出國報告（出國類別：進修）

美國以家庭為中心的早期療育服務與成效學習

服務機關：臺大醫院

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派赴國家：美國

出國期間：自 **104** 年 **07** 月 **2** 日至 **104** 年 **9** 月 **30** 日

報告日期： **104** 年 **10** 月 **16** 日

摘要

美國聯邦政府透過法令調整要求各州收集高品質的早期兒童成效資料至今十年有餘，聯邦政府方面仍積極提供技術資源協助各州進行早期兒童成效資料分析與解釋，進一步做為政策調整與早期方案的依準，其整體理念是幫助孩子預備未來適應能力。目前的成果正是利用大數據整合的價值，從資料結果帶動政策調整，及方案改善的正向循環。此外，即使政府有再好的政策，如要落實確實必需慎選執行策略與方式，以及考量時機與人力，才能有效的發揮影響力。在早期兒童成效政策執行上，早期兒童成效技術資源中心運用了科學方法，透過執行科學與改善科學的工具與原則，確認早期成效的共識與合作夥伴，並深思熟慮的思考根本問題以及尋求任何可能的解決策略，亦步亦趨的從聯邦政府的教育辦公室到基層服務提供者，都攜手朝向支持家長、協助孩子成長的路邁進，此成功經驗與施行過程值得臺灣借鏡。

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壹、進修目的

臺灣的早期療育依著預防勝於治療的觀點，致力於全面性的篩檢早期發現相關發展的問題，及早提供多方專業資源治療與服務，以把握幼童的治療黃金期，來維持或促進發展障礙的幼童之發展，然而時至今日，預防的成果，或說早期療育的成效指標一直遲遲未能有明確的結果。在國建署的「兒童發展聯合評估中心服務品質專案管理計畫」中，大力推動各縣市成立聯合評估中心並發展以家庭為中心以及早療成效評估，目前成效評估仍是現今各早療中心積極努力的方向，本文藉由深入了解美國當地早療方案的執行方式與成效方案，除幫助本院早期療育的成效與服務外，也希望作為國健署或相關早療教育單位推行以家庭為中心及兒童成效評估之參考。

美國推行早期介入已有四十多年歷史，一直是世界各國的標竿指標，其早期介入在預防醫學的成效，已經有追蹤三十年的正向成效。近十年來，聯邦政府補助各州推行嚴謹及完整的早療介入計畫與成效評量，以及成效改善方案，從結構面、法令面與實務面落實納入家長，推動到宅/在家提供介入服務，在學校提供融合教育，力行支持家長與老師協助孩子學習與發展的早期介入方案，目前在各州已有良好成果。此外，各方學者也積極投入世代研究，除了能了解早期療育的長效性外，也能回饋到早期介入實務工作上，以從生活扎根的為這群遲緩/身心障礙孩童的未來做準備。

貳、參訪過程機構介紹

一、Frank Porter Graham Child Development Institute

位在美國北卡羅來納大學山教堂分校的法蘭克-波特-格雷厄姆兒童發展機構(Frank Porter Graham Child Development Institute at the University of North Carolina at Chapel Hill, USA，FPG) 是一個針對兒童與家庭國際性、大型、跨專業的研究中心，FPG 今年正要歡度 50 週年，FPG 每年有近 100 個計畫，近 300 位研究人員，以及豐碩的研究成果，尤其北卡羅來納州的自閉症個案發生率高達 1/68，推動高品質親子互動，尤其是促進幼兒社交情緒的發展，除了能及早篩檢自閉症外，社交情緒能力的建立可視為兒童早期學習的基礎，有利於幼兒上學的適應；此外針對西班牙與英文雙語的北卡羅來納內嬰幼兒(高比例的低社經家庭)及早接受高品質的雙語教學與學前準備；同時，為延續研究成果，建置並積極推廣跨國際及早療專業人力發展培訓課程。FPG 中心除領先研究及專業發展培訓外，也積極提供各州技術支援合作，執行改善早期學習與早期療育相關服務品質。

FPG 中心在兒童早期發展領域國際知名，常是學術參訪熱門機構，2014 年 FPG 主任與浙江師範大學簽署備忘錄，推動當地兒童教師師資培育及相關專業發展；同年度，新加坡 KK 婦幼醫院專業團隊派人到 FPG 專案之一的兒童成效技術支援中心(Early Childhood Technical Assistance Center-ECTA center)參訪兩週，了解實證執業，提升早療方案的成效，並參觀當地療育單位。雙方於參訪時簽署備忘錄，延續繼續合作關係，與 ECTA 中心主任 Kasprzak 博士合作，以提升新加坡早療社區執業與早療成效。

二、The Carolina Institute for Developmental Disabilities (CIDD)

這是北卡羅來納大學山教堂分校之兒童發展障礙專業機構，以多專業、跨團隊方式提供兒童、青少年及成人臨床服務，包括診斷釐清、診斷解釋、介入與治療計畫，

以及提供父母諮詢等。專業人員包括醫師、心理醫師、語言治療師、物理治療師、職能治療師、精神科醫師、聽力師、社工師與特教專家等。CIDD 接案時會依據個別個案與家庭情況轉介合適門診與安排團隊成員，例如聽力與發展門診，除心理師、職能治療師及語言治療師外，會再安排手語翻譯師等。我曾參與多次評估，其團隊包含博士後研究生通常有五到十人，在一個治療專業主持下，先與家長介紹在場人員與進行方式，再分頭評估，並利用評估室的單面鏡與多角度攝影機，讓所有人都能在不影響評估下觀察。整個團隊、一個家庭、一整天評估、訪談、討論，形成共識與建議，對每個家庭與孩子能充分討論與深入了解，最後提供家長們跨專業討論的共識與結果，及提供完整的報告書。

轉介到 CIDD 評估的孩子多是相當複雜，CIDD 的專業在該州已然成為權威，有些州立學校直接與 CIDD 簽約，協助複雜個案的評估，處理學校與家長的調解問題，作為最後諮詢的關卡，像是身心障礙學生的最適學習管道與合適的 IEP 目標等。一次評估費用約是 3000 美金，視個案的身分而決定費用來源。聲明遠播之下，理所當然的，等待評估的個案排程大致是一年。

三、TEACCH 北卡羅來納大學的 TEACCH 自閉症方案是大學下的社區區域中心，

TEACCH 自閉症方案是由 Dr. Eric Schopler 在 1972 年創立，目前是全世界自閉症治療方案的典範，其總部為在北卡羅來納大學山教堂分校，北卡羅來納州共有七個地區 TEACCH 中心，提供自閉症診斷評估、家長訓練、家長支持團體、社交遊戲與休閒團體，高功能自閉症個案諮詢以及就業支持等服務。此外，TEACCH 也提供全國與國際訓練課程，提供教師、各區照顧人員與各專業的培訓。TEACCH 的宗旨是提供創新示範方案的自閉症服務，個別化的了解自閉症個案的文化、學習策略與偏好，實際生活的影響等，希望能協助自閉症個案的充分參與。

TEACCH 自閉症機構教堂分校目前收案以成人追蹤評估居多，學齡孩童為其次，在評估前完成 family interview 確認評估需求。在自閉症診斷評估後，等待治療的家長必須先上 family teaching session 認識自閉症，了解怎麼結構化教孩子解決問題與學習。 個別治療部分提供自閉症個案每週一小時，兩位指導員的方式協力家長學習，由於待排個案多，僅能提供 8-12 次的課程。

TEACCH 自閉症方案機構教堂分校在每個暑假提供課程培訓，密集的七週，每週五天的訓練種子學員學習 TEACCH 自閉症方案，為的就是服務更多有需求的孩子。

四、早期兒童技術支援中心(The Early Childhood Technical Assistance Center ，ECTA)

兒童成效中心其實成立大約二十多年，是特教辦公室五年計畫經費補助的技術支援中心，過去曾經是 National Early Childhood Technical Assistance Center 、National Early Child Outcome Center(ECO) ，目前中心名稱為 Early child technical assistance center(ECTA)。為協助各州政府回報早療成效，2003 年起 Early Childhood Outcomes Center(ECO)致力兒童與家庭成效指標的建立，而其後在兒童成效指標的施行上與各州有長期合作關係，協助各州建立有效果也有效率的早療方案。而在兒童成效資料的收集及與其他中心合作，例如 IDEA 全國資料中心(IDEA-IDC)、國際早療系統改善中心(NCSI)、早期兒童資料系統(DaSy)等中心，合作致力於早期兒童成效收集的品質與資料分析。在 ECTA 中心有多年與各州早期療育相關政策與專業人員培訓合作的經驗，因此目前各州施行早療系統改善上，非常仰賴 ECTA 中心之技術支援，提供關鍵性的早療系統改善之適用性與方法。

參、簡介美國早期療育組織與架構

一、早期療育之行政組織與法令依據(IDEA)

美國是由州聯邦組成的國家，各州與中央聯邦政府都有司法主權，此外，各地方政府，像是郡、部分市、甚至大型州立大學也擁有自治權，可以自己制定法令，因此與早療相關的行政組織與規定非常的多元，各州早療方案分屬不同主管單位，像是北卡羅來納州 Health and Human Services，德州在 Assistive and Rehabilitative Services，有些州則在健康、教育或公衛部門。在財政上，各州為符合法令要求提供免費的早期介入與學前教育服務，然因其地方稅收與可支配財源不同，各州可能因其財政狀況而微調早期療育的收案標準。

美國之早療法令依據是美國聯邦政府自 1994 年公布的 The Individuals with Disabilities Education Act (IDEA)，其中明訂了各州與地方政府如何提供身心障礙兒童早期療育、特殊教育與相關服務。在 IDEA 法令中的 Part C 是 0-3 歲兒童的早期療育；IDEA 法令中的 Part B 是指特殊教育，為了讓發展遲緩兒童及早入學，其教育 5 歲延伸到 3 歲，Part B 中 619 法條是有關 3-5 歲發展遲緩兒童學前特教方案(又稱為小 b 方案)。在美國 50 州、聯邦特區及境外領土共有 58 個早療方案，在龐大的系統下，加上各州自治/自決、政策、財源、教育、醫療等歧異多，各州得自訂的發展遲緩標準與醫療診斷(Eligibility) (詳見附錄一)，符合標準的遲緩幼兒會召開嬰幼兒個別計畫方案(IFSP)會議，依據家長意願協調各項服務，並依據家庭收入與保險，安排療育頻率。

此外，美國政府要求所有早療的服務提供對接受早療的孩子或一般社會大眾，負起成效探討的責任(accountability)。美國教育部特教辦公室(the Office of Special Education Programs ，OSEP)要向國會議會回報早療成效，也因此特教辦公室提供各州身心障礙教育(Individuals with Disabilities Education Act ，IDEA) 的補助款，進而能要求各州政府提供早期療育(0-3 歲)及學前特教(3-5 歲)的身心障礙兒童在接受服務後的成效，以利後續調整療育或改善治療方案。過去，特教辦公室補助各州早期兒童方案的同時就要求州政府在成果計畫(State Performance plan)及年度成果報告（Annual Performance Reports，APR）回報早期兒童資料，當時要求的指標是服務的內容以及接受服務人數的統計。然自 2004 年起，特教辦公室要求各州政府的 SPP/APR）要分別就早療方案(IDEA Part C，0-3 歲兒童)以及特教學前方案(IDEA-part B-619， 3-5 歲孩童)部分，納入兒童與家庭成效 。

APR 指標的設定確實成為影響了各州早療導向的風向球，除了嬰幼兒通報率與報告時程完成率外，各州在早療收案與結案時特別注意兒童成效與家庭成效資料;嬰幼兒在自然環境療育的百分比，讓各州要求地方提供服務時必須到宅。

以下詳細介紹早療方案(SPP Part C indicator)成果指標包括:

(一) 、 30 天內服務達成率(timely service delivery): 指嬰/幼兒依據嬰幼兒個別計畫方案(IFSP) 在 30 天內接受到服務的百分比。

(二) 、早療服務場域(setting):指早療嬰/幼兒依據 IFSP 在家或當地社區接受療育的百分比。

(三)、兒童成效(Child Outcomes):有多少百分比嬰/幼兒的 IFSP 在(A).正向的社會-情緒技巧；(B). 知識與技巧學習與運用；(C).滿足自身生活需求上三指標上有進步，分別以兩項總結指標呈現進步百分比

1.總結指標 1(summary statement1):嬰/幼兒在三歲或結案時，在三項兒童成效指標上之年齡期待發展上有進步。

2.總結指標 2(summary statement2):嬰/幼兒在三歲或結案時，在三項兒童成效指標上已經達到年齡期待。

(四)、家庭成效(Family Outcomes):家長回報早療在以下三面向對家庭幫助的百分比:
(A). 知道權益；(B). 溝通孩子的需求；(C). 幫助孩子發展與學習上

(五)、0-1 歲兒童的通報率

(六)、0-3 歲兒童的通報率

(七)、45 天內 IFSP 完成率(timeliness of IFSP): 指在 45 天內完成嬰幼兒個別計畫方案(IFSP)的百分比

(八)、兒童轉銜(Early Childhood Transition):指多少百分比的幼兒轉出早療方案在以下三個條件符合的百分比(A).IFSP 中有包含轉銜計畫；(B).通知地區學區中心有多少孩子可能符合上學條件；(C).召開轉銜會議。

(九)、申訴案件(Hearing Requests Resolved):多少百分比的申訴透過輔導會議解決。

(十)、調解案件(Mediation Agreements):多少百分比的調解達成協議。

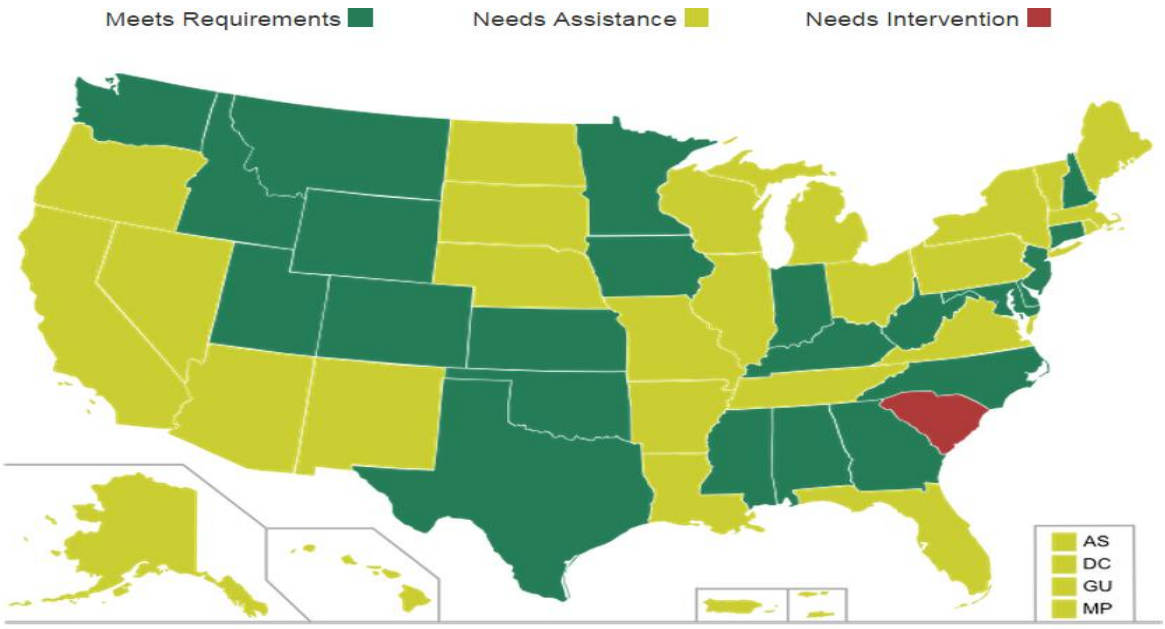
(十一)、州成效改善計畫(State System Improvement Plan，SSIP):SPP/ARP 要求廣泛性、全面性、可達成、跨年度的 SSIP。

特教方案(SPP Part B indicator)成果指標橫跨 3 歲到 21 歲，其指標有稍作調整，但仍關心最少限制環境下的學習、轉銜及兒童成效(準備技巧)與家庭參與。特別是，美國早療方案(IDEA Part C，0-3 歲兒童)與學前方案(IDEA Part B-619，3-5 歲兒童)的服務是分屬不同的環境-早療方案的幼兒在家接受療育服務，幼兒轉入學前方案時，就要轉到機構或學校中學習。轉銜對幼兒與家長來說是很大的改變，仍成功適應，確保在家的學習能延續到學校中，IDEA 特別將幫助幼兒成功轉銜的三個關鍵:計畫、知會、開會列為 APR 的要求指標要求，來確保各州做好幼兒轉銜。(詳見附錄)

然而在提供要求各州提供資料的壓力同時，教育部特教辦公室也補助相關的技術支援(TA)中心，讓各州依自己的需求尋求合作或協助，從協助的角度，政府與地方一起提升早期兒童服務品質，同時要求與並提供支持-是雙贏成功的關鍵。

二、早期兒童資料系統(The Center for IDEA Early Childhood Data Systems , DaSy Center)

Early Childhood Outcomes Center(ECO 中心)早期的任務是協助全國建立共同的目標與成效指標，與協助各州執行年度成效報告，然而為了長期收集成效，確保資料的延續性以及促進各州改善早療實務，在特教辦公室也在 2007 年補助建置早期兒童資料系統，協助各州在早療方案 (IDEA Part C，0-3 歲兒童)與學前方案(IDEA Part B-619，3-5 歲兒童)兩個年齡層的成效資料收集並協助各州與跨州改善早期兒童方案與政策。特教辦公室認為唯有高品質的資料才能制定各州個別化的 Results Driven Accountability(RDA) Matrix，後續利用這些成效資料來評定各州早期兒童成效以及改善早期兒童療育服務。以下圖為例，特教辦公室依據各州個別化制訂的 RDA Matrix 程式算出 2015 年的 Part C 表現(Part C profile)。



為確保各州留意早期兒童資料的收集與完整性，依據 IDEA616 法條，各州表現若達成 80%以上為符合要求，60-80%為需要協助，60%以下為需要介入(如上圖，南卡羅來納州是 2015 年唯一落在需要介入的州別)；連續兩年落在 need assistance 的州， 特教辦公室會採取強制行動，如要求該州接受技術支援以協助改善早期兒童表現；若連續三年落在 need intervention，該州就被要求提出 corrective action plan，其療育經費也會被凍結(IDEA §616)。各州政府所提供的州資料，是由各地方政府提報，因此各州也依據公式與成果來要求各地方政府改善服務提供與早期兒童資料的收集與完整性。整各行政系統從上到下層級究責，層層監督與改善早期兒童的服務與成效。特教辦公室在其成果網頁上建制資料共享，讓各州詳細的成果報告資料都能公開查閱，也讓州與州間能分享與相互合作。

以上這些資料，是 DaSy 收集各州資料回報的成果，讓特教辦公室能進而要求各州對其早期兒童系統負責，強調改善身心障礙兒童療育與教育成果，及提升兒童功能成效。而各州在 IDEA 要求的 APR 報告中的早期兒童資料收集、分析與回報會因而更謹慎，而有更高品質早期兒童資料，形成正向循環。其實，早療與學前方案的相關人員能定期的使用這些資料來執行早療計畫，就是早期兒童資料改善的實質意義。

三、早期兒童系統架構(ECTA System Framework)

特教辦公室為了協助各州建立有效的早療方案，在 ECTA 協助下，開發一個符合各州早療與學前方案的多樣性的系統架構。從文獻回顧及專家會議收集建議，並與六個州合作試行，建置了一個能符合各州早療與學前服務多樣性的系統架構。

此架構共涵蓋六個面向，而每一個面向都涵蓋幾項品質指標，而符合高品質指標是指有計畫、及時與高品質，以下介紹六個面向對兒童早期方案成功的重要性:

Governance:確認行政結構與夥伴關係，可以有效率及具影響力的支持全州的早療與學前讓所有符合收案條件的兒童與家長都能平等的接受服務提供。

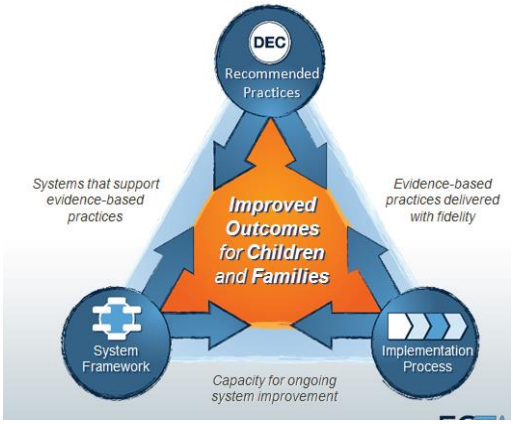
Finance:確認州內財源與資源可以提供早療與學前方案能施行實證執業。
Personnel/Workforce :確認州內提供早療與學前服務的相關人員都有資格，具知識、技巧與能力，且有足夠的人力來提供州內早療與學前方案。

Data System :確認州內有開發與提升早療與學前資料系統，以及改善 IDEA 資料品質。

Accountability & Quality Improvement:提供成果報告的策略與指引，以提供高品質、有效性與有效率實證執業，提升兒童與家庭成效。

Quality Standards: 確認整個早期照顧與教育方案及服務品質有持續的接受評估與改善

確保各相關中心與人員的合作關係才能建構全面性的系統架構，上從州政府、下到各地區，都落實實證早療方案。因此，ECTA 在建構 personnel/workforce 面向時與 Early Childhood Personnel Center group(CSPD)合作，讓各州專業發展政策制定者參與 ECTA 的早療架構的建構， 以確保 CSPD 對其專業人力落實實證訓練。此外，ECTA framework 其中 data system 與 DaSy 中心的系統架構相容，以確保兒童早期方案的延續性與實務成效。左下圖為 ECTA 系統架構，右下圖則為 ECTA 系統參考架構與實證執業、及成效改善的示意圖。ECTA 系統架構可作為各州做為其早療方案評估、找出改善方案及發展有效率與效果的實證執業之參考架構。

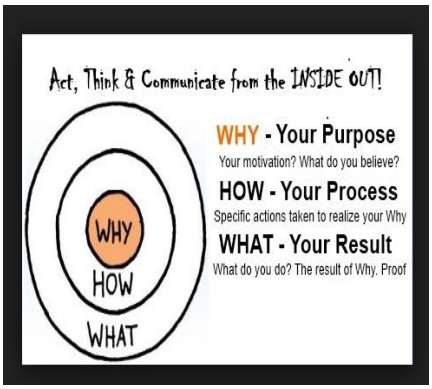


ECTA 的系統架構的開發，在各州擬訂 SSIP 時可作為早療系統內架構的問題分析(infrastructure analysis)，實際幫助各州全面檢視其兒童早期系統的優勢與弱勢，而針對各品質指標，ECTA 可提供各州技術支援，提供相關資源/支援與工具來協助改善這些品質指標，各州可再依據結果選定符合自家需求的努力方向，設定行動計畫。

肆、早療成效方案介紹

在介紹成效前，先了解在美國早療成效改善系統中採用兩大概念:

一、黃金圓圈(the golden circle)



是 Simon Sinek(2009) 提出決策"Start With Why" *How Great Leaders Inspire Everyone to Take Action* ，他以市場行銷為例，如果推銷產品是由外圈到裡圈，清楚解釋要賣什麼產品，產品的好處是什麼，要消費者買他們家的產品，然似乎沒有很大的說服力，但若裡圈(WHY)開始，提出讓人信服的理念、主動關注產品，甚至願意嘗試新產品，就像蘋果公司，每有新產品上市就大排長龍，其企業經營的方式不同，至今，還能在市場上獨佔鰲頭，其來有自。the golden circle 的思考模式，近似於目前早療成效與實證執業推動的概念，在早療成效方案的每一個決策或討論廣泛的被採納:

- What is the problem?
-Why is it happening?
-What shall we do about it?
-How well is the solution work?

早療服務的相關的人員眾多，參與會議的人員經常也會不同，然而為了達成 APR 或 SSIP 的要求，會議的效率與聚焦於問題是每個會議的重點，因此所有會議的議程，都是照著這樣的架構並結合數據分析:
目前州早療資料上的問題是什麼? 為什麼成果分數低?
我們要怎麼改善? 這些做法能改善多少?

套入臺灣的早療現況來看:
早療資源濫用的問題是什麼？家長為什麼擔心治療頻率不夠？
要怎麼幫助家長有信心協助孩子發展？如果幫助家長瞭解及學習如何幫助孩子，可以達到什麼樣的效果。

在臺灣，早療大多數都在醫院、機構中執行，所有的早療人員都懷抱著接受早療的兒童在接受治療後孩子能自動類化技巧到生活中的"夢想"，這個類化的"夢想"在有了 implementation science 後，有更踏實的類化步驟，與實現的可能。

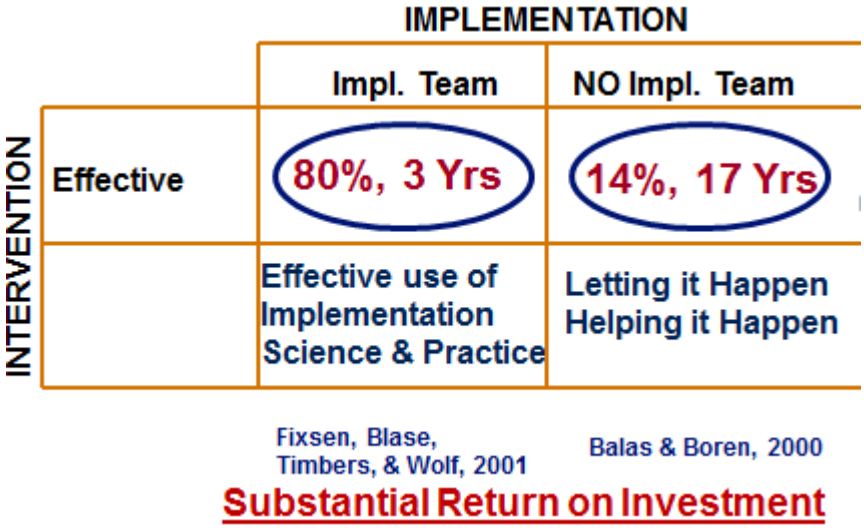
二、執行科學(implementation science)

突然的要求全面實行實證執業或以家庭為中心只會讓早療人員喘不過氣來，根據經驗，靠法令、規定、提供資金、補助、獎勵，只能有 5-15%的成功機率。一個機構內可能只有 20%的人準備好要改變-做實證執業，由於人都有強烈的慣性，唯有透過仔細計畫、執行策略能幫助做好準備。

美國龐大的早療體系的成效運作成功的關鍵，是導入了執行科學(Implementation Science)。這門科學起源於 1960 年代，2002 年起在 FPG 資助下，Dean Fixsen 與 Karen Blas 創立了國際執行網絡(the National Implementation Research Network , NIRN) 加速 implementation science 領域的發展，這是一門利用系統化的運作，將學術研究結果或

實證執業(evidence-based practices)導入實務的科學，因 FPG 是其資助者，其組織內的 ECTA 中心也藉由 implementation science 逐步落實早療成效。歷經數十年來，implementation science 已經更了解如何落實實證執業方案，以及如何更有效的運用到不同的場域中，在大社會架構下了解實證執業的成效，執行是最重要關鍵。

根據統計，運用 implementation science 的實務執業在 3 年內的成功率是 80%，沒有運用 implementation science 的執業在 16 年內只有 14%的成功率。執行科學有提供相當豐富的執行工具來促進思考與執行方式，使用工具的時機與適當性，得視各州或各使用地區的個別需求決定。



三、早期兒童成效(Early Child Outcome)

為協助各州政府回報兒童早期成效，特教辦公室在 2003 年起資助 Early Childhood Outcomes Center(ECO)舉辦全國高峰會議[1](Leadership conference)來找出兒童早期成效的指標以及如何執行兒童早期成效評估。ECO 中心與各界相關的兒童早期利害關係人(stakeholders)[2]，包括家長、早療人員、老師、當地/局/聯邦教育局人員及研究學者共同定義兒童與家庭成效，其中很關鍵性的步驟是共同定義了早療與學前教育階段的成效目標-讓幼童有個主動、成功參與的童年，以及能勝任未來各種環境-在家、托兒所、學前機構以及社區(to enable young children to be active and successful participants during the early childhood years and in the future in a variety of settings—in their homes with their families, in child care, in preschool programs, and in the community) ，這也就是對特殊兒童的最終目標，「兒童早期成效」的重要意義是無論在醫療或教育界中，採用共用的語言，此目標是功能性的，而非單一面向。對 0 到 5 歲的兒童，以及 5-21 歲的學生均採用此一貫的成效指標。在此會議中並制定了三項兒童功能性成效指標是與終極目標息息相關，此三項成效指標為:

成效一：正向的社會-情緒技巧(包括社交關係)

(Outcome 1: positive social-emotional skills (including social relationships)

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[1] **Leadership:** A person or group of people who provide guidance, inspiration and direction to a group in order to accomplish a result.

[2] **Stakeholders**: Individuals or groups who have invested time, money, energy and/or interest into something. Stakeholder groups should include representation of persons who are affected by or invested in any proposed change/innovation such as parents, personnel, administrators, or others who can provide relevant information, personal experience or expertise to the proposed work.

成效二：知識與技巧學習與運用(包括早期的語言/溝通以及學前兒童早期的讀寫能力)
(Outcome 2: acquisition and use of knowledge and skills (including early language/ communication and early literacy– for preschoolers)
成效三：滿足自身生活需求上的改變:
(Outcome 3: use of appropriate behaviors to meet their needs)

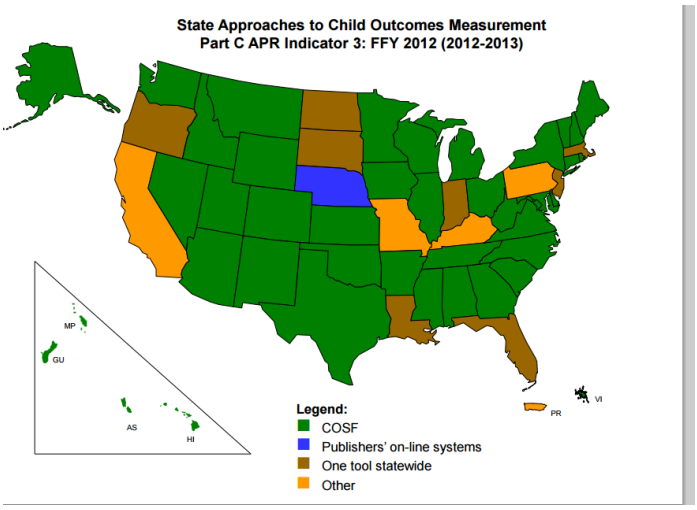
為了評估兒童早期成效指標，2005 年 ECO 中心開始建置兒童成效總表(Child Outcome Summary)，做為評估方法，其中一個重要的評估原則是透過團隊討論，包括家長，依據兒童發展年齡總結孩子目前三項成效指標能力現況，並參考成效樹狀圖(附錄二)，在七點量尺上推估兒童早期成效現況。

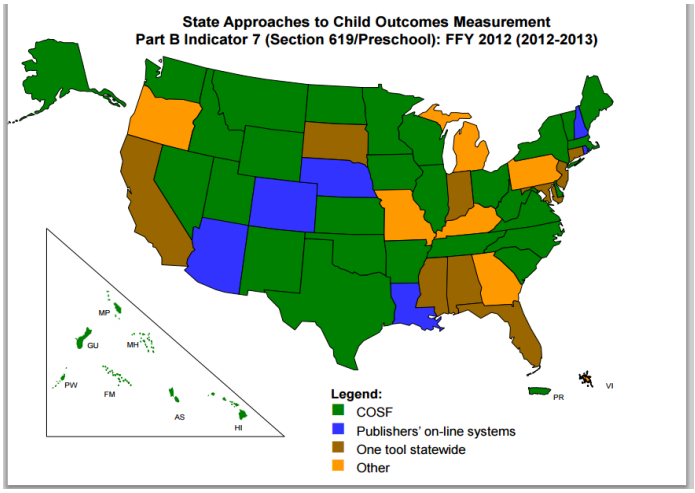
由於三個兒童功能性成效指標的建置是從上千個早期兒童利害關係人(stakeholders)，包括家長討論出來，是兒童能成功的參與在各個環境的活動中所必須具備，反應出兒童早期必須達成的目標，深具社交信度(socially validated)，是整合且功能性來看孩子的，因為兒童要能成功適應各種環境，需要的是整合的能力，不是從單一評量工具或兒童單一功能程度決定成效，例如兒童是否會分類珠子 vs. 兒童能否找出一對的鞋子；兒童能否命名三個物品 vs 兒童能說出她想玩的物品，後者的例子才是功能性的表現。

採用這三項兒童早期成效指標可以協助兒童早期專業人員及家長更有方向的討論兒童發展現況，協助個別教育計畫方向的擬定(在學齡前稱為 IFSP，學齡期稱為 IEP)，也能讓兒童早期服務更落實在幫助孩子未來適應能力的準備。2011 年起 ECTA 中心開始採用兒童成效總結過程(Child Outcome Summary Process)取代兒童成效總表，來強調透過團隊的過程來討論兒童早期成效。

在各州 APR 年度報告中，要提出兒童在三大成效指標的進展狀況，兒童早期成效評估至少要有兩個時間點的資料:第一次收案（enter the system），以及結案(exit the system)，例如六個月的兒童因發展遲緩轉介到當地兒童早期中心評估，第一次評估收案的資料就會包含兒童成效評估。而當孩子接近三歲，準備轉出到學前特教系統時，會再做一次兒童成效評估，也就是結案評估，APR 報告中也會回報收案資料的完整性，以確保各州都有收案與結案評估。

全國制訂了兒童早期共同的目標與成效指標，而多數的州有採用 ECO process，做為每年的成效報告，然而為了長期收集成效，確保資料的延續性以及促進各州改善兒童早期實務，在資料的完整性與品質上 ECTA 中心與 DaSy 持續合作，協助





各州收集兒童早期成效的資料並進一步協助各州與跨州改善兒童早期方案與政策。目前各州在 part C 早療方案（0-3 歲）、特教 Part B 方案（3-5 歲及 5 歲以上）採用 Child Outcomes Summary (COS) process 的情形如上圖(IDEA 公佈之 2014 年早期兒童成效詳見附錄三)。

四、家庭成效(Family Outcome)

在 2003 年特教辦公室得的資助下，Early Childhood Outcomes Center(ECO 中心)除定義了兒童早期目標與兒童成效指標外，也同時建立了家庭成效，設定了五個家庭成效指標:

1.家長了解孩子的優勢、能力與特殊需求(Families understand their child's strengths, abilities, and special needs)

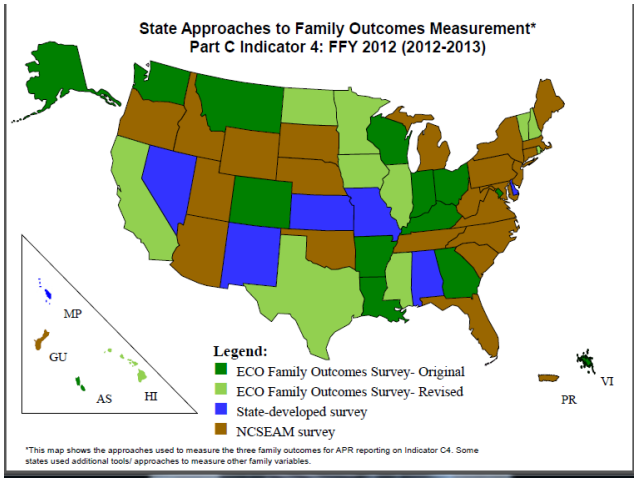
2.家長了解他們的權益及能有效為孩子爭取權益(Families know their rights and advocate effectively for their child)

3.家長能幫助孩子發展與學習(Families help their child develop and learn)

4.家長有支持系統(Families have support systems)

5.家長能在社區找到想要的早療服務與活動(Families access desired services, programs, and activities in their community)

依著這些成效指標，ECO 中心設計了家庭成效問卷(the Family Outcomes Survey，FOS)，是由父母填答的五分量尺問卷，在 2006 完成 FOS 版本，2010 年則發表了家庭成效問卷修訂版(The ECO Family Outcomes Survey-Revised or， ECO FOS-R) 。特教辦公室要求各州早療方案(IDEA Part C，0-3 歲兒童)以及特教學前方案(IDEA-part B-619， 3-5 歲孩童)的 APR 中採用了其中有三個指標。每一年全國的家庭成效結果，都公布在網站上，呈現給大眾(詳見附錄四)。然而各州家庭成效調查上使用的工具與方法，如圖所示，區分為四種家庭成效工具，此外，各州在家庭成效調查上沒有統一的調查方式與時程，而問卷回收率也偏低。今年七月特教辦公室舉辦全國高峰會議中，針對家庭成效議題討論，由全國資料中心(IDC)邀請各中心成為 family outcome cooperative，深入了解各州對家庭成效的評估做討論。



雖然 ECTA 有兒童早期成效評估與家庭成效指標與評估建議，然而各州在收集資料的品質上各不相同，為了確保資料的完整性除了要求團隊會議決定成效外，各州也紛紛研究如何在 IFSP 與 IEP 報告中融入成效指標，已確定所有的目標都是團隊討論，且一致的。(附錄五為在 IFSP 中融入早期兒童與家庭成效評估之建議)

伍、實證執業建議

其實聯邦政府早期兒童部(Division for Early Childhood，DEC)自 1990 年代開始，就由學者針對早期介入/早期兒童特殊教育提出執業建議，並在 1993 年發表第一版。隨著新的實證研究的發表，融合(inclusion)及以家庭為中心(family-centered)觀念的影響，早期兒童部重新檢視執業建議，結合實證研究文獻資料的證據力，在 2005 年提出針對 0-5 歲兒童的實證紙業原則第二版，從評估、兒童導向執業、家庭為基礎執業、跨專業模式以及輔具應用五大面向建議直接服務原則。隨著早期兒童成效與家庭成效的進展，為了落實兒童早期服務針對孩童未來的適應能力，各州早療專家在 2008 年齊聚一堂，建立「任務與重要原則共識-提供自然環境中早期療育服務 (Agreed Upon Mission and Key Principles for Providing Early intervention Services in Natural Environments) 」，以及建立七項關鍵原則(詳見附錄六)。聯邦政府早期兒童部依據此共識下，修正執業建議，在 2014 年公告了最新版建議執業原則，並於 2015 年 10 月出版。

一、聯邦政府早期兒童部實證執業建議(Division for Early Childhood Recommended Practices，DEC- RPs)

此版本依據現行早期學習與療育的實證研究結果，針對各八大主題建議執業，分別是:

Leadership: 完善的早療方案、學校、機構與組織的支持是早期學習相關人員能否落實實證執業需要的關鍵，尤其相關單位主管的支持，是成功的關鍵。

Assessment: 對疑似遲緩/發展障礙兒童與家庭提供完善的評估是決定早期服務的關鍵，從篩檢、收案到個別計畫、監督進展與成效測量，都仰賴適當的評估。

Environment: 疑似遲緩/發展障礙兒童與家庭應該要在各種環境下，與一般大人及同儕互動、學習、遊戲。環境中的空間、材料、設備與活動安排是支持孩童跨發展領域學習的重要助力。。

Family: 早期學習相關人員要協助家長積極參與孩子的所有決定，參與個別化教育計畫的擬定以及協助家庭達成其目標。

Instruction: 早期學習相關人員或家長、照顧者在指導疑似遲緩/發展障礙兒童時要儘可能促進其學習成效與改善功能表現。在與兒童互動時，要依據兒童的語言、認知、情緒程度調整回應與互動方式，因為互動的品質是兒童學習的基礎，要特別注意兒童學到了社交/情緒能力、溝通、認知發展、問題解決、自主與堅定。

Teaming and Collaboration: 早期學習相關人員與家長間的關係與互動品質會影響早期兒童方案服務的品質。團隊運作與團隊合作可以除了促進大人間的關係，也能有助於兒童與家庭成效。

Transition:在兒童早期轉銜服務是提供兒童與家庭適應新環境的機會，轉銜包括從醫院到家裡，從早療方案到學前方案。

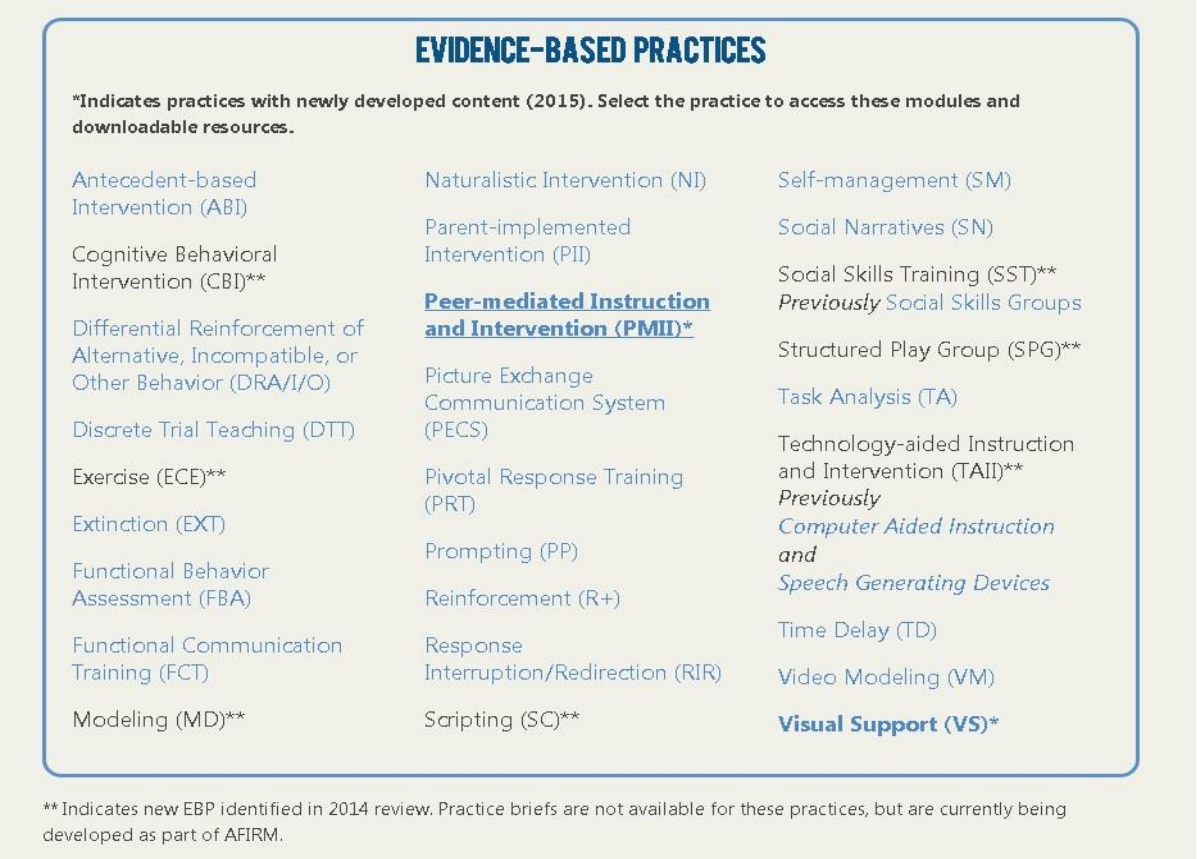
以上每一個主題間其實是高度相關，特別是與家庭一起執業，應該是所有主題的基礎。早期兒童部認為，施行實證執業建議原則，對兒童與家庭成效有正向的成果，且能發揮家庭與兒童之潛能，實證執業的施行品質越高，成效就越大。實證執業原則除具有研究實證外，其原則都是可以觀察的行為，可以在自然環境/融合環境下施行，且是用於所有的一般情境。此外，為了協助早期學習相關人員與家庭學習實證執業，

ECTA 中心建置線上學習以及自我檢核表與建議活動，協助施行實證執業。此外，DEC 正在建置 high quality early intervention-early intervention online curriculum， 針對家庭為中心、兒童學習、自然環境、成人學習、高品質的團隊合作從五個關鍵面向，讓專業人員學習瞭解孩子的學習，自然環境與融合學習重要，與家長合作，coaching 家長與其他專業，以及團隊合作的重要性，預計今年底完成線上學習模組，以推廣執業建議落實於每一項服務中。

此外，ECTA 中心為了讓各專業學會認可 DEC 實證執業原則與其專業建議執業原則做了參照，這些努力，是為了讓各早療相關專業認可與了解現行的執業原則與實證執業、家庭及兒童成效，是一體且一致的(詳見附錄七)。而當各州 SSIP 在推行早療成效改善方案時， DEC 實證執業就成了專業知能發展的最佳訓練材料。

二、自閉症實證指引

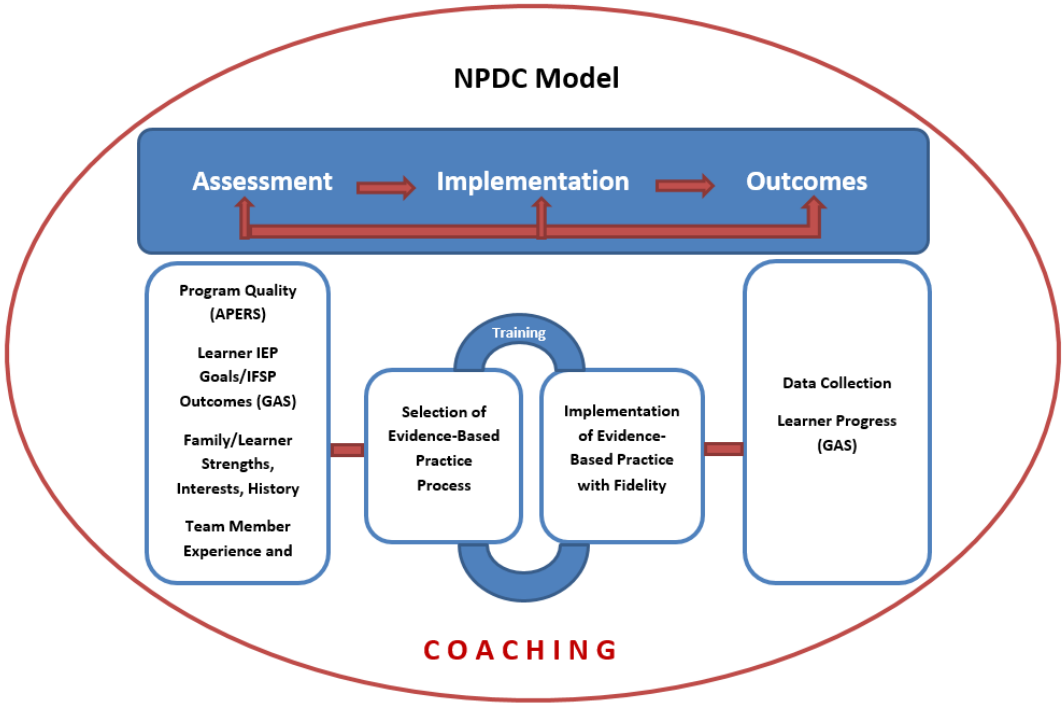
自閉症國際專業發展中心 (the National Professional Development Center on Autism Spectrum Disorders, NPDC)在 2014 年更新了兒童與青少年自閉症實證指引，這是由 UNC-CH 的 FPG 中心學者們所主導的研究計畫，他們從兩萬九千筆自閉症相關研究-隨機試驗/偽實驗與個案研究報告中篩選，找出對 0 到 22 歲自閉症個案具實證的介入



指引- 目前有二十七項(如上表所示)。NPDC 係依據此實證指引舉辦專業培訓課程，加強相關人員的知能，此外，NPDC 同步建置自閉症實證指引的線上學習模組-(Autism Focus Intervention Resource Modules-AFIRM)供專業人士、教師、家長、同儕等之學習參考。目前 AFIRM 已經完成了 Peer-Mediated Instruction and Intervention (PMII)以及 Visual Supports。

為了落實學習者的成效，NPDC 運用 adult learning 教學的原則，設計了學習者模

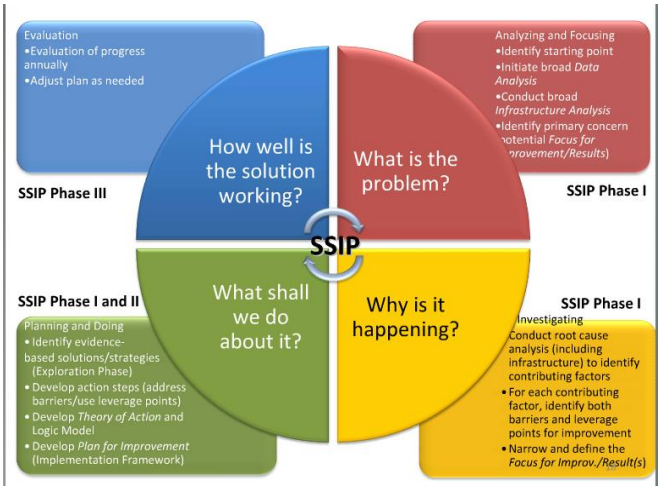
式-分成評估、執行、成效三個環環相扣步驟，並輔以 coaching 來提升相關人員對自閉症「有效的評估」、「實證的介入」以達成「正向的成效」。在 NPDC 與 FPG ASD Toddler 計畫的長期合作下，目前已經有 12 個州，超過 75 間學校採用 NPDC model。



為確保每一個步驟的執行品質，NPDC 設計了 Autism Program Environment Rating Scale (APERS) 幫助了解自閉症個案的服務品質指標，協助專業知能課程的安排、提供 coaching/consulting 的依據以及 NPDC model 的成效。APERS 分為學前/小學版與國/高中版本，此工具有助於分析自閉症個案的服務中，哪些環節還需要加強，以促進介入成效。

NPDC model 的建置與線上學習在 DEC 更新 2014 年實證執業之前完成，由於其成效豐碩，目前 DEC 實證執業線上課程設計與培訓課程，正是參考 NPDC 的做法，如何透過 coaching 與 mentoring 讓學習者能更充分理解，若家長/教師學會了方法，就能幫助自閉症學童有效學習。

陸、州系統改善計畫(state system improvement plan，SIPP)



美國早療與學前方案目前正如火如荼的在進行州系統改善計畫，從計畫到執行，全面檢視並改善州內的早療表現。由於 IDEA 或聯邦法令要求各州執行兒童早期成效近十年，特教辦公室發現即使各州有遵循法令要求，但身心障礙兒童在入學時沒有做好上學準備，或是與同儕間的能力存在很大的落差，與原本預設成果有落差，於是要求各州檢視所回報的兒童早期成效資料並要求提出改善計畫與成果報告。於是 IDEA 在 2013 年各州成果計畫(SPP)Part C 修改了第十一個成果指標為-州系統改善計畫(SIPP)。這是一個由各州自目前的兒童早期成效表現中，自選指標(State-identified Measurable Result，SiMR)，制定跨年度、可達成的改善計畫。特教辦公室建置 SSIP 的概念就是運用第一章所提的 start from why 以及 implementation science，如上圖所示。

SSIP 分三期執行:

第一年(2013):第一階段-分析:分析兒童早期資料，決定要改善的主題，提出支持改善的架構與建立基礎能力，執行計畫，已於 2015 年 2 月完成。

第二年(2014)，第二階段-計畫:分年度計畫架構、支持兒童早期系統或當地兒童早期特教執行實證執業、方案成效評估計畫，今年度各州進行到第二階段，預計 2017 年 2 月完成。

第三到五年(2015-2018) 第三階段-評估:包括 SSIP 方案進展成果與範疇，修訂 SPP。

由各州的 Part C SSIP 報告其實能一窺各州早療的樣貌，從 SSIP 來講各州早療的故事，藉由各州分析州內早療現況，決定改善主題、調查、計畫、執行、評估成效等，全都涵蓋。大多數的州選擇兒童成效指標的其中一項，以下分別介紹以兒童成效為指標與以家庭成效為指標的 SSIP 與理由:

一、北卡羅萊納州的 SSIP

北卡羅萊納州將增加接受兒童早期在正向的社會-情緒技巧上的進展，將自 16 個區域地區機構選定六家作為種子機構執行改善計畫，而後再擴展到 16 區以達最大成效。

北卡羅萊納州的早療方案為 Infant-Toddler Program (ITP) 提供 0-5 歲有確定診斷或發展障礙兒童早療服務，個案來源是透過社區轉介或主動轉介，目的在提供嬰幼兒及家長早療服務。北卡羅萊納州早療方案在行政體系上隸屬健康與人力資源部的公共衛生署之婦幼健康早療局((N.C. Early Intervention Branch of the Women's and Children's

Health in the Division of Public Health within the N.C. Department of Health and Human Services，NCEI)。實務上，NCEI 與 16 的區域地區機構聯盟(Children's Developmental Services Agencies，CDSAs)，CDSAs 的 service coordinator 負責評估兒童是否符合早療服務資格並制定服務計畫，協調早療孩童與家長的早療服務。CDSAs 除執行、督導與監督各社區早療服務提供者落實早療方案，並且要調度服務提供的即時性，意即若各社區服務提供者沒有辦法在評估後 30 天的時限內提供遲緩兒童早療服務，CDSAs 就要自己提供早療服務並持續尋找合適的早療服務提供者。在收案後 45 天內完成評估及 IFSP 計畫(兩表格如附錄)，依據個別 IFSP 需求提供服務，到宅服務的頻率是兩週，或一個月一次，每次服務的時間為 45 分鐘。

北卡羅萊納州在 SSIP 第一階段選定指標時，回顧過去每年兒童早期資料的表現並與全國資料比較。經過很多次的會議討論，並針對問題原因分析與假設及改善策略(詳見下表，北卡羅萊納州發現其早療兒童在正向的社交-情緒技巧上兒童成效(三 A)的總結表現一(Summary Statement 1-早療嬰/幼兒在三歲或結案時，在三項兒童成效指標上之年齡發展速率上有持續的進步) 持續表現都不佳，利益關係人(stakeholders)發現這個指標剛好與目前州內針對兒童社會/情緒發展的主題相關，若設定這個指標也可以同步促進兒童社交/情緒的成效。透過 SSIP 討論，北卡羅萊納州決定了五組執行團隊，分工合作落實 SSIP 計畫，從組織架構、專業發展、臨床實務、家庭參與、成效整合各方面兼顧下，縝密計畫以提升州內早療孩童的社會/情緒功能，針對相關問題區分團隊任務與目標，並一一提供解決辦法。

Root Causes	**Hypotheses**	**Improvement Activities that Address Root Causes**
There is inconsistency in assessment processes across N.C. that contribute to the types and quality of information that is used for the COS process and the development of IFSPs There is inconsistency and a lack of skill in assessing social-emotional development and positive social relationships across CDSAs	If there is consistency in assessment practices across the state, ratings will be more accurate and overall COS data will improve	2. Expand professional development and Standards 3. Strengthen the State system for planning and dissemination; 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families
The COS process is seen as a tag on, not an integral part of the IFSP process, which impacts data quality	If the COS process were an integral part of the IFSP process, ratings will become more accurate and overall COS data will improve	4. Continued expansion of child outcomes integration pilot 7. Disseminate child outcomes data at the CDSA level and investigate additional/ alternative data to measure child and family outcomes
There is a lack of understanding about what the data mean or how it is used after the ratings are completed	If staff has improved understanding of the purpose and use of the COS data, ratings will be more accurate and overall COS data will improve	4. Continued expansion of child outcomes integration pilot 7. Disseminate child outcomes data at the CDSA level and investigate additional/ alternative data to measure child and family outcomes

Staff don't have the expertise in assessment or intervention needed to adequately address social-emotional needs of children in EI	If staff has training in assessment and intervention, ratings will be more accurate, and children will have appropriate social/emotional goals on their IFSP	2. Expand professional development and standards 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families
Staff comfort with talking with families during assessment, IFSP development and intervention about children's social-emotional needs is low and impacts the assessment of social-emotional needs, the writing of the IFSP itself, and securing intervention services for children with social/emotional needs.	If community service providers and CDSA staff have more confidence/competence in talking with families throughout the IFSP process, parents will develop better skills at communicating their children's needs	2. Expand professional development and standards 5. Creation of an EI service delivery model of clearly defined practice standards for equal access for children and families
Reduced resources for service coordination (less staff, more families) contribute to fewer conversations that promote family understanding of EI, outcomes, IFSP in ways that are meaningful to families	If community service providers and CDSA staff improve their skills engaging families in the EI process, families will develop better skills communicating their children's needs	4. Continued expansion of child outcomes integration pilot 6. Overhaul family outcomes measurement process 9.Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs
Lack of community service providers in rural areas of N.C. create a resource burden on the CDSAs and affect service delivery of IFSP services	If additional community service providers can be identified or novel treatment approaches can be found, IFSP services will be more likely to be delivered as prescribed	1. Establish and expand provider network 8. Explore and implement telehealth options to increase access to social/emotional experts 9. Capitalize on and expand partnerships with other agencies and stakeholders to meet program needs

二、阿肯薩斯州的 SSIP

阿肯薩斯州的 SiMR 選定家庭成效指標之一(四 C)，內容為:

阿肯薩斯州將增加接受早療兒童的家長認為早療有幫助他們的孩子發展與學習的百分比

阿肯薩斯州的家庭成效問卷是由兒童成效中心(ECO)所發展，其資料收集方式為大型寄發問卷給早療收案的家庭，而家長可以選擇紙本、線上或電子信箱，電話或現場等方式填答。其回收的家庭成效資料與全國的資料比較如下

A. Know their rights (68%) versus 87% nationally

B. Effectively communicate their children's needs (71%) versus 88% nationally

C. Help their child develop and learn (75%) versus 90% nationally

從資料來看，有 25-32% 的家長覺得他們不知道怎麼幫助孩子、溝通需求、了解

權益，因此州利益關係人(Stake Stakeholders)[3]同意從早療與改善方案來幫助這些家長，增加這些指標的百分比。

阿肯薩斯州 0-3 歲的早療方案為 First Connections Program，在行政體系上隸屬是發展服務部人力資源署之 lead agency 主責，lead agency 再與地方基層早療機構簽訂 Intra or Inter-Agency Agreements 提供州內發展遲緩兒童的早療服務。其實，阿肯薩斯州早期療育很大的問題是孩童並沒有在自然環境中接受服務，在 2012 年阿肯薩斯州 APR 年度報告資料，州內僅有 33%的幼童在自然環境接受療育。原因是，阿肯薩斯州在早期成立許多發展中心，讓身心障礙嬰幼兒集中接受治療 ，在符合 Medicaid 的條件下，這些孩子可以接受每天五小時，每週五天，以及物理治療，職能治療與語言治療服務。然而，輕重度不一的收容環境，收案條件也不明，且機構提供交通車接送下，缺少與家長的溝通，家長不了解孩子的問題與需求，遑論以家庭為中心。在特教辦公室要求各州在自然環境提供早療服務時，lead agency 要求機構主任明列收案條件，並提供輕症幼兒到宅療育或開放機構收一般孩童以增加融合機會，然雙方面溝通失敗，於是，2013 年阿肯薩斯州政府組織調整，將在發展中心的療育服務撤出早療(part C)。然而，在 IDEA 的規定中，阿肯薩斯州政府仍要承擔其年度報告 APR 中自然環境接受療育的百分比落後於其他州。經過努力，2014 年阿肯薩斯州內已經有 74%的幼童兒在自然環境接受療育，但對照全國有 51 州有 90%的孩童在自然環境接受療育，阿肯薩斯州仍待努力。

在 SSIP 會議中，回顧阿肯薩斯州過去幾年早期兒童成效的資料，與會者認為其分數已達到高原期，若持續增加幼兒的治療頻率來改善成效其時不是一個好方法。因為現況是，如果治療師關起門來只對孩子療育，成效不會延續的生活中；同樣的，若家長不知道如何從日常活動中增加孩童學習機會，就會要求更多的治療，但是治療不會是答案，必須真正介入家庭。因此，與會者假設，從更廣的角度來看:先幫助家長如何教導孩子學習、增加與孩子的溝通，來幫助家長了解孩子的需求，進而要求治療師提供符合生活孩子需求的治療。如此一來，家長的能力與自信增加，家庭成效就有進展，此外，孩子若在生活中學習得更有效率，家長就更有信心，而減少家長對療育的依賴，也能改善目前療育過度醫療導向的問題。

此外，從 2014 年阿肯薩斯州第一季的早療兒童轉介資料來看:

零到一歲 (37%)

一歲到兩歲生日(29%)

兩歲到三歲生日(34%)

有 1/3 的孩子大於兩歲才轉介，太晚轉介接受療育的時間短，就會直接影響三歲結案評估的兒童成效。因此 SSIP 會議也提議，首要增加早期篩檢與教育社會大眾的警覺性，增加醫生或其他轉介系統的運作，及早介入才能有效幫助家長，學習教導孩子的方法。

[3] **State leadership:** The state level administrative personnel who have the authority to carry out and oversee the functions of IDEA Part C and 619. State leadership may also include other State agencies, bureaus, departments and parent organizations that also share a commitment and responsibilities for other programs that provide services and support to young children 0-8 and their families.

三、系統改善計畫參與經驗分享

這次參訪期間，剛好碰上阿肯薩斯州 2015 年第一次的 SSIP group collaboration meeting 會議，自費前往該州實際參與該州的幾場會議，才真正了解早期兒童技術支援實務，以下分享會議心得。

8/31 SSIP Group Collaboration meeting

主持人是 SSIP coordinator- Ravyn Denton，對象是 State stakeholders，由 SSIP 發函所有州內的利害關係人，邀請參與今年 SSIP 計畫的擬定，會議並由 ECTA 中心的 Betay Ayankoya 擔任技術支援，協助會議討論的進展。

主持人報告阿肯薩斯州 2015 早療方案成果報告(Part C determination Report，如下頁)，讓所有的 stakeholders 了解現況與需求。從資料品質、資料完成度到成效指標的進步程度分析逐一報告。

該表是由特教辦公室利用 RDA matrix 算出阿肯薩斯州早療的現況，在兒童成效的完成度只有收集到 52.32%的孩子，比例相當低，大多數結案時有符合轉出到學前特教方案的孩子才有收集到結案資料，可能會影響兒童成效進展之分數。而在兒童成果三指標的進展相較 2013 年有些進步，但與全國的早療成效比較卻是最差。雖是如此，在總分上，阿肯薩斯州落在黃色-need assistance 區間，但州政府 SSIP coordination 很擔心明年的表現可能會落到紅色區間(need intervention) 。希望透過今天會議，與在場 stakeholder 一起努力，提升州的表現。

Arkansas

Part C Results-Driven Accountability Matrix: 2015

I. Results Component - Data Quality

I. (a) Data Completeness: The Percent of Children Included in your State's 2013 Outcomes Data (Indicator C3)

Number of Children Reported in Indicator C3 (i.e. outcome data)	1690	Number of Children Reported Exiting in 618 Data (i.e. 618 exiting data)	3230
Percent of Children Exiting who are included in outcome data	52.32%		
Data Completeness Score[1]	1		

I. (b) Anomalies in Your State's FFY 2013 Outcomes Data.

Data Anomalies Score[2]	2
I. (c) Data Quality Total Score (I.a.+I.b.)	3

II. Results Component - Child Performance

II. (a) Comparing Your State's 2013 Outcomes Data to Other States' 2013 Outcomes Data

Data Comparison Score[3]	0

II. (b) Comparing Your State's FFY 2013 Data to Your State's FFY 2012 Data

Summary Statement Performance FFY 2013						
Summary Statement (SS)	Outcome A: Positive Social Relationships SS1	Outcome A: Positive Social Relationships SS2	Outcome B: Knowledge and Skills SS1	Outcome B: Knowledge and Skills SS2	Outcome C: Actions to meet needs SS1	Outcome C: Actions to meet needs SS1
Performance	68.13%	32.49%	68.52%	34.32%	66.28%	34.50%
Summary Statement Performance FFY 2012						
Summary Statement (SS)	Outcome A: Positive Social Relationships SS1	Outcome A: Positive Social Relationships SS2	Outcome B: Knowledge and Skills SS1	Outcome B: Knowledge and Skills SS2	Outcome C: Actions to meet needs SS1	Outcome C: Actions to meet needs SS1
Performance	58.6%	22.5%	59.6%	20.9%	57.5%	23.1%

Performance Change Score[4]	2	
II. (c) Child Performance Total Score (II.a.+II.b.)	2	
RESULTS AND COMPLIANCE OVERALL SCORING		
Total Results Points Available	**Results Points Earned[5]**	**Results Score**
8	5	62.5
Total Compliance Points Available	**Compliance Points Earned[6]**	**Compliance Score**
14	9	64.29
Results-Driven Accountability Percentage and Determination[7]		
63.39%	**NEEDS ASSISTANCE (yellow)**	

隨後回顧阿肯薩斯州提交的 SSIP 第一階段報告，部分 stakeholder 其實是第一次參加 SSIP 會議，有些人甚至不了解 SSIP 為何，因此藉此回顧提醒與會者，州的系統改善計畫已經到第二年的計畫階段，勢在必行。在特教辦公室在今年六月回覆阿肯薩斯州的 SSIP 第一階段報告，十分肯定阿肯薩斯州自選指標-也認同其方案改善的理由與做法-幫助家長協助孩子的能力開始，來改善兒童成效。阿肯薩斯州已經向各地區發文，由各區表達意願，從自願參與改善方案中，先挑五個地區做專業發展人力的實證訓練以試行 SSIP，希望明年能交出成績。

今日會議的任務是 what are we doing next?與所有的利害關係人-兒童早期方案各區代表，各治療師學會會長，家長代表等等確認改善方向與執行計畫。ECTA 的代表 Betsy Ayrakona 與 阿肯薩斯州已經有合作十年關係，十分了解該州早療現況，因此決定運用執行科學與工具，先確保在場的相關人員有相同的共識。

第一步，先回顧阿肯薩斯州早療的 mission& key principles 開始。當然，所有的早療利害關係人都大概知道兒童早期服務的宗旨與原則，然而，再次確認以及真正認同這些原則的用意是打從內心認同，從觀念改變開始，這是執行非常重要的一步，有些原則例如 with supports and resources all families can enhance their child's learning and development ，就有些治療師不相信家長有能力幫助孩子學習。因此，要求每個人從逐字逐句中，分享自己特別有感觸的字眼，例如 together、learn best，以及想到的經驗，當中，一個地區代表提到，家長從不知道兒童早期的宗旨原來是這樣，也有代表提到這其中太多專家說法像是實證研究，這些字眼家長不了解，也會讓家長退縮，像是不敢發表意見及幫忙孩子爭取權益。

在瞭解以及認同阿肯薩斯州早療的 mission& key principles 後，接下來利用 stakeholders 的管理經營經驗，來重新推銷理想早療方案。分組討論下，讓 stakeholders remarking 兒童早期方案，運用市場行銷的手法販售阿肯薩斯州認可的兒童早期服務品牌，提出產品口號，與可能的市場，仔細的思考從哪些人，哪些地方開始推銷，增加轉介與對阿肯薩斯州兒童早期品牌的認識，集思廣益下，瞭解轉介中斷的可能原因，並盡量觸及所有可能發現遲緩兒童的角落，將最適當的兒童早期觀念運用網絡宣揚到每個家庭。

當然，現實遇到的困難會同時浮現，各利害關係人實際的回饋哪些困難，其他與

會者可能立刻能澄清與支援，或想出解決方式。遇到的問題，如家長搜尋兒童早期的關鍵字可能連結不到正確的訊息，或有些診所礙於經費，根本不買單等等，大家先拋出問題，澄清問題並想解決辦法。後續採取行動前，會從大家投票決定最可行的建議開始，每一個可行的建議，會再思考窗口人員與過去交涉的經驗，再繼續討論最後可影響的人。不難想像，其中有很多政治因素影響，但為了落實 SSIP 的壓力，或是兒童與家庭成效，大家形成了一股爭相自願與推薦分頭執行的負責人。下一步，決定追蹤進度日期，環環相扣，有系統與效率的執行。自願，在最後這個階段，不是為了自身利益了，而是為了行銷阿肯薩斯州早療。

在技術支援(TA)的協助下，從大家的想法開始，有共識、建立原則、願意投入，最後因著共同的目標，而非自身的利益而努力，從一起協力開始建立革命情感，為的是阿肯薩斯州，獲益的所有的家長與孩子。

9/1 跨專業發展高峰會議(cross-sector professional development leadership team)

TA 設定會議主題為 changing the way we work together to improve early childhood outcomes.

阿肯薩斯州的學前代表(619 Coordinator)與早療代表(part C Coordinator)與 ECTA TA 代表 Betsy 事先討論如何開始這一天的會議，讓所有專家比較能投入。最後決定先由 Part C 與 619 coordinator 介紹開始自己希望早療與學前教育的目標，讓在場先有往同一個方向前進的共識。

專業發展高峰會議，由在場每一個人自我介紹其專業，以及對希望今天的 cross-sector professional development 會議的瞭解與期望中了解今天可能會有的成果。與會者有各專業代表，大學教授，機構督導，早療督導，甚至保險代表，都想想了解專業可以怎麼做，來幫助孩子。事實上，每個人覺得沒時間做跨機構、跨專業(cross-sector professional development)，但若想看到兒童成效來反映出各專業努力的成效，就需要大家同心協力。SSIP coordinator Ravyn Denton 再次感性的說非常感謝大家，也知道這是一件非常困難的事，大家都有理想在有限的時間，但如果事情要進展得快，可以自己去做；如果要走得長遠，必須要大家齊心。要大家再想想，缺少了哪些專業代表，要如何邀請他們，可以讓團隊更齊全，認識在場每個人，背景與意向對後續會議與落實可以提供有效率的人選。

雖然專家有很多想法或專業利益/立場，但在同一條船上有共同航行的目的地，如何同舟濟，是個難題。TA 建議先訂好 rule of engagement ，要求與會專家自訂規則，在這個 leardership 會議中，大家要怎麼合作，必須遵守的事項，例如設定會議流程，確認流程是與目的方向一致，也確認與下次會議相關;尊重與傾聽不同意見，預定時間與提供資源，預定待完成事項等，由於是這個會議參與者發表意見，同意一起遵守，投入會議角色的分配，讓大家對於會議的規劃，流程與成果都特別投入。此外，透過 ECTA system framework 的 personnel/workforce 自我檢視，瞭解今天 leadership team 的重要性。如果是超出此會議的主軸，可以交付那些人轉達達到其他會議上討論。不清楚的名詞，也會有澄清，與重新定義的機會，讓大家真正在同一個位置，使用相同的語言，才來討論共同目標。在場的州代表一直很緊張，事實上真的，「想要把 SSIP 做成功，大家要一起努力，不希望只是日曆上的一次會議，會議結束後關起門來說這不會成功，希望大家改變心態。」

TA 代表介紹 ECTA framework 其中的 PD 章節，有五個次面向:

Leadership, coordination, and sustainability

Recruitment &retention

Evaluation

State personnel standard s

Perspective personnel development

Inservice personnel development.

今天的高峰團隊屬於第一次面向-Leadership, coordination, and sustainability subcomponent，從此面向的四分檢核表大家開始討論，是否現行品質良好，哪些還沒做到，大家對於高峰團隊的品質開始有了討論。這時有人提出疑問「我們只想負責專業課程培訓?為什麼要有 leadership team?為什麼要跨專業會議?」。藉由提問、澄清、名詞解釋，大家更知道要先定義所有早療相關人員有那些、服務的對象是哪些，以外，所有開課培訓的教師也必須要先有共識，才能往同一個方向去努力。大家漸漸以一個團隊來思考共同的航行方向，才會抵達共同的目的地。

然而，要先知道目的地在哪，才會知道往哪個方向去。於是，大家分組進行遊戲，討論願景-五年後想看到的願景，專業人力發展看起來應該像怎樣、要怎麼達成。分組討論時，有很多關鍵字就出來了，大家分組把覺得重要的願景分享出來再決定一個句子把所有重要的元素擺進去。最後是組成一個句子，讓大家投票。在討論中，大家詳細的咬文嚼字，甚至對於使用 professional 專業一詞很擔心家長覺得交給專家就好，而希望用中性名詞 individual 來指稱。

從上述兩州與參與 SSIP 會議經驗可以看出，美國各州自治下，各地兒童早期執行上有各州的實務的樣貌與問題，聯邦政府透過法令或政策的風向要求，以及全國兒童早期資料建置，促使各州自主改善，讓早期療育落實高品質、具實證、預防性的運作，慢慢的展現成果，將早期療育的理念落實在各角落，成果也指日可待。

從各州的實務面落實成效改善，涉及層級很廣，也是長期的任務，需要真正投入的人參與。每一個決策需要從州到基層都有各方代表持續參與討論，且不只是開會，而是團隊合作一起解決問題，沒有人是權威或是專家的心態，建立合作關係，有效率的討論建立共識、分工與定期聚會，再從每一次的進展，再想想怎麼做得更好。可想見從服務家長與孩子的早療團隊，到改善兒童早期成效的團隊，大家都需要共同的目標，放下專業驕傲，才能做好團隊合作。在這其中，各州方案各異，有些州資源豐富或有其他技術支援協助，總計有 25 州與 ECTA 中心合作 SSIP 計畫兒童早期改善計畫，其中 21 州針對 0-3 歲嬰幼兒族群。ECTA 提供各州詳細計畫、提供個別化資源與建議，除達到 IDEA 法令要求外，也需彈性運用 implementation science 提供的工具，與從各州充分討論做出合適的改善計畫。

其實，無論選擇家庭成效或兒童成效指標，都是落實以家庭為中心，從人-環境-活動的面向來幫助整個家庭，在生活上，每一個學習機會做起，協助家長在家幫助孩子來達到長期成效，而這個長期成效就是孩子未來上學、社區的適應。整個早期療育的概念，落實對家長的支持與協助，從日常生活中、從小、為未來做準備，其成效了帶動孩子、家長、學校老師、社區多贏的局面。

柒、心得與建議

在美國的早療領域核心單位學習三個月，所有的話題圍繞在早期兒童成效與家庭成效，做法是如何支持家長來幫助孩子，專業相關人員由衷相信讓孩子在自然環境下參與及學習是最好的，因此，早期介入在孩子三歲以前提供到宅服務，足三歲仍發展遲緩可開始上學前教室，相關單位培訓教師，增加融合教育的比例，讓孩子仍成功適應學校環境。因此，美國政府監督早療指標就是透過兒童與家庭成效、到宅服務與融合教育比例以及一歲以下遲緩的通報率，來實踐早期發現與落實幫孩子與家庭及早準備未來相關能力。早療相關專業訓練課程以早期兒童部建議執業為主題，將早期兒童成效融入早療兒童的嬰幼兒個別化教育目標中；在學前方案，對學校老師的訓練課程則是支持孩子學習的融合策略，教導與孩子最長時間相處、最親近的家長/老師、兄弟姊妹/ 同儕，來促進孩子的參與。從實證執業到州改善計畫都運用 improvement science 的方法與工具，讓每一個會議或計畫都環環相扣，執行效率非常好，此外說實在的，在美國這段時間，沒有聽到以家庭為中心的口號，但家庭想要的、孩子需要的，在每一個環節上美國都注意到，且盡力在做。

從臺灣醫療界發聲，努力落實兒童早期以家庭為中心，一方面希望落實兒童早期服務的成效到家庭中，除家長與孩子能獲益外，也能減少家長對療育的依賴與健保的負擔，此外，若早期療育兒童在醫療介入的目的能更落實孩子的生活需求或學前準備能力，更能協助兒童融入學習環境，同時相關專業協助教師做好融合教育的準備，也能幫助孩子適應學校環境，發揮潛力適應未來，可能減少家庭壓力與社會負擔。

臺灣的總人口數相當於美國第二大州德州，然而土地面積僅德州的1/20，推動兒童成效這條路美國走了幾十年，兒童成效的政策也走了十年，然因各州政府自治，推動兒童成效的同時也注意各州能承受的壓力與改變系統的幅度，小心翼翼的要把事情做對、做好。目前，美國已經整合其58個州及領地之早療方案成效，並推動早療方案改善，臺灣準備好了嗎?

臺灣推動早療 20 多年，回到早期介入的初衷-為預防做準備，落實介入成效到孩子家庭生活、學校及社區參與等生活中的實境，才是早期介入的終極指標，也就是對家長或孩子的長期目標，然而在臺灣各早療團隊開始注意到以家庭為中心的重要性，然而如何符合臺灣民情、落實實際在兒童評估與治療中，各早療中心都在各自摸索。

一、臺灣現行政策與制度

目前臺灣早療規定制度乃是依循「發展遲緩兒童早期療育服務實施方案」，而此方案之其法源係依據少年福利與權益保障法、特殊教育法、幼兒教育及照顧法與身心障礙者權益保障法擬定，將兒童發展早期發現與篩檢、通報轉介、聯合評估、療育服務、追蹤輔導及家庭支持服務等相關工作項目與措施，明訂社政、衛生、教育、警政等主責或協辦，希望落實並促進早期療育跨單位聯繫合作功能之發揮，以提供發展遲緩兒童及其家庭整合介入之服務。中央政府並依此對各地方政府執行社會福利績效考核，也是監督各縣市早療的依準。在政策上，社家署頒布之「發展遲緩兒童到宅服務實施計畫」及「社區療育服務實施計畫」的，及後續預計推動之督導或訪視作業都朝向落實到宅、社區化，增加家長照顧與教養品質。

除政策制定與行政監督外，在衛生福利部份，國健署編列預算補助各縣市成立「兒童發展聯合評估中心」，讓各縣市的各角落遲緩兒童都有早期發現與早期介入的機會。同時，國健署推動之兒童發展聯合評估中心訪視，乃希望藉此增加各聯合評估中心的服務品質；在社會福利部分，社家署也透過各縣市社會局的社福考核來增加未滿3歲兒童通報數以及辦理托嬰中心評鑑、輔導與訪視稽查，以增加嬰幼兒的轉介與照顧品質；此外，內政部移民署增加對新住民族群的協助及提升家長教養技巧，以提升

新住民家長對兒童早期療育的概念。這麼多的努力下，若能加上從美國的實務成效經驗中，吸取寶貴經驗，也許能急起直追，在寶島臺灣做出更好的兒童成效方案。

上述有兩項與兒童評估與療育品質改善的推動，其一是國健局推動之「兒童發展聯合評估中心服務品質專案管理計畫」，乃是召集醫療、社政、家長與兒童發展聯合評估中心服務品質專案辦公室，研擬與執行，除修訂「兒童發展聯合評估中心輔導訪查基準計畫」加強「綜合報告書暨各專業之病歷範例」，與推行專業督導制度，也要求各聯合評估中心「療育成效評估分析」，從綜合報告、專業督導、成效建議之範本；其二是國健局甫通過之「全民健康保險早期療育門診醫療給付改善方案計畫」，鼓勵醫學中心提供以家庭為中心的服務，希望藉由整合性照護模式提升醫療服務品質，導正早療兒童過度就醫的問題。

試用前文所提的黃金圓圈思考:

- What is the problem?
-Why is it happening?
-What shall we do about it?

臺灣早療孩童過度就醫的問題與阿肯薩斯州早療成效改善方案有部分雷同，然而，美國由於沒有健保，療育資格與療育補助有相對嚴格的認定，在療育個案上已有控管制度，對照臺灣，不乏聽說家長把早療當補習班，甚至擠壓真正有需要孩童的資源，而小學高年級的孩童也經常遲遲不願結案。理當從根本原因，重新徹底分析問題，找出各種可能原因，才能對症下藥。此外，臺灣發展遲緩服務方案，過去大量依賴治療師提供服務，且僅設定「早期發現，減少遲緩的方向」，未設定早療的成效與目的(終點)，而家長認為或被醫療人員教育多做療育就有幫助，因此，即使孩童上學資源豐富，仍不願放棄療育；或因長期依賴治療，而無法自己照顧或帶孩子學習，也可能造成日後的社會問題。多方討論種種的可能，徹底分析早療被濫用的根本原因才能一一對症下藥。

再則以執行策略來看，臺灣在解決早療服務品質或成效上，也有政策制定，督導與訪查，然在醫療、教育、社政等主管機關各自進行，若先有目標或一致的任務共識，如設定服務家庭或孩子的成效目標，並透過評鑑或訪視指標的調整，與聯合評估中心在各指標分數上的自我管理與品質提升，似乎更能誘發主動改善。

其次，目前臺灣推動的「以家庭為中心服務」，多是從國外引進的觀念，臺灣不乏以家庭為中心的研討會，然而家長要接受整合的方案卻不容易，例如各專業間缺乏討論，家長可能接受五種專業以家庭為中心的治療，卻缺乏對孩子一致的目標。此外，由於過往家長習慣醫療導向，視評估的醫生與治療師是專家，在評估或治療上只能聽專家的意見，除了專業的研討會外，增加家長對早療生活化的了解，從家長發聲，要求評估與治療落實在生活中協助孩子，進而改變醫療專家與家長的權力關係，才能落實家長-真正與孩子生活一起的人，才是孩子的專家。

二、聯合評估中心之綜合評估報告書

臺灣自2004年起統一的綜合評估報告書，近年也開始建置Child Health System，有統整的資料庫，可能是未來資料分析的優勢。依據今年國健署「綜合報告書」操作手冊綜合評估報告書的架構如下:

壹、　評估結果報告

一、　主訴與就診問題

(一) 主訴

(二) 就診問題

二、 團隊評估總結

三、 疾病診斷

四、 評估結果

五、 綜合建議

貳、 評估結果與療育建議書

一、 知覺動作功能

二、 吞嚥／口腔功能

三、 口語溝通功能

四、 認知功能

五、 日常生活功能

六、 環境支持

七、 家庭評估

八、 親職功能

參、 病因診斷分類表

此「綜合報告書」的主要目的是決定兒童是否符合發展遲緩資格及各領域遲緩程度，及找出發展遲緩的原因，近似於美國的 eligibility determination form，而非嬰幼兒個別化教育計畫(IFSP)，而在報告書中缺乏兒童之優劣勢之描述，而擬定團隊共同的介入計畫，似乎也不在此報告目的中，因此若以此評估報告書做為成效分析的資料來源，勢必僅能以孩童接受標準化測驗作為指標，然而以標準測驗分數做為成效，表示治療的成效要反應在標準化測驗的建構效度與施測者的信度上，這部分與孩童的日常生活相關性及延續成效到家庭、學校與社區中的概念似乎有段落差。有關兒童成效的指標仍需先回到臺灣早療對所有孩子的目標，先建立共識。

三、綜合建議

在政策推動的同時，也要停下來思考，現在的問題是什麼?建議的做法能否改善問題? 此外即使政策立意良善，但不免擔心是否考慮針對問題核心，能否落實及成功改善問題。回想起美國 implementation science 的回音，「沒有運用 implementation science 的執業在 16 年內只有 14%的成功率。」，如能尋求國外技術支援或合作，讓臺灣在政策方向，實務面都能踏實些的朝向早療的終極目標。

依據進修實務經驗，提供長官與相關單位以下建議:

(一)、院內建議

在本院早療中心部分，可先從調整化評估孩童與家庭的方式，積極納入家長於評估中，勢必要調整標準化評估方式。目前臺大早療中心 已有兩組聯合評估團隊，建議

再成立一組聯合評估團隊，評估對向特別針對適應力、配合度差的個案，例如兩到三歲的疑似自閉症個案，使用測驗工具為 Transdisciplinary Play-based Assessment2(TPBA2)。TPBA2 是北卡羅來納各地的學前評估中心-評估特殊孩子能否”三歲”上學的中心所建議採用的工具，為確保孩子成功轉銜上學，其理念是孩子像家一樣的自在評估，也讓家長可以放心的送孩子上學。目前北卡羅來納有八個示範評估中心，落實 TPBA2 到各區。團隊成員視孩子需求，由多專業組成，如職能治療師、心理治療師、語言治療師、社工師及家長組成。運用標準化評估的架構，但允許孩子主動選擇玩具，主動決定做什麼，評估者跟隨，家長也隨時可以加入，同時評估孩子與家長的自然互動，評估者再從旁誘發孩子更多豐富的遊戲表現-如動作、概念、表達等。透過遊戲引導的彈性，讓孩子像在家一樣自在的接受評估，甚至允許在評估過程中直接使用策略誘發孩子的能力，家長也能從評估中學習到引導技巧。此外，增加家長對評估與治療的適當認識，如治療師都了解以家庭為中心，家長更應該知道以家庭為中心的服務模式，能主動參與評估與治療，在家協助孩子學習；以孩子與家長的需求為優先，而非額外的功課等，更能促進家長親職技巧，增加教養信心。

建立跨專業成效討論團隊，可以共同討論與先建立共識，透過一起工作的過程、學習、經驗分享，角色釋放與合作，做為未來推廣以家庭為中心的示範團隊，可以培訓專業人員，同時也讓家長知道理想的早療服務範例。

(二)、全國性建議: 各聯合評估中心需求評估與自訂改善計畫

現行各早療評估中心現況、需求、資源、實證及準備程度不一，建議參考 ECTA system framework 或 implementation science 從自我檢核開始。唯有，先了解臺灣目前早療系統的優弱勢情形，各中心的現況，才能真正以協助的角度落實各評估中心施行以家庭為中心與成效評估。此外，落實以家庭中心的療育成效，應朝向個案生活上的進展、家長從生活上懂得幫助孩子，才能將療育導向重視孩子生活的需求、家庭的需求，此外，早期療育若是以孩子為中心、以家庭為中心，自然而然的會考量為孩子上學做準備，不需等到上學(特教)老師抱怨孩子，才來做調整。

其次，檢視歷年收集之聯評中心自評表與訪查表，修訂全國性品質與成效指標，透過表單調整政策的落實，例如鼓勵一歲以下嬰幼兒的篩檢率，試辦 SSIP，讓各聯評中心自我檢視自家指標提出改善方案。此外，須重新定位以及調整發展評估報告書與資料庫的用途，或許是做為以家庭為中心與成效分析最好的大數據來源。

(三)、積極尋求相關單位長期合以落實兒童早期成效的推動

臺灣經常邀請國外講者，以協助教育及推動以家庭為中心的服務，像是 Robin McWilliam 博士已經連續兩年來臺，其 Routine-Based Interview/Intervention (RBI，作息本位訪談/介入)，目前在各州早期介入方案中的 IFSP 或是 IEP 正在推動以 RBI 為架構，來了解三項兒童成效的情形。然而，他山之石再好，演講或研討會之精彩，要落實到實務上，仍須了解基層人員的需求，提供必要的協助。美國在兒童成效方案推動上成立很多技術支援中心，大部分接受聯邦政府特教辦公室經費補助，提供各州早療成效的執行，像是阿肯薩斯州與 ECTA 中心的合作已經十年，從最早期的早期兒童成效計畫到最近的州系統改善計畫，都有密集的合作關係。醫師或治療師的臨床工作繁忙，學前教師更是事務繁多，雖有豐富的資訊或資源，然沒有執行協助的人員，要求成效的壓力可能會影響臨床服務或教學品質或無法得到高品質的成效，在此部分，的確需要國外協助。兒童成效相關的技術支援中心，包括 the center on Enhancing Early Learning Outcomes 、the Center for IDEA Early Childhood Data Systems、Early Childhood Personnel Center、the IDEA Data Center、National Center for Systemic Improvement、

Technical Assistance Center on Social Emotional Intervention for Young Children 。此外，每年舉辦的全國兒童成效會議，由各州代表參與，針對目前早期介入的各項主題舉辦研討會，明年預計 6 月在紐奧良召開，如要密集的了解美國兒童成效，這是最好時機。 International Society On Early Intervention 2016 年 6 月，以 The growing need for effective early intervention programs 為主題在瑞典舉辦國際會議，屆時也能了解世界各國的早療成效。

此外，融合教育是目前美國教育大力推動的議題，尤其三、四歲兒童的第一個學校-學前教室，是成功適應的開始。美國從去年開始，National Early Childhood Inclusion Institutes 在北卡羅萊納州教堂山舉辦全國兒童早期融合會議，從了解現行法規的要求，到各州政府的政策支持以及經費補助，提供學前教室教師知識以及態度上的培訓，並增加人力協助。預計 2016 年在 8 月舉辦，對於臺灣特殊教育以及融合議題可以學習很多的相關經驗。

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附錄一

各州早療方案收案條件

Part C Eligibility

States' and territories' definitions of/criteria for IDEA Part C eligibility[1][2][3]

updated March 4, 2015

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Alabama	http://rehab.alabama.gov/individuals-and-families/early-intervention/ei-general-information 10/24/14	25% or more delay in one developmental area (cognitive, physical, communicative, social, emotional or adaptive development)[5].	No	
Alaska	http://dhss.alaska.gov/ocs/Pages/infantlearning/program/program_faq.aspx#4 10/24/14	50% or greater in one or more areas of development.	No	
American Samoa	No web link to eligibility criteria. Web link for Part C program is http://www.helpinghands-as.org/index.html 10/24/14	Any delay in one or more areas of development.	Yes (biological /medical)	*Confirmed eligibility criteria by e-mail – 10/14*

1 Sources: Correspondence with Part C Coordinators, definitions from states' OSEP-approved applications or current Annual Performance Reports (APRs), and/or definitions from states' websites, including their policies and procedures manuals; data current as of October 2014.

2 Note: Diagnosed physical or mental conditions with high probability of resulting in developmental delay, commonly referred to as "established conditions," is an eligibility category required under Part C and, thus, is not included in this table. States develop their own lists of established conditions; most are available on each state's website.

3 As informed clinical opinion remains a part of the regulatory requirements for Part C, the states' references to this in their eligibility definition are generally not included in this table.

4 Date Adopted (if available) or date of most recent policy & procedures manual.

5 These five areas of development (cognitive, physical, communicative, social/emotional or adaptive) are common across states, so will not be specified for each state.

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Arizona	https://www.azdes.gov/uploadedFiles/Arizona_Early_Intervention_Program/azeip_definitions_07_2012.pdf 10/24/14	50% delay in one or more developmental domains.	No	
Arkansas	http://humanservices.arkansas.gov/ddds/Pages/FirstConnectionsProgram.aspx 10/28/14	25% or greater delay in one or more areas of development.	No	
California	http://www.dds.ca.gov/EarlyStart/WhatsES.cfm 10/28/14	Infants and toddlers from birth to 36 months may be eligible for early intervention services if through documented evaluation and assessment they meet these criteria: have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing and are under 24 months of age at the time of referral, with a 33% delay in one or more areas of development or are 24 months of age or older at the time of referral, with a 50% delay in one area of development or a 33% delay in two or more areas of development.	No	
Colorado	http://www.eicolorado.org/index.cfm?fuseaction=Policies.content&linkid=742 10/28/14	25% or greater delay in one or more areas of development when compared with chronological age or the equivalence of 1.5 standard deviations or more below the mean in one or more areas of development.	No	7/11
Connecticut	http://www.birth23.org/referrals/ 10/28/14	Eligible children are those under the age of three who are experiencing a developmental delay of 2 SD (standard deviations) below the mean in one developmental area or 1.5 SD below the mean in two or more areas.	No	2/11
Delaware	http://dhss.delaware.gov/dhss/dms/epqc/birth3/files/de_partc_eligibilityrev.pdf 11/11/14	A 25% delay when compared to age expected level of development in one or more of the following developmental domains: cognition, physical/motor, social-emotional, adaptive; or, A delay of at least 25% in communication (receptive language) without a delay in one of the other developmental domains; children with expressive language delays only are not eligible except based on clinical judgment. Please refer to the "Delaware Guidelines for Young Children with Communication Delays"; or Any delay in communication in conjunction with a 25% delay in one or more of the following developmental domains: cognitive, physical/motor, social-emotional, adaptive; or At least 1.75 deviation below the mean in any developmental domain when measured by a normed, standardized instrument.	No	1/10

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Department of Defense	https://www.edis.army.mil/eip/eligibility.html 11/11/14	Measured delay of 2 standard deviations (or 25%) in one area of development, or 1.5 standard deviations (or 20%) delay in two or more areas of development.	No	4/05
District of Columbia	http://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/Final%20DC%20Part%20C%20Policies.pdf, p. 15 11/11/14	A delay of twenty-five (25%) percent, in two (2) or more developmental areas, as measured by appropriate diagnostic measures and procedures emphasizing the use of informed clinical opinion. In the case of infants born prematurely, the adjusted chronological age [which is calculated by deducting one half of the prematurity from the child's chronological age] should be assigned for a period of up to 6 months.	No	7/13
Florida	http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/resources/es_policy/es_Policy.html, Component 3 11/11/14	Developmental delay meets or exceeds 1.5 standard deviations below the mean in two or more developmental domains or 2.0 standard deviations below the mean in one or more of the developmental domains, as measured by appropriate diagnostic instruments and procedures.	No	7/10
Georgia	http://dph.georgia.gov/services-babies-cant-wait 11/28/14	Have a diagnosed developmental delay confirmed by a qualified team of professionals.	No	
Guam	https://drive.google.com/viewerng/viewer?a=v&pid=sites&srcid=Z2RvZS5uZXR8Z2Vpc3xneDo2YTE1N2Q2MjM1NzZlOWVi, p. 18 11/11/14	Children who are eligible for services include those who are functioning two (2) or more standard deviations below the mean or 30% or greater delay in one or more of the following developmental areas, or who are functioning one and a half (1.5) standard deviations or 22% - 29% below the mean in two or more of the developmental areas:	YES (biological and environ-mental)	6/13
Hawaii	http://health.hawaii.gov/eis/files/2013/05/Eleligibilitycriteria10-21-13.pdf 11/11/14	Child under the age of three (3) years has a significant delay in one or more areas of development, based on one of the following criteria: • Greater than one (1) standard deviations below the mean in at least two or more areas or sub-areas of development • Greater than 1.4 standard deviations below the mean in at least one area or sub-area of development	No	10/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Idaho	http://healthandwelfare.idaho.gov/Portals/0/Children/InfantToddlerProgram/ITP_Eligibility_Criteria.pdf 11/11/14	Performs thirty percent (30%) below age norm or exhibits a six-month delay, whichever is less; adjusted for prematurity up to twenty-four (24) months or as designated by the test manual. • Demonstrates at least two (2) standard deviations below the mean in one (1) functional area. • Is at least one and one-half (1.5) standard deviation below the mean in two (2) or more of the developmental areas.	No	9/08
Illinois	http://www.dhs.state.il.us/page.aspx?item=65651 11/11/14	30% or more delay in one or more area of development.	Yes, At risk for develop-mental delay due to having a parent who has been medically diagnosed as having a severe mental disorder or a develop-mental disability or three (3) or more qualifying risk factors as defined by DHS.	2014
Indiana	http://www.in.gov/fssa/files/FS_Assessment_Team_manual_-_Revised.pdf, p. 13 11/11/14	• 25% or -2 standard deviations from the mean in one or more developmental domains; or, • 20% or -1.5 standard deviations from the mean in two or more developmental domains	No	
Iowa	https://www.educateiowa.gov/sites/files/ed/documents/Iowa%27s%20Early%20ACCESS%20Rules%20%282012%29.pdf, p. 8 11/11/14	A 25% delay in one or more developmental domains.	No	4/12
Kansas	http://www.ksits.org/download/part_c_manual/ELIGIBILITY.pdf, p. XI-3 11/11/14	A child is identified as developmentally delayed when: there is a discrepancy of 25% or more between chronological age after correction for prematurity and developmental age in any one area of development; or, when delays of at least 20% between chronological and developmental age, after correction for prematurity, in 2 or more areas are determined.	No	2013

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Kentucky	http://chfs.ky.gov/NR/rdonlyres/2FA68DC3-86FD-424C-9DB3-99BE1C03021C/0/FirstStepsPolicyProceduresManual7511.pdf, p. 6 11/11/14	The eligibility criterion for developmental delay is: Two (2) standard deviations below the mean in one (1) domain of development or skill area; or, One and one-half (1.5) standard deviations below the mean in two (2) domains of development or skill areas.	No	7/11
Louisiana	http://new.dhh.louisiana.gov/assets/docs/OCDD/EarlySteps/ESPolicySummary042014.pdf 11/11/14	Children are eligible for EarlySteps if they demonstrate a developmental delay of at least 1.5 SD (standard deviations) below the mean in two developmental areas.	No	4/14
Maine	http://www.maine.gov/doe/specialed/laws/chapter101.pdf, p. 71 11/11/14	A delay of at least 2.0 or more standard deviations below the mean in at least one of the five areas of development; or A delay of at least 1.5 standard deviations below the mean in at least two of the five areas of development.	No	7/13
Maryland	http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/infant_toddlers/about/message.htm 11/11/14	Maryland's regulations specify that a child, birth through age two is eligible for early intervention in any one of these ways: • Has a 25% delay in at least one or more of the five developmental areas OR • Manifests atypical development or behavior in one or more of the five developmental areas, interferes with current development, and is likely to result in a subsequent delay (even when diagnostic instruments and procedures do not document a 25% delay). Maryland's Extended IFSP Option offers families the choice to remain on an IFSP beyond their child's third birthday, if their child is determined eligible for preschool special education and related services as a child with a disability.	No	
Massachusetts	http://www.mass.gov/eohhs/docs/dph/com-health/early-childhood/ei-operational-standards.pdf, p. 12 11/11/14	The infant or toddler's development is at least 1.5 standard deviations below the mean in one or more areas of development.	A child is considered eligible for Early Intervention when there is a risk for developmental delays or disorders due to four or more defined risk factors being present	7/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Michigan	http://www.michigan.gov/documents/mde/Eligibility_for_Early_On_352750_7.pdf 11/11/14	Children are found eligible under developmental delay if they have a delay of 20% or 1 standard deviation below the mean in one or more developmental domains.	No	
Minnesota	http://www.health.state.mn.us/divs/cfh/program/cyshn/guidelines.cfm 11/11/14	A developmental delay is demonstrated by a score of 1.5 standard deviations or more below the mean, as measured by the appropriate assessment and evaluation procedures, in one or more of the developmental areas.	No	8/12
Mississippi	http://www.msdh.state.ms.us/msdhsite/index.cfm/41,0,74,html#documents 11/11/14	33% delay in one area of development or a 25% delay in two or more areas of development; The child has to score 2.0 standard deviations below the mean in one developmental area or 1.5 standard deviations below the mean in each of the two areas on the testing protocols administered.	No	
Missouri	http://dese.mo.gov/sites/default/files/se-fs-eligibility-criteria.pdf 11/11/14	A developmental delay, as measured by appropriate diagnostic measures and procedures emphasizing the use of informed clinical opinion, is defined as a child who is functioning at half the developmental level that would be expected for a child developing within normal limits and of equal age. In the case of infants born prematurely, the adjusted chronological age (which is calculated by deducting one-half of the prematurity from the child's chronological age) should be assigned for a period of up to 12 months or longer if recommended by the child's physician. The delay must be identified in one or more of the developmental domains.	No	6/13
Montana	http://www.dphhs.mt.gov/fssac/MontanaPartCRulesAndRegulations.pdf, p. 25 11/11/14	50% delay in one area or 25% delay in two areas.	No	7/13
Nebraska	http://www.education.ne.gov/LEGAL/webrulespdf/CLEAN52_2014.pdf, p. 16 11/11/14	At least 2.0 standard deviations below the mean in one area of development; OR At least 1.3 standard deviations below the mean in two areas of development.	No	7/15/14
Nevada	http://health.nv.gov/PDFs/BEIS/English_ParentHandbook.pdf, p. i 11/11/14	A minimum of fifty percent (50%) delay of child's chronological age in one of the developmental areas, adjusted for prematurity, or a minimum of 25% delay of the child's chronological age, adjusted for prematurity, in any two areas.	No	2/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
New Hampshire	http://www.dhhs.nh.gov/dcbcs/bds/earlysupport/documents/fcess-eligibility.pdf 11/11/14	A 33% delay in one or more of the developmental areas or atypical behavior as documented by the family and qualified personnel.	Yes (child or parent must experience 5 or more conditions or circum-stances from the state's lists.)	
New Jersey	http://nj.gov/health/fhs/eis/documents/policies/njeis-02.pdf 11/11/14	To be eligible, a child must demonstrate measured delays in development of at least: (a) 2.0 standard deviations below the mean in one developmental area; or (b) 1.5 standard deviations below the mean in two or more of the developmental areas.	No	7/12
New Mexico	http://archive.nmhealth.org/ddsd/nmfit/Documents/Eval%20Assessment%20TA%20doc%20April%202013%20(Final).pdf, p. 20 11/11/14	After correction for prematurity, a delay of 25% or greater, 1.5 standard deviations below the mean or greater, or a designation of Significant Atypical Development determined through "Informed Clinical Opinion", in one or more of the five developmental areas.	Yes (Envir-onmental and Medical/ Biological risk)	4/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
New York	http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/11fb5c7998a73bcc852565a1004e9f87/4b971a3906a101dd8525773d004a57fa?OpenDocument 11/11/14	The presence of a developmental delay which affects functioning in one or more of the developmental domains; and, as measured by qualified personnel using informed clinical opinion, appropriate diagnostic procedures, and/or instruments and documented as: (i) a twelve month delay in one domain; or (ii) a 33% delay in one domain or a 25% delay in each of two domains; or (iii) if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one domain or a score of at least 1.5 standard deviation below the mean in each of two domains; or (iv) notwithstanding subdivisions (i)-(iii) for children who have been found to have a delay only in the communication domain, delay shall be defined as a score of 2.0 standard deviations below the mean in the area of communication; or, if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department, including the following: a) for children 18 months of age or older; (i) a severe language delay as indicated by no single words by 18 months of age, a vocabulary of fewer than 30 words by 24 months of age, or no two-word combinations by 36 months of age; or (ii) the documented presence of a clinically significant number of known predictors of continued language delay at 18-36 months of age, in each of the following areas of speech language and non-speech development: (1) Language production; (2) Language comprehension; (3) Phonology; (4) Imitation; (5) Play; (6) Gestures; (7) Social Skills; and, (8) Health and family history of language problems; or, b) for children younger than 18 months of age, documentation that the child has attained none of the normal language milestones expected for children in the next younger age range, and none for the upper limit of the child's current chronological age range, and the presence of a preponderance of established prognostic indicators of communication delay that will not resolve without intervention, as specified in clinical practice guidelines issued by the Department.	No	6/10

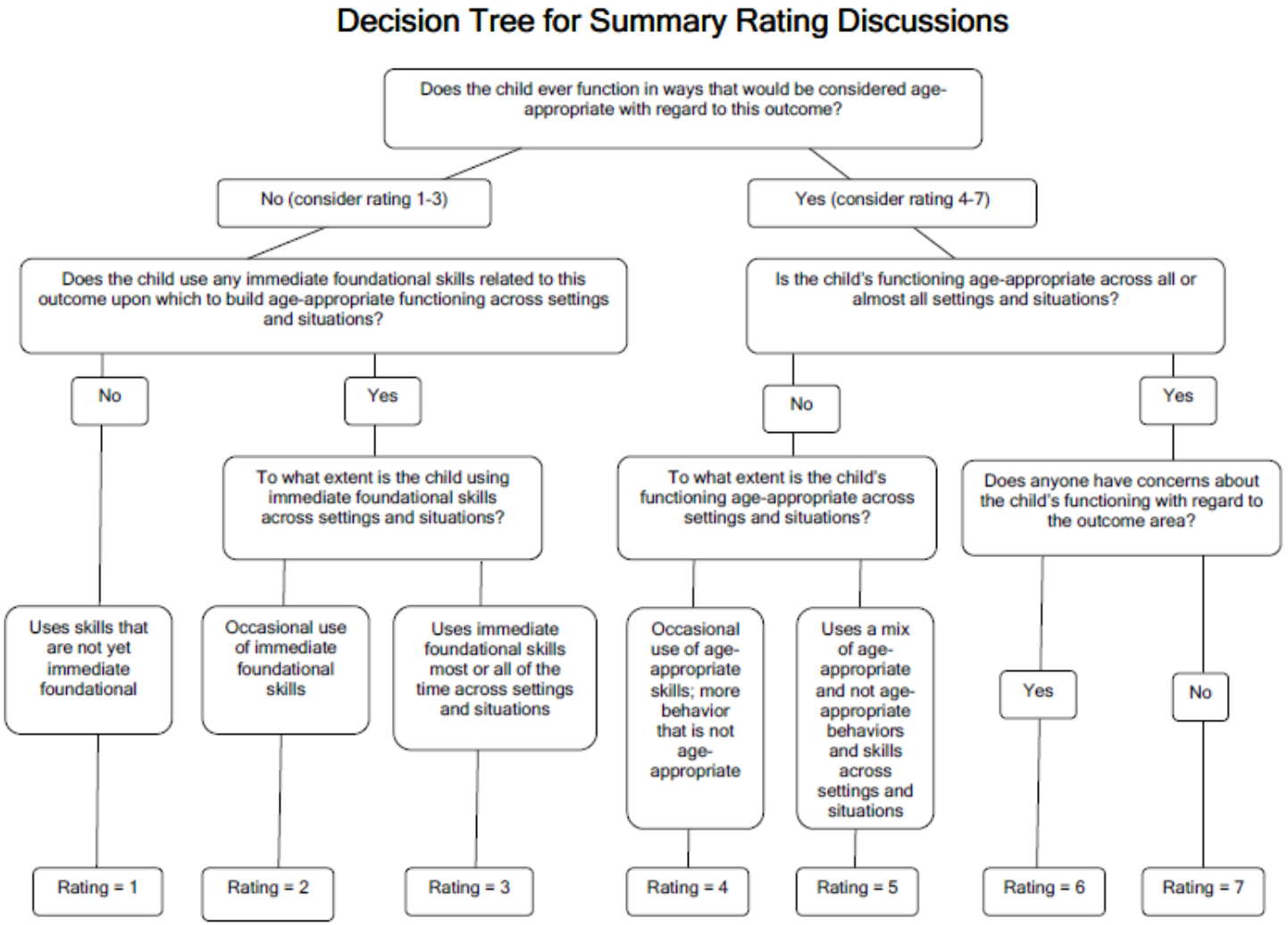
State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
North Carolina	http://www.beearly.nc.gov/index.php/providers/eligibility-referral 11/11/14	The specific level of the delay shall be: • Documented by scores of 2.0 standard deviations below the mean of the composite score (total test score) on standardized tests in at least one of the above areas of development, or • Documented by a 30% delay on instruments which determine scores in months in at least one of the above areas of development, or • Documented by scores of 1.5 standard deviations below the mean of the composite score (total test score) on standardized tests in at least two of the above areas of development, or • Documented by a 25% delay on instruments which determine scores in months in at least two of the above areas of development.	No	7/06
North Dakota	http://www.nd.gov/dhs/services/disabilities/earlyintervention/stateguidelines/ei-policies.pdf, p. 13 11/11/14	25% below age norms in two or more areas of development ; or 50% below age norms in one or more areas.	No	2/13
Northern Marianas Islands	http://www.cnmipss.org/commissioner-of-education/curriculum-instruction-assessment/special-programs/early-intervention-program/ (website under development) 11/11/14	25% delay in one or more developmental domains.	No	
Ohio	http://codes.ohio.gov/oac/3701-8 11/11/14	A developmental delay means functioning at 1.5 standard deviations below the mean or more in at least one of the developmental domains.	No	9/12
Oklahoma	http://ok.gov/sde/sites/ok.gov.sde/files/1401%20Criteria%20for%20Eligibility.pdf 11/11/14	A delay in developmental age compared to chronological age of 50% or a score 2 SD below the mean in one of the developmental domains or sub-domains; OR a delay in developmental age compared to chronological age of 25% or score 1.5 SD below the mean in two or more of the developmental domains or subdomains.	No	12/12

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Oregon	http://www.ode.state.or.us/gradelevel/pre_k/eiecse/medicalconditions.pdf 11/14/14	Two standard deviations or more below the mean in one or more of the developmental areas, or 1.5 standard deviations below the mean in two or more of the developmental areas.	No	8/12
Pennsylvania	http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/p_034104.pdf 11/14/14	25% delay or 1.5 standard deviation below the mean in one area of development.	No	4/13
Puerto Rico	http://www.salud.gov.pr/partcprogram/Others/PoliciesandProcedures%20FEB%202013.pdf 11/11/14	Quantitative and qualitative criteria listed for each area, including: Motor, cognitive and language skills: 2.0 standard deviations below the mean or 33% delay; 1.5 standard deviations below the mean or 25% delay with other delays Social-Emotional and Adaptive skills: informed clinical opinion	No	2/13
Rhode Island	http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/EI%20Policies%20and%20Procedures%202.Eligibility%20November%202013.pdf, p. 2 11/11/14	Developmental delay is defined as 2 standard deviations below the mean in at least one area of development, or 1.5 standard deviations below the mean in two or more areas of development	No	11/13
South Carolina	http://scfirststeps.org/babynet/ *(website being revised; policies and procedures not currently posted)* 11/28/14	A child is identified as eligible on the basis of documented developmental delay when the discrepancy between chronological age and developmental age is one of the following: • Minus 2 standard deviations or a Developmental Quotient (DQ)/Standard core (SS) of 70 in one or more domains of development, or • Minus 1.5 standard deviations or a Developmental Quotient (DQ)/Standard Score (SS) of 78 in two or more domains of development.	No	7/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
South Dakota	http://legis.sd.gov/rules/DisplayRule.aspx?Rule=24:14:07:02 11/11/14	At least a 1.5 standard deviation below the mean; OR a child born at 28 weeks gestation or less.	No	20 SDR 223, effective July 7, 1994; 35 SDR 82, effective October 22, 2008; 36 SDR 96, effective December 8, 2009.
Tennessee	http://www.tn.gov/education/early_learning/TEIS_eligibility.shtml 11/11/14	A 25% delay in two developmental areas or a 40% delay in one area.	No	
Texas	http://www.dars.state.tx.us/ecis/eligibility.shtml#eligibility 11/11/14	At least 25% delay which affects functioning in one or more areas of development.	No	9/11
Utah	http://www.utahbabywatch.org/docs/foreiproviders/policies/Final%20Policies/Eligibility%20Criteria%207%2013.pdf 11/11/14	1.5 standard deviations at or below the mean, or at or below the 7th percentile in one or more areas of development.	No	7/13
Vermont	http://education.vermont.gov/documents/educ_sped_guide.pdf, p. 49 11/11/14	A developmental delay is a clearly observable and measurable delay in one or more of the developmental areas, and the delayed development shall be at the level that the child's future success in home, school, or community cannot be assured without the provision of early intervention services.		1/13
Virginia	http://www.infantva.org/documents/PracManCh5-5-12.pdf, p. 1 11/11/14	At least 25% below chronological or adjusted age, in one or more of areas of development, OR Children who manifest atypical development or behavior, which is demonstrated by one or more specified criteria (even in the absence of a 25% developmental delay). For children born prematurely (gestation < 37 weeks), the child's adjusted age is used to determine developmental status. Chronological age is used once the child is 18 months old.	No	4/13

State	Web link to definition/ criteria and date link last verified	Level of Developmental Delay Required for Eligibility	Serving At-Risk	Date adopted[4]; other comments
Virgin Islands	http://ectacenter.org/~pdfs/topics/earlyid/VI_partc_elig.pdf 11/11/14	A 25% delay in one or more of the above stated developmental domains when comparing functional age to chronological age; OR Standardized test scores of 1.5 standard deviations below the mean.	No	2005
Washington	http://del.wa.gov/publications/esit/docs/ESIT_policies_procedures.pdf, p. 12 11/11/14	A 25% delay or a 1.5 standard deviation below age level in one or more of the developmental areas.	No	4/13
West Virginia	http://www.wvdhhr.org/birth23/eligibility/reveligibilitypolicyformat2013.pdf, p.2 11/11/14	A very substantial delay (demonstrating the equivalent of a 40% delay in functional abilities/developmental skills) in one or more areas of development; OR A substantial delay (demonstrating the equivalent of a 25% delay in functional abilities/developmental skills) in two or more areas of development; OR Substantially atypical development in two or more developmental areas, even when evaluation does not document a 25% delay; OR Five or more risk categories, that when present in combination, are likely to result in substantial developmental delay if early intervention services are not provided, as defined in policy.	Yes – 5 or more risk categories	2/13
Wisconsin	http://www.dhs.wisconsin.gov/children/birthto3/family/qualify.htm 11/11/14	25% delay or atypical development that adversely affects a child's development.	No	*4/14*
Wyoming	http://www.health.wyo.gov/ddd/earlychildhood/partcinfo.html (then link to pdf file for Part C Policies and Procedures, p. 25) 11/11/14	1.5 standard deviations below the mean or 25% delay in one or more developmental areas.	No	3/13

附錄二、早期兒童成效樹狀圖 decision three of Early Child Outcomes



附錄三:IDEA 2014 公布之兒童成效 Early Child Outcomes

Outcomes for Children Served through Programs: 2012-13

In 2012-2013, for Part C indicator 3

- The percentage of children who showed greater 66% and 71% across the three outcomes. These faster rate when they left the program than when
- The perceptage of children who exited the expectation ranged from 52% for knowledge relationships.

	Showed greater than expected growth (%)	Exited the program within age expectations (%)
Part C—Early Intervention (birth through age 2)		
Social relationships	66	61
Knowledge and skills	71	52
Action to meet needs	71	59
Part B—Preschool (ages 3 through 5)		
Social relationships	80	59
Knowledge and skills	80	53
Action to meet needs	80	65

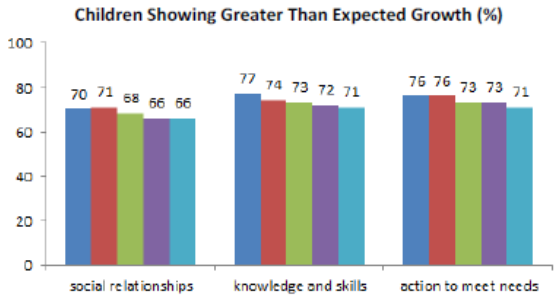
Note: Data for Part C are based on 41 states weighted to represent the nation. Data for Part B Preschool are based on 41 states weighted to represent the nation.

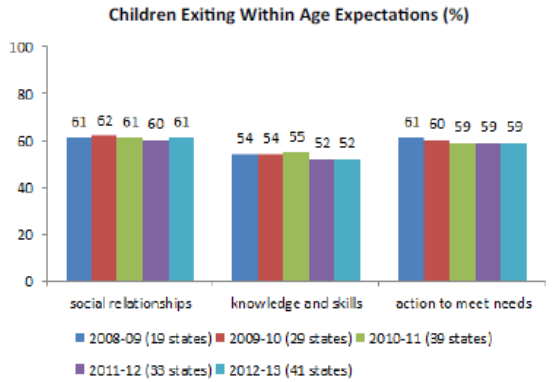
IDEA'S Early Childhood

than expected growth was between children were acquiring skills at a they began it.

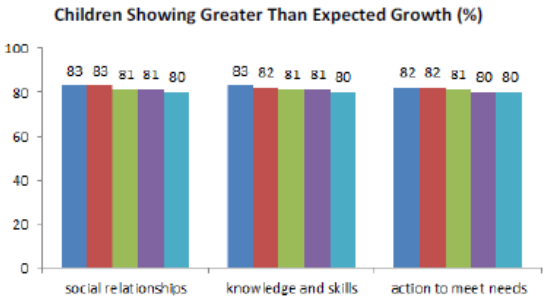
program functioning within age and skills to 61% for social

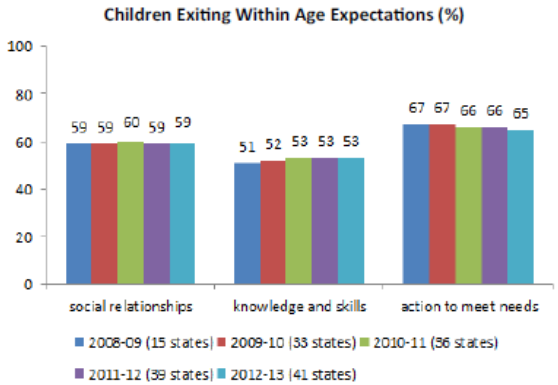
Part C– Early Intervention: Data Across Years





Part B– Preschool: Data Across Years





附錄四 IDEA 2014 公布之家庭成效 Family Outcomes

Outcomes for Families Served through IDEA'S Early Childhood Programs: 2012-13

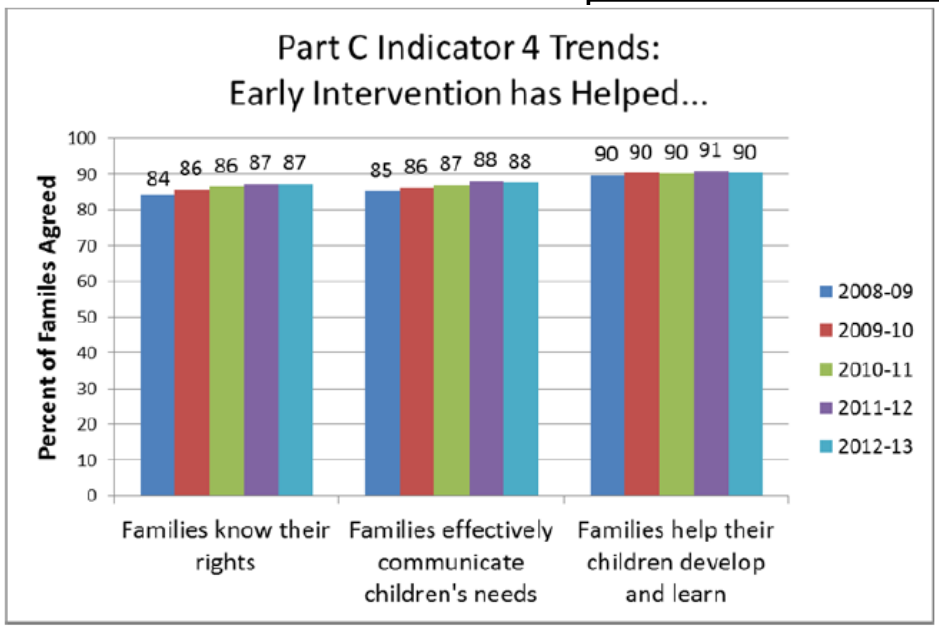
Average Performance Reported by States

Percentage of famiils reporting that early intervention services have helped the family(Part C Indicator 4):

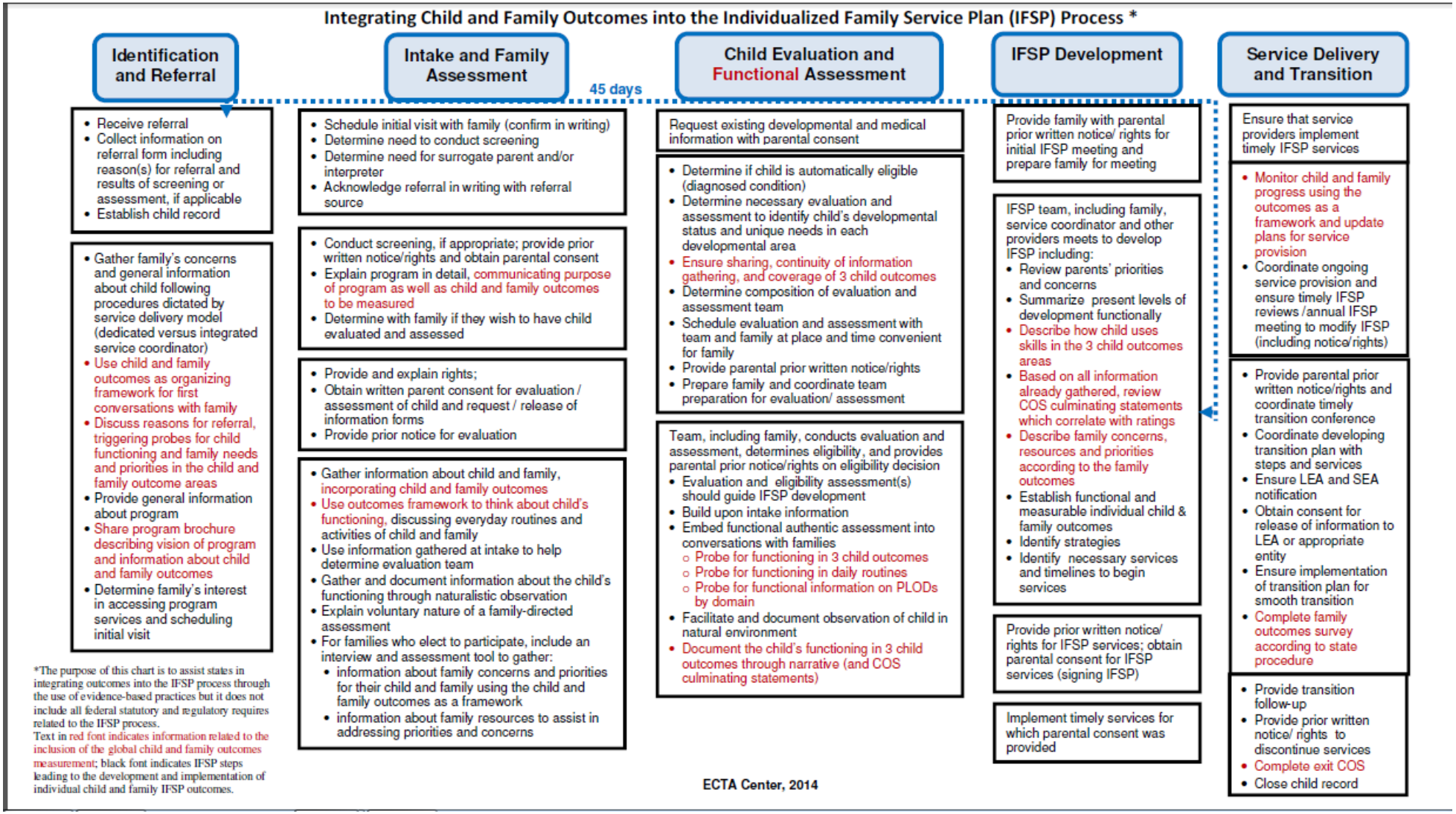
A. Know their rights: 87%
B. Effectively communicate their children's needs:88%
C. Help their children develop and learn 90%

Response Rates by Distribution & Return Approaches		
Distribution and return approaches	**Response Rate**	**# of States**
In-person distribution	**59%**	**19[1]**
With in-person return: 73% response rate (n=5)		
With mailed return: 43% response rate (n= 7)		
With multiple return methods[2]: 61% response rate (n= 6)		
Mailed distribution	**27%**	**20**
With mailed return: 24% response rate; (n= 12)		
response rate (n= 8)		
	37%	**16**
te (n= 3)		
response rate (n= 13)		
erage	**40%**	**55[3]**

did not report their survey return method.
include mail, online, in-person, phone, etc.
survey approach for distribution and return



附錄五、在 IFSP 中融入早期兒童與家庭成效評估



附錄六 2008 年早療專家對早療服務的任務與重要原則共識

03/11/08

TA Community of Practice:

Mission and Key Principles for Providing Early Intervention Services in Natural Environments

MISSION

Part C early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

KEY PRINCIPLES

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
2. All families, with the necessary supports and resources, can enhance their
3. The primary role of a service provider in early intervention is to work with and support family members and caregivers in children's lives.
4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs.
5. IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
6. The family's priorities, needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
7. Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

Workgroup on Principles and Practices in Natural Environments: Susan Addision, Betsy Ayankoya, Mary Beth Bruder, Carl Dunst, Larry Edelman, Andy Gomm, Barbara Hanft, Cori Hill, Joicey Hurth, Grace Kelley, Anne Lucas, Robin McWilliam, Stephanie Moss, Lynda Pletcher, Dathan Rush, M'Lisa Shelden, Mary Steenberg, Judy Swett, Nora Thompson, Julianne Woods, and Naomi Younggren.

附錄七、各專業學會與 DEC 實證執業原則之比較

KEY PRINCIPLES OF EARLY INTERVENTION AND EFFECTIVE PRACTICES: A CROSSWALK WITH STATEMENTS FROM DISCIPLINE SPECIFIC LITERATURE by Regional Resource Center Program

The principles identified in this document were cross walked with statements from the literature, position statements, and/or resources of the professional organizations that provide support to early intervention services including:

- **American Association on Intellectual and Developmental Disabilities (AAIDD)**
- **American Academy of Pediatrics (AAP)**
- **Division of Early Childhood of the Council for Exceptional Children (DEC)**
- **National Association for the Education of Young Children (NAEYC)**
- **National Association of School Psychologists (NASP)**
- **American Speech-Language-Hearing Association (ASHA)**
- **American Occupational Therapy Association (AOTA)**
- **American Physical Therapy Association (APTA)**

The starting point for this document was the "*AGREED UPON PRACTICES FOR PROVIDING EARLY INTERVENTION SERVICES IN NATURAL ENVIRONMENTS*" document, which includes practices that support the key principles of providing early intervention services in natural environments. The document, developed by the Workgroup on Principles and Practices in Natural Environments, reflects practices validated through research, model demonstration, and outreach projects implemented by workgroup members. The document includes the consensus opinions of the workgroup members, who avoided endorsing any specific model or approach.

States may find this document useful for reviewing the agreed upon practices across all disciplines. In some instances the literature may use different terms to refer to practices. This document reflects statements from the literature, resources, and/or position statements of the various professional organizations, but is not attributing meaning to those statements. References used in developing this publication are included at the end of this document.

1. Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• Learning activities and opportunities must be functional, based on child and family interest and enjoyment • Learning is relationship-based • Learning should provide opportunities to practice and build upon previously mastered skills • Learning occurs through participation in a variety of enjoyable activities	**AAIDD** • All young children who are at-risk for or who have been identified with intellectual and/or developmental disabilities should have access to high-quality, affordable developmental services in natural environments. • When early childhood services are provided in natural environments, both children and families will experience increased community inclusion during early childhood and across the life span. **AAP** • Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care. **AOTA** • Occupational therapy works with children, families, and others to achieve health, well-being, participation in life through active engagement in occupations—activities of daily living (ADLs) and instrumental activities of daily living (IADLs)—such as education, work, play, leisure, sleep, and social participation. It facilitates the child and family's participation in meaningful occupations that are desired and important in the school, family, and community contexts. • Understanding the environments and contexts in which occupations can and do occur provides practitioners with insights into their overarching, underlying, and embedded influences on engagement. • ADLs, sensory-based play, and social participation are the foundations for learning, which takes place in the context of relationships. • Occupational therapists have expertise to address both mental and physical health in a variety of early childhood settings. In the neonatal intensive care unit (NICU), intervention is provided to enhance growth and development for premature or medically fragile infants and build family capacity to care for their child. Occupational therapists who work in early intervention programs in clinics, homes, or community settings provide interventions that incorporate individual learning opportunities for children within their natural routine and activities. In all of these environments, occupational therapists collaborate with others to support participation. • Occupational therapy practitioners partner with family members and caregivers to promote the child's development by recommending learning opportunities within the family's daily routines. Conversations with the family help occupational therapy practitioners gain a perspective of how the child spends his or her time; what activities the child wants or needs to do; and how the environment in which the child lives, plays, and attends school supports or hinders occupational engagement. • Services in the home allow the practitioner to gain a perspective on the family's values, routine, and relationships; consequently, he or she can suggest therapeutic activities that easily fit into the family's daily routine. In home-based services, occupational therapists provide the culturally relevant strategies that match the child's environment and the family's resources. They focus on the child's participation in play and everyday activities, recognizing that children can easily generalize skills when learned and practiced in their natural environment. **APTA** • Natural environments are home (family life) and community-life settings that are natural and typical for children without a disability and their families. • Settings where the child, family, and care providers participate in everyday routines and activities that are important to them and serve as important learning opportunities. **ASHA** • Services are developmentally supportive and promote children's participation in their natural environments. • Early speech and language skills are acquired and used primarily for communicating during social interactions.

	○ … intervention occurring within the child's and family's functional and meaningful routines. ○ … services and supports—including speech-language and audiology treatment—are provided in the locations where the families typically spend their time. • Children learn through participating in their everyday activities and meaningful experiences with their family and caregivers. **DEC / NAEYC** • Providing access to a wide range of learning opportunities, activities, settings, and environments is a defining feature of high quality early childhood inclusion. • Opportunities for learning in the child's natural settings must be identified including the learning opportunities that occur in those settings. • More active involvement of parents in their child's program appears to be related to greater developmental progress. • Regular caregivers and regular routines provide the most appropriate opportunities for children's learning and receiving most other interventions. • Young children learn through ongoing interactions with their natural environment rather than in isolated lessons or sessions. **NASP** • Early environments matter and nurturing relationships are essential.

3. **The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child's life**

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• EI providers engage with the adults to enhance confidence and competence in their inherent role as the people who teach and foster the child's development • Families are equal partners in the relationship with service providers • Mutual trust, respect, honesty and open communication characterize the family-provider relationship	AAIDD • Families are the constant in children's lives, and the primary source of lifelong support and early learning. • Families should be supported in making informed decisions and in partnering effectively with professionals to achieve positive outcomes. AAP • Families and providers work together as partners at all levels of decision making. • The concerns of both parents and child health professionals should be included in determining whether surveillance suggests that the child may be at risk of developmental problems. • A medical home provides patient- and family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life. • Providing sufficient information, encouraging partnership, being sensitive to values and customs, spending enough time, and listening to the family's concerns are core elements of a medical home. AOTA • Only children and families can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting children and families' input, practitioners help foster their involvement and can more efficiently guide interventions. • The expertise of the occupational therapy practitioner—and, more importantly, the parent—emerge through the family–professional relationship. • Developing positive partnerships with the family and others is essential, facilitating the sharing of family and professional expertise and wisdom to problem-solve solutions and strategies together. • Regardless of the setting, collaborating with the family is essential for understanding and building trust for an ongoing partnership. • Occupational therapy practitioners can bring their "therapeutic use of self" to all team and family interactions, coaching and guiding rather than directing and doing. • Parents highly value training that facilitates their skills for improving their child's communication, play, and behavior. • Effective interventions for infants and toddlers served by early intervention programs incorporate parent education (e.g., child development, ways to enhance parents' sensitivity to their children's needs, and the encouragement of responsive interactions). • Studies reviewed in *Systematic Review of Occupational Therapy Interventions to Improve Cognitive Development in Children Ages Birth–5 Years* (Clark & Schlabach, 2013), demonstrated that providing parents with information about their preterm infant and activities to stimulate development or recognize their child's cues enhanced cognitive outcomes. • Studies reviewed in *Systematic Review of Interventions to Promote Social-Emotional Development in Young Children With or At Risk for Disability* (Case-Smith, 2013) revealed that interventions in which parents (most often

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	mothers) are coached on strategies to increase their social-emotional support, responsiveness, sensitivity, and positive effect with their infant or toddler were found to have moderate positive effect. • Using modeling, coaching, and feedback, relationship-focused interventions can enhance parents' responsiveness, sensitivity, and flexibility. These characteristics, in turn, can have a positive influence on a young child's development, including social-emotional function. Parents' full engagement seems important to the success of these interventions. • Parent-mediated interventions can have a high impact, given the constancy and importance of the parent–child relationships when they focus on the interaction between parent and child, while also considering parent variables (e.g., skills, style, and personality) and child variables (e.g., developmental level, sensory responsiveness, perception, and behaviors). **APTA** • The choice of team approach should be based on the needs of the child and family: o A shared framework of trust. o Clearly defined roles and responsibilities. o Respectful and empathetic open communication. • Provide families with emotional, informational, and material resources to support the achievement of Individualized Family Service Plan (IFSP) outcomes. • According to Chiarello and Kolobe, "team collaboration is the process of forming partnerships among family members, service providers, and the community with the common goal of enhancing the child's development and supporting the family." **ASHA** • Families provide a lifelong context for a child's development and growth. • The family, rather than the individual child, is the primary recipient of services to the extent desired by the family. • Young children learn through familiar, natural activities, it is important for the SLP to provide information that promotes the parents' and/or other caregivers' abilities to implement communication- enhancing strategies during those everyday routines, creating increased learning opportunities and participation for the child. • The SLP shares information and resources, and coaches the parents about including communication activities throughout the child's day, with content individualized to meet the specific needs of the child. • SLPs should look for ways to join in the caregiver-child interactions, rather than expecting the caregiver to observe or join the SLP-child activities. **DEC / NAEYC** • Families are the constant in a child's life, thus practices should honor and facilitate the family's caregiving and decision-making roles. • Families or parents are considered central and the most important decision maker in a child's life. • Family members, practitioners, specialists, and administrators should have access to ongoing professional development and support to acquire the knowledge, skills, and dispositions required to implement effective inclusive practices. • Recognizing the central role of the family, providers, agencies and family members must work together as a team, rather than as individuals. **NASP** • We must work with school administrators, teachers, and families to develop comprehensive intervention programs that are developmentally appropriate, family centered, and sensitive to cultural and linguistic differences.

4. The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• Families are active participants in all aspects of services • Families are the ultimate decision makers in the amount, type of assistance and the support they receive • Child and family needs, interests, and skills change; the IFSP must be fluid, and revised accordingly • The adults in a child's life each have their own preferred learning styles; interactions must be sensitive and responsive to individuals • Each family's culture, spiritual beliefs and activities, values and traditions will be different from the service provider's (even if from a seemingly similar culture); service providers should seek to understand, not judge • Family "ways" are more important than provider comfort and beliefs (short of abuse/neglect)	**AAIDD** • Children and families must have access to a system of evidence-based services which is community-based and coordinated and responsive to individual and cultural differences. • Services should build on the strengths of the child and family, address their needs, and be responsive to their culture and personal priorities. **AAP** • Patients and families participate in quality improvement activities at the practice level. • Families are respected and listened to and receive appropriate information necessary to share in decision making on behalf of their child. **AOTA** • Occupational therapy intervention is individually designed and aims to improve the family and child's desired and expected occupational engagement and participation through the implementation of strategies and procedures directed at the child and/or family, the activity, and the environment. • Occupational therapy practitioners working in early intervention use a family-centered model, in which the family members are active participants and ultimate decision makers for supports and services. Parents have reported that they learn intervention strategies best when they are actively involved and have opportunities to attempt strategies in the presence of a therapist. • The needs of the child may be the initial impetus for intervention, but the concerns and priorities of the parents, extended families, and funding agencies are also considered. Occupational therapy practitioners understand and focus intervention to include the issues and concerns surrounding the complex dynamics among the child, caregiver, and family. Overall, services should be flexible, focus on relationships, consider all of the child's developmental strengths and limitations, and emphasize family priorities. • Occupational therapy practitioners, with their holistic approach to clients, consider the influence of the family's culture, values, beliefs, and spirituality. They recognize and support the value and importance of culturally sensitive practice. Occupational therapy practitioners support a family's engagement in culturally meaningful occupations and recognize that culture influences the choice of activities. • Occupational therapy practitioners gain an understanding of the relationships between aspects of the domain (e.g. occupations, child and family factors, performance skills, performance patterns, and the context/environment) that affect performance and support client-centered interventions and outcomes. • Pediatric occupational therapy practitioners promote the participation of all children and their families in everyday activities or occupations, including morning routines. When there is a particular area of concern, the occupational therapist can create an individualized strategy based on the specific needs of the child and family. **APTA** • Invite and encourage families and care providers to identify their priorities and outcomes as an initial step in the planning process. • Strengthen and develop lifelong natural supports for children and families. • Recognize family members and care providers as the primary influence for nurturing growth, development, and learning. **ASHA** • Services are family-centered and culturally responsive: An aim of all early intervention services and supports is responsiveness to family concerns for each child's strengths, needs, and learning styles. • An important component of individualizing services includes the ability to align services with each family's culture

	and unique situation, preferences, resources, and priorities. **DEC / NAEYC** • Respect for all children and families is a fundamental value supported by DEC. • Teachers and others who work with and on behalf of children and families must respect, value, and support the culture, values, and languages of each home and promote the active participation of all families. • Practitioners' use ongoing data to individualize and adapt practices to meet each child's changing needs. **NASP** • Cultural differences between service providers and families must be recognized. • Practitioners must be aware that families' communication styles, belief systems, and perceptions of disability, may vary greatly from their own. • Provide advocacy and leadership in building comprehensive, collaborative systems of care that value parents as equal. partners, respect individual differences and incorporate multicultural perspectives while insuring access to high-quality early educational environments for all young children.

5. **IFSP outcomes must be functional and based on children's and families' needs and priorities**

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• Functional outcomes improve participation in meaningful activities • Functional outcomes build on natural motivations to learn and do; fit what's important to families; strengthen naturally occurring routines; enhance natural learning opportunities • The family understands that strategies are worth working on because they lead to practical improvements in child & family life • Functional outcomes keep the team focused on what's meaningful to the family in their day to day activities	**AAIDD** • Early childhood services should also provide family support that responds to families' strengths and needs and improves family quality of life. **AAP** • Parents and child health professionals have valuable observation skills, and they share the goal of ensuring optimal health and developmental outcomes for the child. In the optimal situation, the child health professional elicits parental observations, experiences, and concerns and recognizes that parental concerns mandate serious attention. • Emphasize care that puts the patient first, emphasizes open communication, and supports the patient and his or her caregivers. • Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met • Management plans should be based on a comprehensive need assessment conducted with the family. • A medical home means that your pediatric primary care provider knows your child's health history, listens to your concerns and needs (as well as your child's), treats your child with compassion, has an understanding of his/her strengths, develops a care plan with you and your child when needed, and respects and honors your culture and traditions. **AOTA** • When developing an IFSP with a family, outcomes reflect the family's hopes for the child's participation in home and community life. • IFSP methods should describe coaching the parent within regular family activities, rather than exclusively outlining therapist–child interactions. • Listening to and learning from what the family has to say goes a long way toward designing effective early intervention for a child with a disability. • Implicit are clients' belief systems and underlying assumptions regarding their desired occupational performance. Clients' perception of success when engaging in desired occupations is vital to any outcomes assessment. • At various points in the provision of occupational therapy services, the occupational therapy practitioner and the family will discuss and prioritize outcomes so that the therapist's evaluation and intervention will match the child's and the family's desired outcomes. **APTA** • Emphasize children's, families', and care providers' abilities during everyday activities, rather than teaching a new skill out of context. • Provide physical therapy within the context of family and child routines and activities. **ASHA** • Consultative and collaborative models are closely aligned with inclusive practices; involve services delivered in natural environments, and focus on functional communication during the child and family's natural daily activities and routines. • Functional and meaningful child communication goals reflecting the family's priorities are critical. • A thorough exploration of the caregiver's objectives for the child will enhance the development of goals for

	consultation and lead to clear, relevant, and jointly established expectations. • Agreeing upon the learning priorities promotes collaboration. **DEC / NAEYC** • Team members focus on the individual child's functioning (e.g. engagement, independence, social relationships) in the contexts in which he or she lives, not the service. • Functionality is stressed to ensure that children receive intervention aimed at valued outcomes or outcomes that matter in their daily lives. **NASP** • Developmentally appropriate practices take into account what is known about child development and learning, what is known about the unique needs, strengths and interests of each child, and what is known about the cultural and social environments in which each child lives. • Parents should be encouraged to target goals for their child, learn about their legal rights and responsibilities and exchange information with providers.

6. The family's priorities needs and interests are addressed most appropriately by a primary provider* who represents and receives team and community support

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• The team can include friends, relatives, and community support people, as well as specialized service providers • Uses good teaming practices • One consistent person needs to understand and keep abreast of the changing circumstances, needs, interests, strengths, and demands in a family's life • The primary provider* brings in other services and supports as needed, assuring outcomes, activities and advice are compatible with family life and won't overwhelm or confuse family members (*Primary provider and transdisciplinary method may be used interchangeably in some instances and in others have different meanings.)	**AAP** • The medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty, ancillary and related community services. • Establishing an effective and efficient partnership with early childhood professionals is an important ingredient of successful care coordination for children within the medical home. **AOTA** • AOTA agrees with principle six in *Seven Key Principles: Looks Like/Doesn't Look Like* (Workgroup on Principles and Practices in Natural Environments, 2008), "The family's priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support" and that best practice includes "bring[ing] in other services and supports as needed." Further, practice should not result in "limiting the services and supports that a child and family receive," that the intent is not to "provide all the services and supports through only one provider who operates in isolation from other team members," and that no one should be "providing services outside one's scope of expertise or beyond one's license or certification." • Under IDEA Part C, occupational therapy is a primary service. An occupational therapist may be the sole service provider and can also work as part of a collaborative team that enhances the family's capacity to care for the child's health and development within daily routines and natural environments. Occupational therapists can provide services as a primary service provider, service coordinator, and/or multidisciplinary team evaluator. • Occupational therapists should receive team consultation and support in order to provide services using a primary provider approach. **APTA** • The choice of team approach should be based on the needs of the child and family. There has been a recent shift toward the recommendation and use of transdisciplinary teaming, particularly in early intervention settings. • When a team functions in a transdisciplinary fashion, the primary provider can change as the child's and family's needs change. In this team approach, physical therapists share aspects of their discipline and learn aspects of other team members' disciplines. • Role release was described by Lyon and Lyon as the deliberate process of sharing information and skills and was conceptualized as occurring across multiple levels. • It is important that the family and other team members understand that when performing the activities that the physical therapist taught them, they are implementing specific activities to support their child's development, not providing physical therapy. • Within the transdisciplinary approach, Rush, Shelden, and Hanft describe a primary coach approach to teaming where a single, long-term service provider is assigned as the primary coach to the family or caregivers. **ASHA** • A transdisciplinary model typically includes some type of "role release" of one professional to another and is sometimes implemented as a primary provider model. • The use of transdisciplinary models with a primary service provider may be appropriate for SLPs. • Teams benefit from joint professional development and also can enhance each other's knowledge and skills through role extension and role release for specific children and families. • SLPs may serve as either primary providers or consultants in transdisciplinary models, and should be

	considered for the primary provider role when the child's main needs are communication or feeding and swallowing. • In some instances, one professional on the team is designated as the primary service provider (PSP); this model helps avoid fragmentation of services and frequent home visits from multiple professionals. • When using the PSP model, the team must communicate regularly to support one another—as well as the child and family—to ensure maximum progress. • The designation of the PSP should be a team decision and individualized for each child and family. DEC / NAEYC • Transdisciplinary model of service delivery is recommended to avoid fracturing (or segregating) services along disciplinary lines. • A critical value embedded in transdisciplinary practices is the exchange of competencies between team members.

7. **Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations**

Early Intervention Key Principles	Supporting Statements from Discipline Specific Literature
• Practices must be based on and consistent with explicit principles • Providers should be able to provide a rationale for practice decisions • Research is on-going and informs evolving practices • Practice decisions must be data-based and ongoing evaluation is essential • Practices must fit with relevant laws and regulations • As research and practice evolve, laws and regulations must be amended accordingly	**AAIDD** • Services should be delivered through research-based practices. **AAP** • Decisions regarding appropriate therapies and their scope and intensity should be determined in consultation with the child's family, therapists, and educators (including early intervention or school-based programs) and should be based on knowledge of the scientific evidence for their use. • Evidence-based medicine and clinical decision-support tools guide decision making. **AOTA** • AOTA believes that occupational therapy practitioners working in early childhood and school settings should have a working knowledge of the federal and state requirements in order to ensure that their program policies are in compliance. Occupational therapy practitioners also should be familiar with their state's occupational therapy practice act and related rules and regulations in order to ensure that occupational therapy services are provided accordingly. Essentially, all occupational therapists and occupational therapy assistants must practice under federal and state law, including laws regulating the practice of occupational therapy. • Occupational therapy practitioners apply evidence-based research ethically and appropriately to the evaluation and intervention process in accordance with *Standards of Practice* (AOTA, 2010c) and the *Occupational Therapy Code of Ethics and Ethics Standards 2010* (AOTA, 2010b). Throughout the intervention process, information from the evaluation is integrated with evidence from literature, professional judgment, client values, theory, frame of reference, and practice. • Occupational therapy is a science-driven profession that applies the most up-to-date research to service delivery. Evidence supports the effectiveness of adding an occupational therapist to a treatment plan and IFSP team. Interventions are used as part of a broad approach that considers performance skills (motor, process, social interaction); activity demands; performance patterns (habits, routines, rituals, roles); and contexts/environments. **APTA** • Physical therapists apply the latest research related to restoring function, reducing pain, and preventing injury. • Hooked on Evidence is APTA's "grassroots" effort to develop a database containing current research evidence and clinical scenarios on the effectiveness of physical therapy interventions. **ASHA** • The ASHA Position Paper document includes conclusions and recommendations derived from available empirical evidence that were formed by consensus of the ASHA Ad Hoc Committee on the Role of the Speech-Language Pathologist in Early Intervention through five face-to-face meetings and nine phone conferences between November 2004 and December 2007. • SLPs recognize that in areas for which empirical evidence is lacking, extrapolations from evidence with other populations and applications of principles stemming from theoretical models, societal norms, and government mandates and regulations also are relevant for decision making. • Services are based on the highest quality internal and external evidence that is available: Early intervention practices are based on an integration of the highest quality and most recent research, informed professional judgment and expertise, and family preferences and values.

	• Research about service delivery models in early intervention is in an emerging phase, and as a result, some practices may be based more on policy and professional and family preferences than on theories or research. **DEC / NAEYC** • DEC Recommended Practices have two primary goals: 1. To produce an empirically supported set of recommendations for practice with young children with disabilities birth though age 5, their families, and those who work with them. 2. To increase the likelihood of the use and adoption of the Recommended Practices by identifying "indirect supports" necessary for improving direct service practice. • Practices are supported by research evidence, experience and values of stakeholders, and field validation. • The field now has a good deal of research for guiding practitioners' decisions related to organizing and influencing children's experiences. **NASP** • NASP encourages the use of empirically based, culturally sensitive, developmentally appropriate practices that are implemented in the child's natural environment whenever possible. • Ideally, the school psychologist must work in unison with other early childhood intervention professionals to ensure that programs are based on methods with solid empirical support. • Utilize research from areas of child development, developmental psychopathology, risk and resilience, and disability prevention to promote adoption of empirically demonstrated instructional practices in areas such as emergent literacy, socialization and problem-solving skills and self-management.