU	Carolyn Burger Kim Peterson	(216) 424-9591

AGENCY NAME/ADDRESS	PREFIX	COANTACT PERSON	TELEPHONE
Dayton Public Schools Parent Infant Prog. HLLP: 258 Wyoming Street Dayton, Ohio 45409	OHD	Donna Gagliardi	(513) 222-0542
Findlay Program for Hearing Imp. 200 West Lincoln St. Findlay, Ohio 45840	OHI	Henry Benz Rebecca Morris	(419) 422-6121
Four County Prog. for Hear. Imp. Fulton County Sch. 602 South Shoop Ave. P.O. Box 338 Wauseon, Ohio 43567	OHF	Dorothea Groth Jean Krebs	(419) 335-1070 267-5128
Fremont City Schools 211 South Park Ave. Fremont, Ohio 43420	OHS	Alex Gorobetz Priscilla Monoc	(419) 334-3871
Hamilton County Board of Ed. 11083 Hamilton Ave. Cincinnati, Ohio 45231	OHH	Jack Collopy Maggi Cobb	(513) 742-2200
Hopewell SERRC 5799 West New Market Rd Hillsboro, Ohio 45133	OHP	Barb Munich-Deger Gail Mullen	(513) 393-1904
Mansfield City Schools 856 West Cook Rd Mansfield, Ohio 44906	OHM	Betty Keefer Sheila Finnerty Karen Pflederer	(419) 522-0611
Toledo Public Schools McKesson School 1624 Tracy St. Toledo, Ohio 43605	OHT	Carol Quick Penny Mueller	(419) 666-5180
Younstown Public Schools Administration Annex 1025 West Rayen Ave. Youngstown, Ohio 44502	OHY	Cathie Porter Rich Weber	(216) 788-6992 (216) 743-1151
Zanesville City Schools Parent Infant Program 1200 North 6th Street Zanesville, Ohio 43701	OHZ	Elaine Horn Martha Mitchell	(614) 454-9751 Ext. 260

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
OKLAHOMA			
Oklahoma State Dept. Education 2500 North Lincoln Oklahoma City, OK 73105-4599	OKX OKY	Cathy Peri	(405) 521-4869
OREGON			
Cascade Regional Program 905 Fourth Ave. Southeast Albany, Oregon 97321	ORA	Lila Kuykendall	(503) 967-8822
Mid-Oregon Regional Prog. H.I. 3400 Portland Rd. Northeast Salem, Oregon 97303	ORX	Maureen Casey Eleni Lathourakis	(503) 588-6677
Union Education Service Dist. Route 4, Box 4778 1100 K Ave. La Grand, Oregon 97850	ORU	Margaret Decker	(503) 963-4106
Jackson Education Service Ctr. Southern Oregon Reg. Prog. 101 North Grape St. Medford, Oregon 97501	ORJ	Lewis L. Keller	(503) 776-8575
Portland Public Schools Columbia Regional Prog. H.I. 532 Southeast 14th St. Portland, Oregon 97214	ORP	Nancy S. Horner	(503) 280-5840
Central Oregon Regional Program 520 Northwest Wall St. Bend, Oregon 97701	ORC	Kathy G. Emerson	(503) 389-9711 Ext. 287
PENNSYLVANIA			
Scranton State School for Deaf 1800 North Washington Ave. Scranton, PA 18509	PEX	Linda Hurwitz	(717) 961-4546
Pennsylvania School for the Deaf Early Intervention Prog. 100 West Schoolhouse Lane Philadelphia, PA 19144		Kathleen Bachus	(215) 951-4725

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
SOUTH CAROLINA			
South Carolina School for the Deaf Cedar Springs Station Spartanburg, SC 29302	SCA	Patrick Dowling Carol Mabry	(803) 585-7711
SOUTH DAKOTA			
South Dakota School for the Deaf 1800 East 10th St. Sioux Falls, SD 57103	SDX	K.W. Boesen Fran Noteboom	(605) 339-6700 339-6717
TENNESSEE			
Memphis Oral School for Deaf Project HI-PHI 711 Jefferson Memphis, Tenn. 38105	TNM	Joan Ward Kay Healey	(901) 577-8490
Tennessee School for the Deaf 2725 Island Home Blvd. Knoxville, Tenn. 37920	TNX	Don Thompson Susie McCamy	(615) 579-2452 (615) 594-6022
TEXAS			
Services for the Deaf 4241 Piedras Dr. E. Suite #181 San Antonio, TX 78228		Paula Archer Texas SKI*HI Prog.	(512) 735-1214
Cluster A			
Amarillo RDSPD 1300 Wallace Blvd. Amarillo, TX 79106	TAD	S.S. (Buddy) Stephens	(806) 359-7681
Ector County ISD/RDSPD P.O. Box 3912 Odessa, TX 79760	TOM	Brenda Barragan Barbara Bingham	(915) 332-9151
El Paso RDSPD P.O. Box 20100 El Paso, TX 79998	TXE	Cynthia DeWolf	(915) 799-4078
Lubbock RDSPD 1628 19th St. Lubbock, TX 79401	TXU	Karen Alley	(806) 766-1170 (806) 744-2342 Home: 797-3114

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Cluster B			
Abilene ISD 2970 South 6th St. Abilene, TX 79605	TAB	Anne Rose P.A.	
Arlington RDSPD 2315 Stonegate Arlington, TX 76010	TAR	Karen Hill	(817) 460-7211
Crowley P.O. Box 688 Crowley, TX 76036	TXY	Cheryl Ferguson	(817) 297-4651
Denton RDSPD Box 5199 Denton, TX 76202	TDD	Anna Oliver P.A.	(817/383-4241
Waverly Park Elementary 3604 Cimmaron Trail Fort Worth, TX 76116	TXF	Martha Harvill	(817) 244-9398
Education Serv. Ctr., Reg 15 P.O. Box 5199 San Angelo, TX 76902	TBS	Brenda Morris	(915) 658-6571 Ext. 126
Santa Rita Elementary 615 South Madison San Angelo, TX 76901		Carol Bailey	(915) 653-6815
Memorial Elementary Del Rio, TX 78840		Carol Burgess P.A.	(512) 774-3521
Brownwood High School 10th and Slayden Brownwood, TX 76801		Renee Beckham	(915) 646-9549
Five County Cooperative 131 West Church Street Weatherford, TX 76086	TXS	Elizabeth Boston	(817) 599-5022
Wichita Falls, ISD P.O. Box 2570 Wichita Falls, TX 76307	TWF	Susan Mayo	(817) 720-4317 Ext. 294
Birdville ISD 6125 E. Belknap Ft. Worth, TX 76117	TSB	Dianne Fisher	(817) 831-0951

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Plano School District 7400 Redriver Dr. Plano, TX 75025	TXP	Olga G. Djordjevic Debbie English	(214) 517-1831
Sherman ISD 505 East College Sherman, TX 75090	TXD	Christy Watts P.A.	(214) 893-8322
Temple RDSPD P.O. Box 788 Temple, TX 76503	TBT	Claire Wells	(214) 788-3795
Texarkana RDSPD Wake Vaillage Elem. School 400 Wildcat Drive Texarkana, TX 75501	TDT	Claudia Bright	(214) 838-4261
Tyler RDSPD P.O. Box 2035 Tyler, TX 75710	TXT	Connie Wilson P.A.	(214) 595-3481
Waco RDSPD 3320 West Waco Dr. Waco, TX 76710	TXW	Bill Davis Supervisor	(817) 756-3373
Waxahachie RDSPD Box 977 Waxahachie, TX 75165	TSW	Karen Lonon Diagnostician	(214) 937-4631

Cluster D

North Harris County Cooperative RDSPD 14910 Aldine Westfield Rd. Houston, TX 77032	THZ	Kathy Andrews P.A.	(713) 449-1011
Golden Triangel Cooperative RDSPD 1025 Woodrow St. Beaumont, TX 77705	TXX	Diane Richardson P.A.	(409) 833-7527
Brazoria-Fort Bend Coop. RDSPD c/o Guidance & Counseling 3911 Avenue I Roseberg, TX 77471		Gus McHam P.A.	(713) 341-3544 3546
Brazoria-Ft. Bend Coop. Drawer Z Freeport, TX 77541	TBF	Amelia Torres P.A.	(409) 233-2271

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Plano School District 7400 Redriver Dr. Plano, TX 75025	TXP	Olga G. Djordjevic Debbie English	(214) 517-1831
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Temple RDSPD P.O. Box 788 Temple, TX 76503	TBT	Claire Wells	(214) 788-3795
Texarkana RDSPD Wake Vaillage Elem. School 400 Wildcat Drive Texarkana, TX 75501	TDT	Claudia Bright	(214) 838-4261
Tyler RDSPD P.O. Box 2035 Tyler, TX 75710	TXT	Connie Wilson P.A.	(214) 595-3481
Waco RDSPD 3320 West Waco Dr. Waco, TX 76710	TXW	Bill Davis Supervisor	(817) 756-3373
Waxahachie RDSPD Box 977 Waxahachie, TX 75165	TSW	Karen Lonon Diagnostician	(214) 937-4631

Cluster D

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Brazoria-Ft. Bend Coop. Drawer Z Freeport, TX 77541	TBF	Amelia Torres P.A.	(409) 233-2271

AGNECY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Bryan ISD 101 Nor Texas Ave. Bryan, TX 77803	TBB	Laura Perkisn P.A.	(409) 361-5272
Galveston- Brazoria Coop. 400 South Kansas League City, TX 77573	THM	Galia Harrington Cathy Kaufman P.A.'s	(713) 338-1664
Tyler Co. Coop P.O. Box 37 Colmesneil, TX 75938	THC	Pam Barnes P.A.	(409) 837-2225
Conroe RDSPD 702 North Thompson Conroe, TX 77301	TDC	Cora Weidmann P.A.	(409) 760-7758
Northwest Harris County Coop. RDSPD 14102 Reo St. Houston, TX 77040	THN	Alisa Moore P.A.	(713) 462-5351
East Harris County Coop. RDSPD 302 Wye Dr. Baytown, TX 77521	THE	Margaret Lozar Marlis Hodges P.A.'s	(713) 428-2575
Houston RDSPD 3830 Richmond Ave. Houston, TX 77027	TXH	Lois Thompson Doris Calderon	(713) 892-6708
Education Service Ctr, Region 6 441 FM 2821 East Huntsville, TX 77340	THH	Patti Hill P.A.	(409) 295-8202
Liberty Co. Coop. RDSPD 1600 Grand Avenue Liberty, TX 77575	THL	Lana Prather P.A.	(409) 336-8701
New Caney Drawer 429 New Caney, TX 77357	TBN	Ruth Burnett P.A.	(713) 689-5460
Austin County Coop. 110 Main St. Sealy, TX 77474		Monica Gross P.A.	(409) 885-2987
Victoria RDSPD P.O. Box 1759 Victoria, TX 77901	TXV	Martha Worsley P.A.	(512) 576-3131

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Montgomery Cty. Coop. RDSPD P.O. 377 Willis, TX 77378	THW	Rita Bieber P.A.	(409) 856-4571
Ten-West Co. Coop-Katy 502 Addicks-Howell Rd. Houston, TX 77079	TDK	Paula Evans P.A.	(713) 493-6430
Cluster E			
Austin RDSPD 2117 West 49th St. Austin, TX 78756	TAA	Patti Fujii P.A.	(512) 451-2931
Brownsville ISD 2467 Price Rd. Brownsville, TX 78520	TBV	Kathy Rodriquez P.A.	(512) 546-0411
Corpus Christi RDSPD 4331 Adkins Corpus Christi, TX 78411	TXI	Pat Johnson	(512) 854-7943
Education Serv. Ctr., Reg. 13 RDSPD 5701 Springdale Rd. Austin, TX 78723	TXZ	Elise Hoaglund P.A.	(512) 929-1313
Kerrville RDSPD 1035 Barnett st. Kerrville, TX 78028	TSK	Laura Skeen	(512) 257-2203
Laredo RDSPD 1702 Houston St. Laredo, TX 78040	TLA	Belinda Pena P.A.	(512) 727-4401
McAllen RDSPD 2000 North 23rd St. McAllen, TX 78501	TXM	Becky Guerra Nelson Jones P.A.'s	(512) 686-2321
San Antonio RDSPD 4551 Dietrich Rd. San Antonio, TX 78219	TXA	Nancy Ward P.A.	(512) 661-8243
Texas School for the Deaf P.O. Box 3538 Austin, TX 78764	TSD	Dorothy Armistead P.A.	(512-442-7821
Myer Elementary School 2502 Avenue Q Hondo, TX 78861	TXB	Brenda Vavricek	(512) 426-3161

AGENCY NAME/ADDRESS	PREFIX	CONTACT NAME	TELEPHONE
Sunshine Cottage 103 Tuleta San Antonio, TX 78212	TAS	Lisa Lopez Cindy Hackett P.A.'s	(512) 824-0579
Northeast Independent Sch. Dist. 2123 Bitters Rd. San Antonio, TX 78217	TSA	Jan Longfellow	(512) 653-3920
UTAH			
Utah School for the Deaf - PIP 846 20th St. Ogden, Utah 84401	UTX	Skip Reese, Dir.	(801) 399-9631
VERMONT			
Regional Prog. Hearing Impair. Child. Special Education Services P.O. Box 551 Shelburne, Vermont 05482	VTX	Laurel Kintner	(801) 985-2551 2552
WASHINGTON			
ESD # 112 1313 Northeast 134th St. Vancouver, Washington 98685	WAV	Dick Yule, Dir.	(206) 574-3216
WEST VIRGINIA			
West Virginia Sch's Deaf/Blind 301 East Main Romney, West Virginia 26757	WVA	Max Carpenter Carol Babash Mongold	(304) 822-3521
WISCONSIN			
Wisconsin Sch. for Deaf 309 West Walworth Ave. Delavan, Wis. 53115	WIS	John Shipman	(414) 728-2677
Curative Rehabilitation Ctr. Speech & Hearing Dept. 1000 North 92nd St. Wauwatosa, Wis. 53226	WIC	Judy Huibregtse	(414) 259-1414

AGENCY NAME/ADDRESS	PREFIX	CONTACT PERSON	TELEPHONE
Wausau Sch Dist. Grant Elementary Sch. 500 North 4th Ave. Wausau, Wis. 54401		Kathy Furlano-Hennes	(715) 842-1521
River Falls Public Schools Westside School 1007 West Pine St. River Falls, Wis 54022		Laurie Moyer	(715) 425-0116
CESA #6 2300 Ripon Rd. P.O. Box 2563 Oshkosh, Wis. 54903	WIO	Sandra Berndt John R. Kotek	(414) 233-2372
CESA #8 Corner Lake and Main Gillette, Wis 54724	WIG	Sue Proctor	(414) 855-2114
CESA #9 328 North 4th St. Tomahawk, Wis 54487	WIT	Jim Larsen	(715) 453-2141
CESA #11 P.O. Box 158 Elmwood, Wis 54740	WIR	Tom W. King, Dir.	(715) 639-4201
CESA #12 301 13th Ave. East Ashland, Wis 54806	WIA	Tom Potteston Karen Mostelle	
WYOMING			
Wyoming School for the Deaf 539 South Payne Casper, Wyoming 82601	WYX	Marge DeVore	(307) 237-3634
The Learning Center Box 3441 Jackson, WY 83001		Judy Bogle, Reg. Dir. Martha Ptasnik Box 45 Pinedale, WY 83941	(307 733-3791

APPENDIX D

TENNESSEE SCHOOL FOR THE DEAF
and
EDUCATIONAL RESOURCE CENTER FOR THE HEARING IMPAIRED
2725 Island Home Blvd.
Knoxville, Tennessee 37920

May 9, 1990

Dear Colleague:

As the attached letter from Dr. Tom Clark at SKI*HI Institute indicates, I would like to request your assistance with a very special project. Being the director of a SKI*HI adoption site puts you in a very select category. SKI*HI is one of only a few nationally validated programs for young handicapped children. With the emphasis in Public Law 99-457 on serving 0-5 age children, many locales are starting home-based programs, but there is little information available to them which specifies what the experts (YOU and your colleagues!) in the field of home-based early intervention believe to be the key components of quality home-based programming. You have a chance to assist in providing information to help these fledgling programs and at the same time help your own program.

Enclosed please find a copy of the "Home-Based Program Evaluation Instrument" that appears in the SKI*HI publication, The Management of Home-Based Programs for Infant, Toddler and Preschool Age Handicapped Children. I would like to request that you complete the instrument following the instructions included with the instrument. Using your responses and those of all the directors of other SKI*HI replication sites throughout the United States, I plan to validate the instrument. The instrument will then be reprinted, giving item weights for each item, so the directors of either new or existing programs can use it both to evaluate and to enhance their programs by adding those components from the instrument that are rated as most important by current SKI*HI program directors. How will this help you?

1. Before you mail the completed survey, make a copy for yourself. In doing so, you will have done your program needs assessment for the coming year. You will be able to use the information to plan staff inservice and to set priorities.

2. The tallied results from all programs will be shared with SKI*HI Institute so they can develop strategies and materials for satisfying needs that are widely felt.

3. In a few months the revised instrument should be available to you to assist you with making program decisions based on input of all SKI*HI adoption site directors.

In compliance with University of Tennessee informed consent guidelines, please be assured that participation is entirely voluntary and you may withdraw without repercussion. No risks are being incurred by you or your program. Your personal responses will be kept confidential and will be reported in an aggregated format only. Returning the completed instrument constitutes informed consent to participate. Should you have questions, please write or call.

I greatly appreciate your cooperation in this project. Thank you in advance for participating in this worthwhile endeavor.

Sincerely yours,

Donald V. Thompson, Director
Comprehensive Educational Resource Center
(Doctoral Candidate)
(615) 579-2452

Doctoral Committee Members

Dr. Norma Mertz (Chair)
Educational Leadership
University of Tennessee

Dr. Olga Welch
Special Education
University of Tennessee

Dr. George Harris
Educational Leadership
University of Tennessee

Dr. Charles Hargis
Special Education
University of Tennessee

Survey mailed at no cost to Tennessee School for the Deaf

APPENDIX D

SKI*HI INSTITUTE

Department of Communicative Disorders
Utah State University
Logan, Utah 84322-9605 Phone (801) 752-4601

Project SKI*HI, INSITE, REAP, VIP, Tactile Signing, NDN Developer Demonstrator, Early Intervention Inservice

MEMORANDUM

TO: SKI*HI Adoption Sites

FROM: Thomas C. Clark, Director
SKI*HI Institute

DATE: October 26, 1989

SUBJECT: Home-Based Program Evaluation Instrument.

Don Thompson of the Tennessee School for the Deaf developed a home-based program evaluation instrument which appears on page 313-331 of the Management of Home-Based Programs for Infant, Toddler, and Preschool Age Handicapped Children published by the SKI*HI Institute.

Don is now planning to validate this instrument and needs your help. He would like the administrators of SKI*HI and/or INSITE programs to assist him in this evaluation.

I believe this to be a valuable study and would encourage you to participate with him in completing the instrument and the field test information. I strongly urge you to support Don in this study. It will result in an instrument we can all use.

APPENDIX E

REVISED HOME-BASED PROGRAM EVALUATION INSTRUMENT

The pages which follow contain the 222 items which were validated for inclusion in the Revised Home-Based Program Evaluation Instrument. The instrument is divided into 14 domains and can be used in its entirety, or individual domains can be selected and used as separate instruments. Within each domain, a number of stimulus statements or items are listed which have been identified as related to program quality. In reality, the stimulus statements reflect legal mandates from either legislation or case law, are statements derived from empirical research reported in the early childhood special education literature, originated from curricula and/or position papers on key program components related to program quality, or represent expert opinion as to the task-analyzed steps for reaching the desired result for that particular domain.

The first column provides space for recording whether that particular program quality indicator is being implemented in the program being evaluated. Columns 2 and 3 contain the means and standard deviations assigned by the national panel of experts who served as respondents for the validation study. Each respondent was asked to rate each item on a Likert-type scale ranging from 1 (Strongly agree that the item is related to quality home-based programming for young, handicapped children) to 6 (Strongly disagree that the item is related to quality home-based programming). **The smaller the number, the closer the item is related to quality programming.**

Programs using the instrument would complete column 1, then develop an action plan for program enhancement, choosing the items having the lowest means and standard deviations from among those items not being implemented.

This material is copyrighted and should only be used with author permission. A computerized version of this instrument is planned which will guide the user through the assessment of program strengths and areas of need, and will result in a set of annual goals, objectives and timelines for goal attainment.

APPENDIX E

APPENDIX E.1 Domain 1: Public Awareness/Child Find

	YES	MEAN	STD
1. The agency has a written plan for promoting public awareness and child find in order to insure that children residing within its service area who are in need of early identification services are located.	___	1.714	0.897
2. A brochure describing the agency's services has been developed.	___	1.486	0.770
3. The brochure is being disseminated to all agencies/organizations serving infants and young children, including the following:			
a. day care centers	___	1.884	1.071
b. public health departments	___	1.587	0.848
c. pediatricians' and general practitioners' offices	___	1.594	0.879
d. state departments of education	___	1.935	1.045
e. state legislators	___	2.230	1.206
f. school systems	___	1.734	0.956
g. hospital nurseries	___	1.635	0.914
h. college programs which train medical personnel	___	1.919	1.195
i. "at risk" clinics	___	1.540	0.709
4. Radio public service announcements (PSAs) have been developed.	___	2.313	1.149
5. Radio PSAs have been disseminated to all radio stations in the agency's geographic region.	___	2.343	1.153
6. Radio PSAs are updated and radio stations are sent new PSAs three or more times per year.	___	2.576	1.256
7. A system for monitoring radio PSA use by each station has been developed and station managers are given positive feedback for airing the PSAs.	___	2.712	1.203
8. A 24-hour call-in service has been established so that persons responding to PSAs can do so at any time.	___	2.909	1.357
a. If yes, is it toll free?	___	2.560	1.299
9. News release articles have been developed for newspaper distribution.	___	2.060	1.020
10. Staff members have been trained on how to enlist newspaper support.	___	2.612	1.196
11. Staff members are compensated for public service announcement activities (radio, TV, newspaper, health fairs).	___	2.881	1.366
12. News articles regarding the agency's services appear at least annually in every newspaper in the agency's service delivery area.	___	2.104	1.024
13. Television public service announcements (PSAs) have been developed:	___	2.424	1.232
a) all stations in service delivery area have received copies.	___	2.375	1.218
b) spotchecks are made to insure that PSAs are being aired.	___	2.491	1.204
c) station managers are praised for airing the PSAs.	___	2.418	1.246

APPENDIX E.1 (cont.)

	YES	MEAN	STD
14. The agency has developed the following materials for use at health fairs and organization conferences:			
a) video or slide program description	___	2.194	1.149
b) posters	___	2.262	1.100
c) scrapbook	___	2.542	1.140
d) brochures	___	1.918	0.963
15. The agency has a newsletter that is mailed at least quarterly to the following:			
a) parents of enrolled children	___	1.909	0.981
b) hospital	___	2.623	1.162
c) medical service providers (physicians, audiologists, PT/OTs, etc.)	___	2.410	1.077
d) policy makers (legislators, local judges, state agency staff)	___	2.508	1.182
e) school systems	___	2.367	1.080
16. The agency provides speakers for the following:			
a) university medical school classes	___	1.984	1.008
b) physicians/nurses professional associations	___	1.952	0.898
c) civic organizations	___	1.891	0.773
17. The agency encourages visits from personnel of other agencies which serve infants and young children.	___	1.621	0.646

APPENDIX E.2 Domain 2: Screening

	YES	MEAN	STD
1. The state birth certificate application contains information about family history of impairment.	___	1.969	1.212
2. A procedure has been established so that "at risk" indicators on the birth certificate are monitored and children who are "at risk" are being referred for screening.	___	1.828	1.140
3. A directory of appropriate places to refer families of "at risk" children has been developed and disseminated.	___	1.515	0.764
4. A follow-up system is used for families who fail to respond to the initial efforts to have their children brought for testing.	___	1.538	0.786
5. Screening of children is provided at no cost to families.	___	1.433	0.885
6. Hospital high risk screening procedures have been developed.	___	1.371	0.628
7. Hospitals are following the screening procedures.	___	1.443	0.690
8. Intensive care nursery babies are all screened for various handicapping conditions.	___	1.339	0.671
9. Cribogram screenings are being conducted on all newborns in the service delivery area.	___	1.737	0.889
10. Hospitals outside the service delivery area which may serve families within your service delivery area are included in your efforts to locate all impaired infants.	___	1.650	0.833

APPENDIX E.3 Domain 3: Referral and Diagnosis

	YES	MEAN	STD
1. Procedures have been developed to clearly identify the path that agencies doing the screening of newborns must take in order to refer a child to your agency.	___	1.535	0.728
2. A plan has been developed for determining which agencies understand how to refer a child to your agency?	___	1.671	0.751
3. Regular contact is made with public and private agencies, including audiologists, physicians, etc., who have initial contact with handicapped children, to insure that they always remember to refer children.	___	1.514	0.732
4. Contact is made within ten calendar days with the family of each child referred.	___	1.368	0.765
5. Acknowledgements are made on all referrals.	___	1.333	0.556
6. Those agencies/professionals who refer a child to your program are given ongoing information about the child referred.	___	1.718	0.754
7. Initial diagnostic evaluations are performed by qualified individuals in order to confirm the child's sensory impairment/s.	___	1.296	0.541
8. All areas of suspected impairment are examined by qualified diagnosticians.	___	1.310	0.596

APPENDIX E.4 Domain 4: Census

	YES	MEAN	STD
1. An accurate census is maintained on all children in the agency's service delivery area.	___	1.909	0.917
2. All appropriate individuals/agencies are notified, including the following:			
a. lead agency for implementing P. L. 99-457. (State Dept. of Education; Dept. of Public Health; Dept.of Human Resources, etc.)	___	1.682	0.956
b. local school district where family resides.	___	1.532	0.777
c. legislators	___	2.482	1.268

Domain 5: Assessment and Individualized Family Service Plan

APPENDIX E.5

	YES	MEAN	STD
1. Written policies and procedures have been established and implemented to appropriately assess children who are suspected of needing early intervention services.	___	1.388	0.572
2. All children enrolled have been determined eligible for services.	___	1.209	0.407
3. Objective data gained from standardized instruments are being gathered on all children enrolled.	___	1.379	0.571

APPENDIX E.5 (cont.)

	YES	MEAN	STD
4. An Individualized Family Service Plan (IFSP) has been developed with each family and includes the following mandated components:			
a. An objective assessment of the child's present levels of performance in physical development, cognition, speech and language skills, psychosocial development and self-help skills.		1.241	0.773
b. The family's strengths and areas of need as they relate to the child's development.		1.143	0.350
c. Child and family outcomes that are anticipated, along with criteria, timelines and procedures used for determining progress.		1.306	0.556
d. The specific early intervention services needed to meet the unique child and family needs including frequency, intensity and method of service delivery.		1.311	0.463
e. The designation of a case manager responsible for implementing the IFSP and coordinating with other agencies and individuals.		1.206	0.405
f. A plan for transitioning the child from the infant and toddler (0-2) programs of Part H into the services provided to older children under Part B.		1.328	0.503
5. The multi-disciplinary team that is called to develop the IFSP includes individuals who provide related services.		1.435	0.775
6. Ecological inventories are used to determine the demands of the current environments on the child (home, school, etc.) as well as those of the next educational placement. (An ecological inventory is an identification of specific skills needed for minimum functioning in various environments, including the home, workplace, leisure/recreation, and community. Expectations are based on the skills of non-handicapped age peers. Specific goals are then established, such as "To dress without assistance." The process for reaching this goal is then task analyzed and a discrepancy model is used for teaching any missing steps.)		1.547	0.865
7. Data from the child's formal assessments and ecological inventories are considered in setting IFSP goals.		1.984	1.008
8. Child and family progress are formally reassessed at least quarterly, or in compliance with state guidelines.		1.593	0.716
9. Parents are apprised in writing of child progress in compliance with state guidelines and have all assessment results explained soon after data are gathered.		1.433	0.667
10. Child progress data are used in making decisions such as that of determining communication modality.		1.369	0.483
11. Child staffings are held at least semi-annually.		1.409	0.696
12. Child progress data are kept and aggregated for determining program impact.		1.703	0.979
		1.538	0.681

APPENDIX E.5 (cont.)

	YES	MEAN	STD
13. Training needs are prioritized with respect to:			
a. their usability across settings	___	1.596	0.645
b. their immediate applicability	___	1.463	0.534
c. their appropriateness for the child	___	1.370	0.520
14. Targeted skills are stated as behavioral objectives and incorporated into the IFSP.	___	1.540	0.793
15. Local education agency special education personnel are invited to all multi-disciplinary team meetings.	___	1.762	0.987
16. Educational decisions on each child are based on evaluation data.	___	1.508	0.726
17. The child's present levels of performance are assessed regularly using appropriate instruments.	___	1.338	0.473
18. Multi-disciplinary team meetings are held on each child at least twice annually.	___	2.048	1.119

APPENDIX E.6

Domain 6: Parent Advisor Program Implementation

	YES	MEAN	STD
1. Each family receives a weekly home visit of 1-2 hours duration provided by a trained parent advisor.	___	1.324	0.645
2. The major thrust of the home visit is to equip the parent with the skills necessary for helping their handicapped child reach targeted goals.	___	1.139	0.346
3. Each parent advisor writes weekly lesson plans for each family and forwards them to their case manager/supervisor for review and feedback.	___	1.836	1.016
4. Each parent advisor is using the home visit curriculum/s and other curriculums materials appropriately.	___	1.352	0.533
5. Each parent advisor varies the activities and approaches utilized to suit the unique needs of the families receiving services.	___	1.225	0.418
6. Each parent advisor is following the home visit format while at the same time is tailoring the presentations to the learning styles of the parents.	___	1.225	0.509
7. Each parent advisor is attempting to involve in the home visit all of the significant individuals in the child's life.	___	1.380	0.566
8. Each parent advisor is involving the parents effectively in decision-making, planning, and conducting of home visits.	___	1.282	0.509

APPENDIX E.7 Domain 7: Recruitment and Selection

	YES	MEAN	STD
1. The agency has developed a plan which specifies the academic credentials and backgrounds required of staff to be hired.	___	1.431	0.573
2. The agency disseminates information about training opportunities to agencies which potentially have contact with individuals with the desired backgrounds.	___	1.931	0.948

APPENDIX E.7 (cont.)

	YES	Mean	S.D.
3. Lists of individuals within the state with desired credentials have been secured, including the following, if applicable:			
a. state Teacher Certification lists	___	2.400	0.989
b. state Speech, Language, Hearing Association membership lists	___	2.404	1.106
c. LEA Special Education personnel lists	___	2.268	0.973
4. University training programs are contacted and apprised of your program and its employment opportunities.	___	2.046	0.999
5. Job descriptions have been developed which clearly outline the duties to be performed.	___	1.577	0.816
6. An application has been developed or adopted on which pertinent work history, educational information, and demographic information can be recorded.	___	1.985	1.015
7. Each applicant's references are checked before employment is offered.	___	1.500	0.630
8. A reference response form is being utilized to record the impressions of persons knowledgeable of each applicant's skills and abilities.	___	1.969	1.037
9. Documentation of education is secured on each applicant before employment is begun.	___	1.529	0.806
10. State-mandated health requirements are met by each staff member prior to beginning employment.	___	1.657	0.939
11. Each applicant's level of interest and level of mastery during pre-employment training are considered.	___	1.672	1.013
12. Each applicant submits a letter of intent/contract, specifying acceptable compensation rates for home visits and training.	___	2.662	1.428

APPENDIX E.8 Domain 8: Staff Development

	YES	Mean	S.D.
1. Staff have been taught to appropriately utilize the assessment instruments used by the program.	___	1.411	0.659
2. Staff have developed the interactional/interpersonal skills needed to communicate program information effectively to parents and professionals by matching the instructional strategies used in presentation with the learning style of the recipients of the instruction.	___	1.181	0.419
3. Staff understand the rights of children and their parents and have been trained to deal with procedural safeguards and due process.	___	1.300	0.488
4. Staff know how to plan and implement an individualized family service plan (IFSP).	___	1.167	0.408
5. Staff have been trained on how to complete the necessary record-keeping documents used by the program.	___	1.466	0.704
6. On-going staff development activities are planned.	___	1.479	0.704
7. A needs assessment is used in determining the staff development activities offered.	___	571	0.623

APPENDIX E.8 (cont.)

	YES	MEAN	STD
8. Staff completing the needs assessment are given the opportunity to give input on both their perceived level of skill and the skill level required for the specific topic on which training is being considered.	___	1.882	0.738
9. Training programs have been developed to give program staff the initial training needed to begin program implementation.	___	1.437	0.575
10. The initial training program is of sufficient scope to equip individuals with the academic and experience backgrounds accepted by the program to begin program implementation.	___	1.444	0.550
11. Staff training is offered at times and locations which allow potential staff to participate.	___	1.606	0.778
12. Training objectives have been categorized and training activities have been developed to give each staff member the necessary level of theoretical knowledge and practice needed to perform the task.	___	1.571	0.599
13. The needs assessment instrument used to determine staff training includes statements of knowledge and competencies which represent "most promising educational practices."	___	1.781	0.760
14. The persons completing the needs assessment are asked to rate the need for training with regard to these "most promising practices" along two dimensions: 1) the level of knowledge or skill required for the job at hand; and 2) the individual's current level of skill on that competency.	___	2.210	1.002
15. Staff's expressed training needs are an important consideration in the programs planned.	___	1.603	0.645
16. A collegial atmosphere exists among program staff so that needs and alternatives are freely shared.	___	1.397	0.689
17. Collegial supervision experiences are encouraged to promote skill enhancement.	___	1.597	0.754
18. Inservice training involves sufficient demonstration, practice and feedback to accomplish the desired level of mastery.	___	1.592	0.683
19. A follow-up plan has been designed to reinforce learning.	___	1.704	0.739
20. Inservice programs are evaluated and the results are used to aid in planning future programs.	___	1.634	0.697
21. In-service training is provided which is designed to shore up weaknesses noted in the parent advisors performance.	___	1.723	0.850

APPENDIX E.9 Domain 9: <u>Staff Supervision</u>

	YES		
1. Each parent advisor (person providing direct services to families in their homes) has been assigned to a supervisor (person who has had special training in the use of the curriculum being followed and has demonstrated skill in providing direct servies to families, and who directly surervises the parent advisor).	___	1.667	0.943

APPENDIX E.9 (cont.)

	YES	MEAN	STD
2. Each case manager/supervisor personally provides direct services to one or more families of handicapped children in order to keep the supervisory staff person in touch with the "real world" of service provision.	___	2.323	1.266
3. Case managers are assigned responsibility for all the families within a particular geographic region and are held accountable for insuring that services are provided to their targeted families.	___	1.742	0.974
4. Supervisors assign cases to parent advisors in their regions and assist in the initial meeting of each family and the parent advisor by introducing the parent advisor, giving a program overview, gathering case history information, and planning the assessments to be done.	___	2.045	1.093
5. The case manager assists the new parent advisor with assessing each child and and family and in writing the Individualized Family Service Plan to be followed.	___	2.169	1.171
6. The supervisor requires weekly lesson plans on each child from each parent advisor. Parent advisors write lesson plans for each child each week and forward them to the case manager for review and feedback.	___	2.091	1.138
7. The supervisor reviews the lesson plans, provides written comments, and returns a copy to the parent advisor.	___	2.354	1.294
8. Each parent advisor records the results of each home visit and submits monthly reports to the case manager/supervisor.	___	2.154	1.167
9. Supervisors maintain weekly telephone contact with each parent advisor.	___	2.031	1.022
10. The supervisor schedules time for face to face contact with each parent advisor to problem solve and answer questions.	___	1.742	0.858
11. The supervisor and/or other person knowledgeable of best practices does formal observations on each parent advisor at least twice yearly and provides feedback on performance and suggestions for better serving the family.	___	1.803	0.821
12. Prior to each observational home visit, a preobservation conference is held with each parent advisor.	___	2.227	1.178
13. During the observational home visit, the supervisor rates the parent advisor on the previously agreed upon components of the successful home visit.	___	2.123	1.157
14. A post observational conference is held and an improvement plan is written.	___	2.092	1.106
15. Case managers make visits with each new parent advisor as frequently as necessary to insure that quality services are being provided.	___	1.750	0.829
16. Each parent advisor has a written job plan which details major job responsiblities and identifies indicators of exceptional job performance in each category of responsibility.	___	1.908	0.972

APPENDIX E.9 (cont.)

	YES	MEAN	STD
17. Each parent advisor has the job plan explained by the supervisor so that understanding is assured.	___	1.781	0.943
18. Each parent advisor is held responsible for performing duties as outlined in the job plan.	___	1.692	0.910
19. The job plan is reviewed periodically with each parent advisor and progress toward meeting the targeted objectives is discussed and documented.	___	1.844	1.019
20. Parent advisors are afforded the opportunity to do collegial supervision and receive compensation for doing so.	___	2.500	1.146
21. Parent satisfaction questionnaires are mailed annually to each family receiving services, giving them opportunity to provide input regarding parent advisor performance.	___	2.031	1.030
22. The parent survey results are scrutinized by the case manager and shared with the parent advisor when appropriate.	___	1.984	1.000
23. The program has developed ways for documenting that scheduled visits are actually made.	___	1.864	0.903
24. The parent signs a home visit log at the completion of each home visit.	___	2.879	1.376
25. Home visit logs are forwarded monthly to each case manager for scrutiny.	___	2.800	1.480
26. The supervisor compares the home visit log with the invoice submitted by the parent advisor.	___	2.968	1.490
27. The supervisor approves all home visits and training/consultation hours prior to their performance by the parent advisor.	___	2.471	1.509
28. Travel claims are monitored by the Supervisor and compared with the home visit logs to insure accuracy.	___	2.348	1.441

APPENDIX E.10 Domain 10: Funding and Financial Management

	YES		
1. The program annually develops a written summary of program impact student achievement gains, per child costs, and total program costs.	___	2.059	0.998
2. The program annually develops a program improvement plan which targets additional families and/or geographic regions to be served during the following funding year.	___	2.090	1.103
3. The improvement plan includes information concerning the impact that failure to provide requested program will have upon the families.	___	2.242	1.103
4. The project impact information and the improvement plan request are submitted in a timely fashion to the appropriate funding authorities.	___	2.000	1.023
5. Individuals who make funding decisions are kept apprised of the program's merit throughout the year.	___	1.809	0.959

APPENDIX E.10 (cont.)

	YES	MEAN	STD
6. A workable system has been established and implemented for contracting services with part-time and or full-time staff.	___	1.848	1.033
7. Management procedures have been implemented for authorizing home visits, consultation/training hours, and travel prior to their performance by the contract staff.	___	1.866	0.896
8. Control procedures have been implemented to document that the services billed have actually been provided.	___	2.082	1.121
9. Contract staff are required to submit invoices for services and reimbursement for travel so that an accurate paper trail can be maintained.	___	1.857	1.037
10. Contract staff receive payment for services in a timely manner.	___	1.661	0.915
11. Allocated funds are budgeted and managed throughout the project year so that service interruptions are avoided.	___	1.444	0.751
12. Accurate records are maintained on each disbursement.	___	1.547	0.789
13. Compensation and reimbursement records are maintained on each contract parent advisor.	___	1.633	0.966
14. Each contract parent advisor receives a Form 1099 at the completion of each calendar year to document payments received.	___	1.963	1.053
15. Accurate census information is maintained to document children served.	___	1.578	0.844
16. Management strategies have been designed to provide for the purchase of the following support services in all sections of the service delivery region:			
1. Physical Therapy	___	1.400	0.712
2. Occupational Therapy	___	1.404	0.746
3. Vision Services	___	1.418	0.779
4. Psychological Support	___	1.305	0.719
5. Audiological Services	___	1.217	0.580

APPENDIX E.11 Domain 11: Support Services

	YES		
1. Adequate funding has been allocated for the purchase of the various support services needed by each child in the program.	___	1.531	0.918
2. Persons qualified to provide the following support services have been identified in each geographic section of the service delivery area:			
1. Physical Therapy	___	1.569	0.841
2. Occupational Therapy	___	1.556	0.850
3. Vision Services	___	1.613	0.904
4. Audiological Services	___	1.339	0.566
5. Psychological Support Services	___	1.492	0.588
6. Medical/opthalmological Services	___	1.500	0.645
3. Parent advisors understand how to access needed support services.	___	1.522	0.605
4. Parent advisors are utilizing support services appropriately.	___	1.478	0.580

APPENDIX E.11 (cont.)

	YES	MEAN	STD
5. Persons providing support services understand the child's total program and the part that their particular area of expertise plays in the child's overall program.	___	1.439	0.654
6. Support service providers are encouraged to participate in the multi-disciplinary team meetings held on children who are receiving their services.	___	1.485	0.717
7. Support service providers are compensated for participating in M-Team meetings.	___	2.180	1.287
8. Parent advisors are endeavoring to empower parents with the skills to access needed support services without parent advisor assistance so that the child's needs can continue to be met after formal intervention and parent advisor assistance have ceased.	___	1.391	0.570
9. Parent advisors are seeking to help parents become cooperative, facilitating, child supporters as opposed to being demanding child advocates.	___	1.371	0.590
10. Parent support groups are available to every parent enrolled in the program.	___	1.479	0.767
11. Ongoing evaluation of parent support groups is done to insure that groups remain vibrant and meet targeted needs.	___	1.868	0.953
12. Training activities are developed to assist support service providers in tailoring their services to the needs of a preschool handicapped child.	___	1.779	0.837
13.Support service providers are compensated for participating in in-service training opportunities.	___	2.047	1.230

APPENDIX E.12 Domain 12: Transitioning From Home-Based to Center-Based Program

	YES		
1. Each parent advisor is familiar with all center-based program options available in their locale.	___	1.397	0.622
2. Each parent advisor of a child nearing transition to a center-based program has visited the center-based options available.	___	1.377	0.592
3. Accurate assessment of the child's needs and competencies is made prior to transitioning in order to insure that an appropriate program is planned.	___	1.261	0.529
4. The parents are assisted in visiting all center-based options prior to a placement decision being made.	___	1.420	0.750
5. Placement in a particular center-based program is recommended because the program is believed to best meet the child's needs at that particular developmental level, and not just because the child has reached a specific age level.	___	1.319	0.648
6. Provisions have been made for the family to continue receiving home visits as needed until the program is completed.	___	1.439	0.654

APPENDIX E.12 (cont.)

	YES	MEAN	STD
7. Teachers from both the home-based program and the center-based program into which the child is transitioning are fully aware of the services provided by the other, have regular contact, and respect each other professionally.	___	1.409	0.602
8. Parents know what to expect from the new program.	___	1.439	0.654
9. Both the home-based program and the center-based program are willing to make modifications as needed to help the child adjust to the new setting.	___	1.388	0.668
10. Ongoing communication and consultation between the home-based program and the center-based program occurs after placement in the center-based program in order to insure satisfactory adjustment.	___	1.394	0.649
11. Steps are taken to insure that parents sense closure after a reasonable period of transition time has elapsed.	___	1.576	0.799

APPENDIX E.13

Domain 13: Materials and Equipment Lending Library

	YES		
1. An adaptive equipment/toy lending service is available to the children enrolled in the program.	___	2.043	1.006
2. A Hearing Aid Loaner Bank service is available for trial periods and during times when personal aids require repair.	___	1.485	0.757
3. A materials lending service which includes books, pamphlets, video and audio tapes is available to parents and professionals.	___	1.443	0.624
4. Control procedures have been established which allow for adequate accounting of items loaned.	___	1.551	0.713
5. Procedures are being followed to keep loaner items in good repair.	___	1.574	0.734
6. Parents and professionals are utilizing these lending services at an appropriate rate.	___	1.612	0.791

APPENDIX E.14

Domain 14: Measurements of Achievement/Satisfaction

	YES		
1. All staff are given at least annual opportunities to voice concerns about program policies and procedures and to make recommendations for program improvement.	___	1.478	0.628
2. Exit interviews are conducted with all staff who leave the program in order to discover areas of dissatisfaction and weakness and to discuss strategies for remediating these problem areas.	___	1.846	0.845
3. Child and family progress data are aggregated and analyzed to insure that the rate of progress of families in the program parallels that of other similar programs.	___	2.014	1.021
4. Child and family progress data are analyzed by parent advisor to determine if program quality is being maintained by all staff.	___	1.896	1.053
5. Home visit completion rates are analyzed to insure that all families are receiving an adequate quantity of service.	___	2.057	1.081

APPENDIX E.14 (cont.)

	YES	MEAN	STD
6. Parent surveys are mailed annually to each family receiving services to determine satisfaction with the program and to elicit input for program enhancement.	___	2.058	1.128
7. Longitudinal studies are done on children who have completed the program in order to assess the sustained effects of the program.	___	2.162	0.964
8. Parents of children who have exited the program are surveyed at appropriate intervals to get their ideas/input for program enhancement.	___	2.072	0.786
9. Collaborating agencies/individuals are surveyed annually to determine their satisfaction with the program and to glean ideas from them about ways to improve the program.	___	2.217	0.976
10. Programs into which children who have completed the home-based program are transitioned are surveyed regarding the unattended needs of entering children which should have been addressed in the home-based program.	___	1.913	0.717

APPENDIX F

APPENDIX F.1

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 1: PUBLIC AWARENESS/CHILD FIND

DOMAIN MEAN: 2.114

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.8967	1.7143	74	11	1.3661	2.8806	71
2	0.7698	1.4857	74	12	1.0241	2.1045	71
3A	1.0705	1.8841	73	13	1.2317	2.4242	70
3B	0.8477	1.5873	67	13A	1.2183	2.3750	60
3C	0.8789	1.5938	68	13B	1.2041	2.4909	59
3D	1.0453	1.9355	66	13C	1.2460	2.4182	59
3E	1.2065	2.2295	65	14A	1.1492	2.1940	71
3F	0.9559	1.7344	68	14B	1.0999	2.2623	65
3G	0.9138	1.6349	67	14C	1.1398	2.5424	63
3H	1.1954	1.9194	66	14D	0.9632	1.9180	65
3I	0.7088	1.5397	67	15A	0.9805	1.9091	70
4	1.1488	2.3134	71	15B	1.1617	2.6230	65
5	1.1532	2.3433	71	15C	1.0770	2.4098	65
6	1.2560	2.5758	70	15D	1.1821	2.5082	65
7	1.2031	2.7121	70	15E	1.0796	2.3667	64
8	1.3565	2.9091	70	16A	1.0077	1.9844	68
8A	1.2986	2.5600	70	16B	0.8985	1.9524	67
9	1.0204	2.0597	71	16C	0.7729	1.8906	68
10	1.1965	2.6119	71	17	0.6459	1.6212	70

APPENDIX F.2

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 2: SCREENING

DOMAIN MEAN: 1.595

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	1.2115	1.9688	68	6	0.6282	1.3710	66
2	1.1396	1.8281	68	7	0.6901	1.4426	65
3	0.7636	1.5152	70	8	0.6707	1.3387	66
4	0.7860	1.5385	69	9	0.8890	1.7368	61
5	0.8848	1.4328	71	10	0.8332	1.6500	64

APPENDIX F.3

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 3: REFERRAL AND DIAGNOSIS

DOMAIN MEAN: 1.465

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.7283	1.5352	75	5	0.5560	1.3333	73
2	0.7506	1.6714	74	6	0.7540	1.7183	75
3	0.7318	1.5143	74	7	0.5411	1.2958	75
4	0.7651	1.3676	72	8	0.5956	1.3099	75

APPENDIX F.4

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 4: CENSUS

DOMAIN MEAN: 1.849

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.9166	1.9091	70	2B	0.7770	1.5323	66
2A	0.9560	1.6818	70	2C	1.2676	2.4821	60

APPENDIX F.5

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 5: ASSESSMENT AND INDIVIDUALIZED FAMILY SERVICE PLAN

DOMAIN MEAN: 1.479

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.5719	1.3881	71	8	0.6675	1.4333	64
2	0.4066	1.2090	71	9	0.4826	1.3692	69
3	0.5712	1.3788	70	10	0.6958	1.4091	70
4	0.7726	1.2414	33	11	0.9792	1.7031	68
4A	0.3499	1.1429	67	12	0.6811	1.5385	69
4B	0.5562	1.3065	66	13A	0.6451	1.5965	61
4C	0.4631	1.3115	65	13B	0.5345	1.4630	58
4D	0.4047	1.2063	67	13C	0.5198	1.3704	58
4E	0.5031	1.3279	65	14	0.7933	1.5397	67
4F	0.7750	1.4355	66	15	0.9874	1.7619	67
5	0.8648	1.5469	68	16	0.7259	1.5077	69
6	1.0079	1.9839	66	17	0.4732	1.3385	69
7	0.7159	1.5932	63	18	1.1188	2.0476	67

APPENDIX F.6

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 6: PARENT ADVISOR PROGRAM IMPLEMENTATION

DOMAIN MEAN: 1.338

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.6451	1.3239	75	5	0.4178	1.2254	75
2	0.3458	1.1389	76	6	0.5090	1.2254	75
3	1.0162	1.8358	71	7	0.5658	1.3803	75
4	0.5334	1.3521	75	8	0.5086	1.2817	75

APPENDIX F.7

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 7: STAFF RECRUITMENT AND SELECTION

DOMAIN MEAN: 1.890

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.5732	1.4306	76	6	1.0147	1.9851	71
2	0.9476	1.9306	76	7	0.6301	1.5000	72
3A	0.9892	2.4000	69	8	1.0373	1.9692	69
3B	1.1060	2.4035	61	9	0.8057	1.5286	74
3C	0.9727	2.2679	60	10	0.9394	1.6571	74
4	0.9989	2.0462	69	11	1.0132	1.6716	71
5	0.8164	1.5775	75	12	1.4280	2.6615	69

APPENDIX F.8

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 8: STAFF DEVELOPMENT

DOMAIN MEAN: 1.544

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.6587	1.4110	77	12	0.5993	1.5714	74
2	0.4192	1.1806	76	13	0.7597	1.7813	68
3	0.4884	1.3000	74	14	1.0022	2.2097	66
4	0.4082	1.1667	76	15	0.6449	1.6029	72
5	0.7038	1.4658	77	16	0.6890	1.3971	72
6	0.7044	1.4795	77	17	0.7543	1.5970	71
7	0.6227	1.5714	74	18	0.6834	1.5915	75
8	0.7382	1.8824	72	19	0.7391	1.7042	75
9	0.5749	1.4366	75	20	0.6969	1.6338	75
10	0.5500	1.4444	76	21	0.8505	1.7231	69
11	0.7778	1.6056	75				

APPENDIX F.9

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 9: STAFF SUPERVISION

DOMAIN MEAN: 2.123

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.9428	1.6667	70	15	0.8292	1.7500	68
2	1.2662	2.3231	69	16	0.9723	1.9077	69
3	0.9741	1.7424	70	17	0.9432	1.7813	68
4	1.0931	2.0455	70	18	0.9102	1.6923	69
5	1.1711	2.1692	69	19	1.0189	1.8438	68
6	1.1379	2.0909	70	20	1.1456	2.5000	68
7	1.2941	2.3538	69	21	1.0303	2.0313	68
8	1.1666	2.1538	69	22	0.9999	1.9836	65
9	1.0224	2.0308	69	23	0.9026	1.8636	70
10	0.8583	1.7424	70	24	1.3764	2.8788	70
11	0.8206	1.8030	70	25	1.4801	2.8000	69
12	1.1780	2.2273	70	26	1.4904	2.9683	67
13	1.1570	2.1231	69	27	1.5095	2.4706	72
14	1.1056	2.0923	69	28	1.4407	2.3485	70

APPENDIX F.10

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 10: FUNDING AND FINANCIAL MANAGEMENT

DOMAIN MEAN: 1.741

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.9983	2.0588	72	11	0.7512	1.4444	67
2	1.1027	2.0896	71	12	0.7892	1.5469	68
3	1.1026	2.2419	66	13	0.9655	1.6333	64
4	1.0228	2.0000	69	14	1.0534	1.9630	58
5	0.9588	1.8088	72	15	0.8442	1.5781	68
6	1.0334	1.8485	70	16A	0.7118	1.4000	64
7	0.8960	1.8657	71	16B	0.7460	1.4035	61
8	1.1205	2.0820	65	16C	0.7791	1.4182	59
9	1.0367	1.8571	67	16D	0.7191	1.3051	63
10	0.9148	1.6613	66	16E	0.5800	1.2167	64

APPENDIX F.11

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 11: SUPPORT SERVICES

DOMAIN MEAN: 1.595

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.9180	1.5313	68	5	0.6543	1.4394	70
2A	0.8407	1.5692	69	6	0.7173	1.4853	72
2B	0.8504	1.5556	67	7	1.2869	2.1803	65
2C	0.9044	1.6129	66	8	0.5702	1.3913	73
2D	0.5664	1.3387	66	9	0.5897	1.3714	74
2E	0.5875	1.4921	67	10	0.7665	1.4789	75
2F	0.6455	1.5000	64	11	0.9534	1.8676	72
3	0.6045	1.5217	73	12	0.8375	1.7794	72
4	0.5801	1.4783	73	13	1.2302	2.0469	68

APPENDIX F.12

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 12: TRANSITIONING FROM HOME-BASED TO CENTER-BASED PROGRAM

DOMAIN MEAN: 1.404

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.6217	1.3971	72	7	0.6025	1.4091	70
2	0.5923	1.3768	73	8	0.6543	1.4394	70
3	0.5289	1.2609	73	9	0.6682	1.3881	71
4	0.7500	1.4203	73	10	0.6485	1.3939	70
5	0.6481	1.3188	73	11	0.7989	1.5758	70
6	0.6543	1.4394	70				

APPENDIX F.13

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 13: MATERIALS AND EQUIPMENT LENDING LIBRARY

DOMAIN MEAN: 1.633

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	1.0062	2.0429	74	4	0.7129	1.5507	73
2	0.7572	1.4853	72	5	0.7340	1.5735	72
3	0.6242	1.4429	74	6	0.7909	1.6119	71

APPENDIX F.14

WEIGHTS ASSIGNED BY ITEM -- ALL SURVEYS

DOMAIN 14: MEASUREMENTS OF ACHIEVEMENT/ SATISFACTION

DOMAIN MEAN: 1.970

ITEM	S.D.	AVG.	N	ITEM	S.D.	AVG.	N
1	0.6281	1.4783	73	6	1.1278	2.0580	73
2	0.8455	1.8462	69	7	0.9642	2.1618	72
3	1.0211	2.0143	74	8	0.7861	2.0725	73
4	1.0528	1.8955	71	9	0.9761	2.2174	73
5	1.0808	2.0571	74	10	0.7171	1.9130	73

APPENDIX G

APPENDIX G.1

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 1: PUBLIC AWARENESS/CHILD FIND

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
PA1	0.6849	1.4444	18	0.8692	1.6667	15	0.9632	1.8649	37
PA2	0.2233	1.0526	19	1.0625	1.7333	15	0.7179	1.6111	36
PA3A	1.0541	1.6667	18	1.1451	1.7857	14	1.0263	2.0270	37
PA3B	0.5329	1.2222	18	0.6455	1.5000	12	0.9678	1.8182	33
PA3C	0.5329	1.2222	18	0.6401	1.4167	12	1.0039	1.8529	34
PA3D	0.7617	1.4444	18	0.6166	1.7273	11	1.1618	2.2727	33
PA3E	1.0973	1.8235	17	0.9959	1.9091	11	1.2332	2.5455	33
PA3F	0.7556	1.3889	18	0.6455	1.5000	12	1.0572	2.0000	34
PA3G	1.2571	1.5556	18	0.6401	1.4167	12	0.7398	1.7576	33
PA3H	1.3669	1.8824	17	1.2134	1.8333	12	1.0867	1.9697	33
PA3I	0.6503	1.2778	18	0.6556	1.4545	11	0.7083	1.7059	34
PA4	1.0830	1.7778	18	1.1902	2.5000	12	1.0811	2.5135	37
PA5	1.0482	1.8889	18	1.1902	2.5000	12	1.1300	2.5135	37
PA6	1.3426	2.4444	18	1.2555	2.5833	12	1.2054	2.6389	36
PA7	1.4118	2.6471	17	1.2114	2.6154	13	1.0830	2.7778	36
PA8	1.4337	2.9412	17	1.4432	2.6154	13	1.2693	3.0000	36
PA8A	1.6394	2.2500	4	1.3844	2.5000	6	1.1353	2.6667	15
PA9	0.9737	1.5882	17	0.9147	2.1429	14	1.0104	2.2500	36
PA10	1.4167	2.4118	17	1.2163	2.4615	13	1.0502	2.7568	37
PA11	1.5806	2.8235	17	1.3889	2.6154	13	1.2302	3.0000	37
PA12	0.6124	1.5000	16	0.9395	2.2143	14	1.0918	2.3243	37
PA13	1.4524	2.1250	16	1.2114	2.6154	13	1.1058	2.4865	37
PA13A	1.2183	2.1250	16	1.3454	2.3000	10	1.1470	2.5333	30
PA13B	1.2103	2.3125	16	1.4229	2.5556	9	1.1160	2.5667	30
PA13C	1.2748	2.0000	16	1.3966	2.2222	9	1.1000	2.7000	30
PA14A	1.0017	1.7647	17	1.5000	2.5000	14	0.9891	2.2778	36
PA14B	1.0533	1.8750	16	1.2802	2.1667	12	0.9885	2.4848	33
PA14C	1.1659	2.3750	16	1.2984	2.3636	11	1.0440	2.6875	32
PA14D	1.0000	1.5000	16	1.1873	2.0833	12	0.7761	2.0606	33
PA15A	0.7043	1.5625	16	0.5756	1.7692	13	1.1338	2.1081	37
PA15B	1.4238	2.8125	16	1.1426	2.1667	12	0.9687	2.6970	33
PA15C	1.1302	2.1875	16	0.8165	2.0000	12	1.0636	2.6667	33
PA15D	1.1990	2.2500	16	1.1426	2.1667	12	1.1290	2.7576	33
PA15E	1.1110	2.1250	16	1.1149	2.0833	12	0.9956	2.5938	32
PA16A	0.7043	1.4375	16	1.0377	2.0000	13	1.0166	2.2286	35
PA16B	1.1130	1.7647	17	0.7592	1.9167	12	0.8022	2.0588	34
PA16C	0.7759	1.5294	17	0.6617	1.8462	13	0.7423	2.0882	34
PA17	0.4556	1.2941	17	0.6739	1.7857	14	0.6578	1.7143	35

APPENDIX G.2

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 2: SCREENING

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
SC1	1.3388	1.8235	17	0.9395	1.7857	14	1.2249	2.1212	33
SC2	1.2616	1.7647	17	0.8113	1.6429	14	1.1791	1.9394	33
SC3	0.7454	1.3333	18	0.8207	1.4286	14	0.7228	1.6471	34
SC4	0.5329	1.2222	18	0.8427	1.4615	13	0.8156	1.7353	34
SC5	1.1337	1.3684	19	0.5951	1.2500	12	0.7988	1.5278	36
SC6	0.5455	1.2353	17	0.7638	1.5000	12	0.6000	1.3939	33
SC7	0.7759	1.4706	17	0.7638	1.5000	12	0.6052	1.4063	32
SC8	0.8360	1.3529	17	0.7378	1.3846	13	0.5266	1.3125	32
SC9	1.0440	1.6875	16	0.7820	1.4545	11	0.8055	1.8667	30
SC10	0.7906	1.5000	16	0.7820	1.4545	11	0.8441	1.7879	33

APPENDIX G.3

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 3: REFERRAL AND DIAGNOSIS

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
RFR1	0.5210	1.2105	19	0.7118	1.6000	15	0.7730	1.6757	37
RFR2	0.7556	1.3889	18	0.6992	1.6667	15	0.7292	1.8108	37
RFR3	0.7406	1.3684	19	0.6182	1.4667	15	0.7556	1.6111	36
RFR4	0.9428	1.3333	18	0.5963	1.3333	15	0.7251	1.4000	35
RFR5	0.4157	1.2222	18	0.7180	1.4667	15	0.5270	1.3333	36
RFR6	0.8188	1.4737	19	0.7118	1.6000	15	0.6891	1.8919	37
RFR7	0.5470	1.2632	19	0.6182	1.4667	15	0.4880	1.2432	37
RFR8	0.7293	1.3158	19	0.5963	1.3333	15	0.5128	1.2973	37

APPENDIX G.4

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 4: CENSUS

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
CNS1	1.0136	1.8125	16	0.6794	2.0000	13	0.9409	1.9189	37
CNS2A	0.8570	1.6250	16	0.7178	1.6429	14	1.0701	1.7222	36
CNS2B	0.7638	1.5000	18	0.6227	1.5714	14	0.8459	1.5333	30
CNS2C	1.1842	2.1875	16	0.8814	2.3636	11	1.3922	2.6897	29

APPENDIX G.5

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 5: ASSESSMENT AND INDIVIDUALIZED FAMILY SERVICE PLAN

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
IFSP1	0.5703	1.2941	17	0.4899	1.4000	15	0.5993	1.4286	35
IFSP2	0.3222	1.1176	17	0.4000	1.2000	15	0.4371	1.2571	35
IFSP3	0.3812	1.1765	17	0.4103	1.2143	14	0.6478	1.5429	35
IFSP4	0.3307	1.1250	8	0.4830	1.2500	4	0.9558	1.2941	17
IFSP4A	0.3307	1.1250	16	0.4000	1.2000	15	0.3307	1.1250	32
IFSP4B	0.6960	1.3750	16	0.6182	1.4667	15	0.3951	1.1935	31
IFSP4C	0.4714	1.3333	15	0.4714	1.3333	15	0.4539	1.2903	31
IFSP4D	0.3903	1.1875	16	0.4422	1.2667	15	0.3903	1.1875	32
IFSP4E	0.4330	1.2500	16	0.4518	1.2857	14	0.5493	1.3871	31
IFSP4F	0.4330	1.2500	16	0.6182	1.5333	15	0.9460	1.4839	31
IFSP5	0.6910	1.4118	17	0.7180	1.4667	15	0.9877	1.6563	32
IFSP6	0.9662	2.0625	16	0.7483	1.8000	15	1.1212	2.0323	31
IFSP7	0.6268	1.5000	14	0.7717	1.7333	15	0.7157	1.5667	30
IFSP8	0.4635	1.3125	16	0.4949	1.4286	14	0.8062	1.5000	30
IFSP9	0.4714	1.3333	18	0.4899	1.4000	15	0.4841	1.3750	32
IFSP10	0.3727	1.1667	18	1.0750	1.6667	15	0.5521	1.4242	33
IFSP11	1.2717	1.7778	18	0.9970	2.0769	13	0.7016	1.5152	33
IFSP12	0.8484	1.5294	17	0.6182	1.4667	15	0.6045	1.5758	33
IFSP13A	0.6110	1.6000	15	0.6249	1.6154	13	0.6704	1.5862	29
IFSP13B	0.5000	1.5000	14	0.6455	1.5000	12	0.4949	1.4286	28
IFSP13C	0.4792	1.3571	14	0.6401	1.4167	12	0.4792	1.3571	28
IFSP14	0.4242	1.2353	17	1.0136	1.8125	16	0.7608	1.5667	30
FISP15	0.4714	1.3333	18	0.9568	1.8667	15	1.1397	1.9667	30
IFSP16	0.7759	1.4706	17	0.9823	1.6875	16	0.4961	1.4375	32
IFSP17	0.4157	1.2222	18	0.4961	1.4375	16	0.4785	1.3548	31
IFSP18	1.5366	2.5000	18	0.8835	2.0714	14	0.7915	1.7742	31

APPENDIX G.6

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 6: PARENT ADVISOR PROGRAM IMPLEMENTATION

	SKI*HI DATA High Child Ach.			SKI*HI DATA Low Child Ach.			SKI*HI DATA No Data Reported		
Item	S. D.	AVG.	N	S. D.	AVG.	N	S. D.	AVG.	N
PAPRG1	0.7406	1.3684	19	0.4330	1.2500	16	0.6667	1.3333	36
PAPRG2	0.4077	1.2105	19	0.2421	1.0625	16	0.3419	1.1351	37
PAPRG3	1.3765	2.0000	19	0.8537	1.7333	15	0.8074	1.7879	33
PAPRG4	0.4403	1.2632	19	0.4635	1.3125	16	0.5951	1.4167	36
PAPRG5	0.4077	1.2105	19	0.4330	1.2500	16	0.4157	1.2222	36
PAPRG6	0.3646	1.1579	19	0.3903	1.1875	16	0.6060	1.2778	36
PAPRG7	0.5813	1.3684	19	0.5995	1.3750	16	0.5415	1.3889	36
PAPRG8	0.4077	1.2105	19	0.5995	1.3750	16	0.5061	1.2778	36

APPENDIX G.7

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 7: STAFF RECRUITMENT AND SELECTION

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
STF_RS1	0.5499	1.4595	37	0.6268	1.5000	14	0.4157	1.2222	18
STF_RS2	0.8036	1.9459	37	0.9610	1.9286	14	1.0957	1.7222	18
STF_RS3A	0.9563	2.5455	33	0.8624	2.2727	11	0.9702	2.0556	18
STF_RS3B	0.9136	2.3103	29	0.9162	2.2222	9	1.4142	2.5000	16
STF_RS3C	0.8712	2.2500	28	0.8165	2.3333	9	1.0879	2.0625	16
STF_RS4	1.1345	2.3529	34	0.7925	1.9091	11	0.6056	1.5294	17
STF_RS5	0.9428	1.6667	36	0.6999	1.7143	14	0.5583	1.2778	18
STF_RS6	1.1549	2.2571	35	0.7071	2.0000	12	0.5882	1.3529	17
STF_RS7	0.6449	1.5278	36	0.6401	1.5833	12	0.4242	1.2353	17
STF_RS8	1.1149	2.0833	36	1.0285	1.8182	11	0.7888	1.6667	15
STF_RS9	0.9242	1.5833	36	0.8356	1.6154	13	0.4479	1.2778	18
STF_RS10	1.0929	1.8333	36	0.7458	1.5385	13	0.6009	1.5000	18
STF_RS11	1.1873	1.7500	36	0.8624	1.7273	11	0.5999	1.4118	17
STF_RS12	1.3660	2.6765	34	1.4374	2.5455	11	1.5541	2.7647	17

APPENDIX G.8

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 8: STAFF DEVELOPMENT

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
STF_DEV1	0.7926	1.5135	37	0.4899	1.4000	15	0.3727	1.1667	18
STF_DEV2	0.3958	1.1944	36	0.4422	1.2667	15	0.3143	1.1111	18
STF_DEV3	0.4199	1.2286	35	0.4989	1.4667	15	0.3812	1.1765	17
STF_DEV4	0.4185	1.1389	36	0.4422	1.2667	15	0.3143	1.1111	18
STF_DEV5	0.8207	1.5946	37	0.6182	1.5333	15	0.3143	1.1111	18
STF_DEV6	0.8572	1.5405	37	0.4714	1.6667	15	0.4157	1.2222	18
STF_DEV7	0.6664	1.6857	35	0.4792	1.6429	14	0.5583	1.2778	18
STF_DEV8	0.7980	1.8571	35	0.5933	1.9286	14	0.6960	1.8750	16
STF_DEV9	0.5984	1.4444	36	0.4989	1.5333	15	0.5455	1.2353	17
STF_DEV10	0.5432	1.4054	37	0.4899	1.6000	15	0.5703	1.2941	17
STF_DEV11	0.8867	1.6389	36	0.7180	1.8667	15	0.4556	1.2941	17
STF_DEV12	0.6304	1.6389	36	0.5735	1.7333	15	0.4330	1.2500	16
STF_DEV13	0.6444	1.7647	34	0.8620	2.0833	12	0.7717	1.7333	15
STF_DEV14	1.0289	2.0625	32	0.7993	2.1667	12	1.0873	2.4667	15
STF_DEV15	0.6299	1.6571	35	0.6268	1.5000	14	0.7043	1.5625	16
STF_DEV16	0.8408	1.4857	35	0.4865	1.3846	13	0.3812	1.1765	17
STF_DEV17	0.8000	1.6000	35	0.8292	1.7500	12	0.4922	1.4118	17
STF_DEV18	0.7131	1.6389	36	0.7118	1.6000	15	0.4922	1.4118	17
STF_DEV19	0.7949	1.7500	36	0.6992	1.6667	15	0.6056	1.5294	17
STF_DEV20	0.7307	1.7222	36	0.6992	1.6667	15	0.5999	1.4118	17
STF_DEV21	0.7186	1.7941	34	1.2637	1.7857	14	0.6268	1.5000	14

APPENDIX G.9

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 9: STAFF SUPERVISION

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
STF_SPV1	1.0588	1.7647	34	0.7592	1.9167	12	0.7624	1.3529	17
STF_SPV2	1.1483	2.1212	33	0.8620	2.0833	12	1.5158	2.7647	17
STF_SPV3	0.9540	1.8235	34	0.9538	1.9167	12	0.7487	1.2941	17
STF_SPV4	1.0290	2.0000	34	0.7298	1.9231	13	1.3793	2.1875	16
STF_SPV5	1.1827	2.2059	34	0.9538	2.0833	12	1.1726	2.0000	16
STF_SPV6	1.0862	2.2353	34	0.8620	2.0833	12	1.4093	1.8824	17
STF_SPV7	1.2412	2.4412	34	1.0375	2.5833	12	1.5000	2.0000	16
STF_SPV8	1.0108	2.0882	34	1.1873	2.5833	12	1.2484	2.0625	16
STF_SPV9	0.9630	2.1176	34	0.7845	2.0000	13	1.2365	2.0667	15
STF_SPV10	0.9540	1.8235	34	0.8285	1.9231	13	0.6092	1.4375	16
STF_SPV11	0.8565	1.8235	34	0.6617	1.8462	13	0.8570	1.6250	16
STF_SPV12	1.0210	2.3235	34	1.1867	2.2308	13	1.4948	2.1250	16
STF_SPV13	1.1561	2.3235	34	1.0672	2.1667	12	1.1990	1.7500	16
STF_SPV14	1.0718	2.2941	34	1.0375	2.0833	12	1.1990	1.7500	16
STF_SPV15	0.9319	1.8824	34	0.6154	1.9231	13	0.5890	1.2857	14
STF_SPV16	0.9393	2.0000	34	1.1180	2.5000	12	0.4635	1.3125	16
STF_SPV17	0.9544	1.9706	34	1.0714	1.9231	13	0.4103	1.2143	14
STF_SPV18	0.9435	1.8529	34	1.0263	1.8462	13	0.4000	1.2000	15
STF_SPV19	1.0556	2.0588	34	1.0714	1.9231	13	0.5890	1.2857	14
STF_SPV20	1.1579	2.4848	33	1.0659	2.3077	13	1.1813	2.7333	15
SRF_SPV21	1.1497	2.1765	34	0.7993	2.1667	12	0.8000	1.6000	15
STF_SPV22	1.1666	2.1818	33	0.6401	2.0833	12	0.4865	1.3846	13
STF_SPV23	1.0556	1.9412	34	0.6794	2.0000	13	0.7043	1.5625	16
STF_SPV24	1.3452	2.8824	34	1.4058	3.1538	13	1.4564	2.5625	16
STF_SPV25	1.3985	2.7273	33	1.5269	3.2308	13	1.5799	2.4375	16
STF_SPV26	1.4439	2.9063	32	1.4473	3.4615	13	1.5861	2.5333	15
STF_SPV27	1.5541	2.7647	34	1.3721	2.7857	14	1.2247	2.0000	16
STF_SPV28	1.3090	2.2727	33	1.5113	2.8462	13	1.4348	2.0625	16

APPENDIX G.10

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 10: FUNDING AND FINANCIAL MANAGEMENT

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
FUND1	0.9461	2.2222	36	0.9129	2.0000	12	0.9737	1.5882	17
FUND2	1.1180	2.1667	36	0.8975	2.1667	12	1.2359	1.8125	16
FUND3	1.1233	2.3636	33	0.8620	2.0833	12	1.2797	2.0714	14
FUND4	1.1130	2.2353	34	0.8771	2.0000	13	0.7180	1.4667	15
FUND5	1.0405	1.9722	36	0.8771	2.0000	13	0.6092	1.4375	16
FUND6	1.0521	1.9143	35	1.0672	1.8333	12	1.0308	1.7500	16
FUND7	0.8089	1.8889	36	0.8975	1.8333	12	1.0897	1.7500	16
FUND8	1.1520	2.2813	32	1.0770	2.2000	10	0.9922	1.6250	16
FUND9	0.9118	1.8529	34	1.2792	2.0000	11	1.1470	1.8667	15
FUND10	0.9301	1.7273	33	0.7810	1.7000	10	0.9980	1.5625	16
FUND11	0.9113	1.5882	34	0.4979	1.5455	11	0.2494	1.0667	15
FUND12	0.8984	1.6765	34	0.7454	1.6667	12	0.4000	1.2000	15
FUND13	0.9931	1.7273	33	0.7810	1.7000	10	1.0498	1.4286	14
FUND14	1.0000	2.0000	30	0.7810	1.7000	10	1.2662	1.8182	11
FUND15	0.9320	1.6000	35	0.7810	1.7000	10	0.5830	1.3125	16
FUND16A	0.7980	1.5161	31	0.4930	1.4167	12	0.5890	1.2857	14
FUND16B	0.8055	1.4667	30	0.6633	1.6000	10	0.5890	1.2857	14
FUND16C	0.9035	1.5714	28	0.4899	1.4000	10	0.5890	1.2857	14
FUND16D	0.6500	1.3548	31	0.4899	1.6000	10	0.6103	1.3571	14
FUND16E	0.5661	1.2581	31	0.4583	1.3000	10	0.5735	1.2667	15

APPENDIX G.11

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 11: SUPPORT SERVICES

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
SSERV1	0.8097	1.6364	33	0.6236	1.6667	12	1.0607	1.5000	16
SSERV2A	1.0347	1.6667	33	0.4865	1.6154	13	0.5995	1.3750	16
SSERV2B	1.0294	1.6970	33	0.5000	1.5000	10	0.5882	1.3529	17
SSERV2C	1.0943	1.7879	33	0.4979	1.5455	11	0.5963	1.3333	15
SSERV2D	0.6000	1.3939	33	0.4583	1.3000	10	0.5590	1.2500	16
SSERV2E	0.6076	1.5455	33	0.4810	1.6364	11	0.5830	1.3125	16
SSERV2F	0.6570	1.5152	33	0.6633	1.6000	10	0.6227	1.4286	14
SSERV3	0.6003	1.4722	36	0.5329	1.8462	13	0.5999	1.4118	17
SSERV4	0.5525	1.4571	35	0.6103	1.6429	14	0.5999	1.4118	17
SSERV5	0.6524	1.4706	34	0.7592	1.5833	12	0.5703	1.2941	17
SSERV6	0.7698	1.5143	35	0.6966	1.7692	13	0.5455	1.2353	17
SSERV7	1.1035	1.9688	32	1.4993	2.5455	11	1.3888	2.2667	15
SSERV8	0.5111	1.2857	35	0.6227	1.5714	14	0.6056	1.4706	17
SSERV9	0.6363	1.3714	35	0.4899	1.4000	15	0.5882	1.3529	17
SSERV10	0.6866	1.4722	36	0.7180	1.5333	15	0.9772	1.4706	17
SSERV11	0.7753	1.8056	36	1.4446	2.3571	14	0.4989	1.5333	15
SSERV12	0.7205	1.7714	35	0.9608	2.0000	13	0.6124	1.5000	16
SSERV13	1.0943	2.1212	33	1.2984	2.3636	11	1.2359	1.8125	16

APPENDIX G.12

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 12: TRANSITIONING FROM HOME-BASED TO CENTER-BASED PROGRAM

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
TRANS1	0.6845	1.4000	35	0.6103	1.6429	14	0.3903	1.1875	16
TRANS2	0.6299	1.3429	35	0.6103	1.6429	14	0.4242	1.2353	17
TRANS3	0.6020	1.2571	35	0.4518	1.2857	14	0.4242	1.2353	17
TRANS4	0.8000	1.4000	35	0.4792	1.3571	14	0.8484	1.5294	17
TRANS5	0.6917	1.2778	36	0.6249	1.3846	13	0.5882	1.3529	17
TRANS6	0.6937	1.3939	33	0.6249	1.6154	13	0.4556	1.2941	17
TRANS7	0.6076	1.4545	33	0.6343	1.4615	13	0.5703	1.2941	17
TRANS8	0.6471	1.4118	34	0.8498	1.6667	12	0.4556	1.2941	17
TRANS9	0.7743	1.4412	34	0.6249	1.3846	13	0.4556	1.2941	17
TRANS10	0.6556	1.4545	33	0.6249	1.3846	13	0.5995	1.3750	16
TRANS11	0.7003	1.5455	33	1.0801	2.0000	12	0.6056	1.4706	17

APPENDIX G.13

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 13: MATERIALS AND EQUIPMENT LENDING LIBRARY

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
LIBR1	1.0493	2.1944	36	1.0690	2.0000	14	0.7848	1.8235	17
LIBR2	0.8310	1.6286	35	0.6057	1.3077	13	0.6809	1.3529	17
LIBR3	0.6449	1.4722	36	0.6227	1.5714	14	0.4242	1.2353	17
LIBR4	0.8032	1.7222	36	0.6343	1.5385	13	0.4242	1.2353	17
LIBR5	0.7787	1.7353	34	0.6343	1.5385	13	0.5999	1.4118	17
LIBR6	0.7654	1.6667	33	0.9484	1.8462	13	0.5999	1.4118	17

APPENDIX G.14

WEIGHTS ASSIGNED BY SKI*HI DATA CATEGORY

DOMAIN 14: MEASUREMENTS OF ACHIEVEMENT/SATISFACTION

	NO CHILD ACHIEVEMENT DATA REPORTED			LOWER CHILD ACHIEVEMENT GROUP			HIGH CHILD ACHIEVEMENT GROUP		
ITEM	S.D.	AVG.	N	S.D.	AVG.	N	S.D.	AVG.	N
MEAS1	0.6821	1.5833	36	0.4865	1.3846	13	0.5882	1.3529	17
MEAS2	0.9508	1.9118	34	0.6680	1.9091	11	0.6910	1.5882	17
MEAS3	1.0999	2.1111	36	0.9897	2.1429	14	0.8235	1.7059	17
MEAS4	0.9996	1.8286	35	1.0326	1.9286	14	1.1813	1.9333	15
MEAS5	1.0104	2.0833	36	1.4514	2.4000	15	0.6818	1.6875	16
MEAS6	1.0541	2.0000	36	1.1802	2.5000	14	1.1659	1.8750	16
MEAS7	1.0238	2.2571	35	0.8601	2.2143	14	0.8992	1.9375	16
MEAS8	0.6866	1.9722	36	0.7954	2.2857	14	0.7806	1.8750	16
MEAS9	0.9280	2.1667	36	0.9794	2.4286	14	0.9798	2.2000	15
MEAS10	0.7318	1.9143	35	0.6389	2.1429	14	0.6343	1.8125	16

VITA

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EDUCATION

1991	Ed. D.	University of Tennessee, Knoxville Major: Educational Leadership
1971	M. A.	University of Tennessee, Knoxville Major: Sociology
1969	B. S.	University of Tennessee, Knoxville Major: Social Studies Education
1967	A. A.	Hiwassee College, Madisonville, TN
1965		Loudon High School, Loudon, TN

EMPLOYMENT

1976-Present	Director, Comprehensive Ed. Resource Center Tennessee School for the Deaf
1972-1976	Rehabilitation Counselor for the Deaf TN Division of Vocational Rehabilitation
1971-1972	Instructor, Sociology Maryville College, Maryville, TN
1970-1971	Graduate Teaching Assistant, Sociology University of Tennessee, Knoxville
1969-1970	Graduate Assistant, Sociology University of Tennessee, Knoxville

CURRENT PROFESSIONAL AFFILIATIONS

Council for Exceptional Children
Division for Early Childhood
TN Division for Early Childhood
National Registry of Interpreters for the Deaf
TN Association for Supervisors of Special Education
Conference of Educators of Agencies Serving the Deaf

CHURCH AND CIVIC ACTIVITIES

Music Director in local church
Soloist