



Indian Children's Program

3rd Semi-Annual Report

1 October 2007 – 31 March 2008

Submitted to
Dr. Rose Weahkee, Project Officer
Indian Health Service
801 Thompson Ave., St. 300
Rockville, MD 20852

by
Marvin G. Fifield, Principal Investigator
Center for Persons with Disabilities
Utah State University
Logan, UT 84322-6800

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NARRATIVE

This narrative provides information on services, training, and other activities of the Indian Children's Program for the period 1 October 07 through 31 March 08 for IHS contract #HHSP 23320072400IC. During this time period, a revised Statement of Work was issued by IHS for the ICP with expanded objectives, reporting requirement, and additional specificity on procedures and report data points. In response, the ICP Consortium submitted a revised Technical Proposal and Cost Proposal addressing the revised Statement of Work. The new contract was approved on April 4, 2008. During the period of October 1, 2007 and April 4, 2008, services were continued as per the previous contract.

The revised Statement of Work for ICP required a new reporting system and database. Anticipating approval of the contract, ICP staff met in a retreat with consultants to design the database and respond to other requirements of the new Statement of Work (see Appendix B, staff minutes).

The report has been prepared to address the specifics in design, format, and data requirements as stipulated in the revised ICP contract (Amendment Modification 0003, 3 April, 2008, Section C3 REPORTS, pages 14-22. Data is reported on children and families served, training and technical assistance, and other community services provided during the period of the report. In addition, this report contains information on administrative and organizational activities undertaken to strengthen and improve the program. This includes staff conference calls and the ICP staff retreat to develop and implement the new data system.

Objectives

The Revised Statement of Work contains 29 objectives. Most of these are procedural in nature, i.e., specifying coordination with local service agencies, qualifications of staff, information on dissemination, referral and follow-up procedures, utilization of the Advisory

Board, and planning and evaluation procedures. During the last three months, each objective has been reviewed by staff and steps undertaken to ensure full compliance. The successful accomplishment of these objectives is reflected in the data reported in the tables of this report together with the following narrative of activities undertaken to address each objective and the 49 information and data points specified in Objective 27:

Objective 1. Procedures to request and maintain a copy of the enrollment card for each child served have been implemented.

Objective 2. Print materials describing ICP services targeted for families, communities, schools, and IHS clinics have been drafted. This information is being placed on the website and will be shared with the Project Officer.

Objective 3. Referral forms have been redesigned. The referral form requires informed consent and permissions for release of information in compliance with Privacy Act regulations and HIPAA regulations.

Objective 4. The ICP clinical teams are constituted as specified in Objective 4 are carrying out the activities and procedures as specified.

Objective 5. Procedures have been implemented to ensure that ICP services are family based, culturally sensitive and relevant to the extent possible. Parents and caregivers are involved in the evaluation and recommendation process. Reports are prepared within 15 days and contain relevant information on diagnosis and results of team conferences and recommendations. The reports are submitted to clients' schools or health care facilities as appropriate. Child assessments include psychological and social development, educational disabilities, mental health, speech, motor, medical, and other disabilities that create special needs. Diagnosis is provided when possible and, clinical services are consumer and family driven.

Objective 6. A template of a memorandum of understanding has been developed and will be negotiated between ICP and appropriate educational, tribal, and IHS referral agencies. (Appendix A, Item 1).

Objectives 7 and 8. Clients are provided assistance in finding the therapeutic services recommended. Most of the therapeutic services are provided by IHS, BIA, public schools, and/or other community service agencies (see Appendix A, Item 3 for a list of organizations and clinics with which the ICP has worked in the past). ICP clinical teams are often asked to provide training to clients, families, schools, and other organizations. This data is summarized in Table 11. A complete list along with descriptive information of training and technical assistance provided is reported in the monthly community visit and activity reports.

Objective 9. A database has been developed and is currently being utilized noting problems detected, diagnoses, recommendations, and follow-up reassessments in compliance with the data points specified in Objective 27.

Objective 10. Clients are notified of pending appointments, follow-up, and rescheduling is undertaken. To the extent possible, transportation is arranged through local tribal resources.

Objective 11. Two basic clinical teams are provided. Arrangements to divide the geographic area between the teams have been established. Clinical team members may visit families individually or in groups as needed. Consistency between clients and staff is planned and there is a similarity of procedures in providing services to various communities. The overall maintenance and supervision of the teams is maintained by the prime contractor.

Objective 12. Team members consist of appropriately certified and accredited or licensed individuals from the disciplines specified in Objective 12.

Objective 13. Transportation for staff to and from homes and the communities of clients is budgeted and provided by the contractor.

Objective 14. Training to children, families, IHS clinic staff, tribal and other service organizations is a major activity of the ICP. A calendar of potential training activities has been developed identifying workshops and technical assistance that is planned for the next six month period. (See appendix A, Note 18B, 23)

Objective 15. Training provided by the ICP is evaluated on standard training evaluation forms. Recommendations of participants are taken into consideration as additional training activities are planned.

Objective 16. Special training in procedures for referring students is undertaken, either in conjunction with other training or separately, as needed. See monthly community visit and activity report.

Objective 17. Database records include information on training provided, training sessions, specificity of number of participants, location, topics, cultural sensitivity (see table ____).

Objective 18. Neurobehavioral clinics are scheduled as requested to the extent possible and within the limited resources of the contract. Such clinics are generally conducted in conjunction with the BIA clinical services or tribal agencies.

Objective 19. Developmental diagnoses, including information on the client, referral source, waiting time, etc., are collected in the database (see Table ____).

Objective 20. A Community Advisory Board has been established with representation as specified. The Board met twice the first year of the contract and is scheduled to meet in June 2008.

Objective 21. The study on Fetal Alcohol Syndrome Defects has been developed in consultation with the Community Advisory Board. This study will be reported and discussed by the Board in its July meeting.

Objective 22. Information on technical assistance and consultation is collected in the data base. Data points include tribe, requesting agency, duration, age of client, follow-up plan, etc. (see table ____).

Objective 23. The data base has been modified to include information on the number of active and closed cases in the ICP tracking system (see table ____).

Objective 24. Funding has been budgeted to employ an American Indian/Alaskan Native student trainee by each of the subcontractors. Individual training plans are developed for each trainee and include opportunities to work directly with families and gain experience in different types of activities, including assessment and providing referrals, recommendations, etc. Trainees submit evaluation forms which are used to evaluate the usefulness of the training and their recommendations for improvement.

Objective 25. An evaluation plan has been designed addressing the various components of the project. This will be presented to the Community Advisory Board for discussion and approval at the July 2008 meeting. This plan will contain the specific data points as requested in Objective 25.

Objective 26. Monthly community visit activity reports have been designed and are being forwarded each month to the Project Officer. These monthly reports will be distributed as specified in Objective 26.

Objective 27. Semi-annual reports are prepared addressing the 49 specified information and data points listed in Objective 27. This report is the first semi-annual report so designed. The report will be reviewed and approved by the Project Officer and distributed as specified in Objective 27.

Objective 28. An annual four to eight page narrative report for the lay reader will be prepared in September 2008. This report will be distributed following submission and approval by the Project Officer.

Objective 29. The initial plans for an on-site evaluation with the Project Officer have been undertaken. Topics, activities, etc., have been outlined. The arrangements for the site visit will be finalized during the next semi-annual period and the site visit conducted and reported.

Required Information and Data Points

The reporting requirements for the semi-annual report are specified in the contract with Indian Health Services under Objective 27 which requires the preparation and submission of semi-annual reports and an executive summary. The contract specified 49 specific information and data points. The remainder of this report is organized around these specific requirements. The majority of the requirements is descriptive in nature and addressed in the narrative below. Information points 35-49 require numerical data taken from the new ICP data base, along with information and instructions as to how this information is to be presented.

To ensure accuracy, each information and data point will be addressed. Tables are provided at the end of this section addressing each of the data points required, and additional narrative will explain the numerical data presented.

Some of the information required is tabular in nature, involving lists of clinics, individual contacts, assessment instruments used, maps, and graphics. In an effort to facilitate the

readability of the report, some of this information is placed in the appendix and will be identified and referred to in the narrative section.

INFORMATION AND DATAPOINTS

1. Utilization of format subheadings addressing specific activities. Where possible, throughout this report subheadings have been inserted identifying specific ICP activities, including assessment and follow-up, training, technical assistance, etc. In addition, such activities are defined either in the report narrative or in the appendix.

2. Formal relationship of the Consortium, shared technical assistance, and joint updates.

The ICP Consortium includes three University Centers for Excellence in Developmental Disabilities: (1) Center for Persons with Disabilities at Utah State University, Logan, Utah; (2) Institute for Human Development at Northern Arizona University, Flagstaff, Arizona; and (3) Center for Development and Disability at the University of New Mexico, Albuquerque, New Mexico. Each of these three Consortium members is a research, training, and service center organized as an academic component of their home university with a mission that addresses the objectives of the ICP. Each Consortium member administers many projects where training, services, research activities are funded from a variety of sources. By co-locating the ICP with projects pursuing similar activities. The resources provided by the Indian Health Service are maximized and coordinate with other service programs. Each Consortium member is a multi-faceted research, training, and service center, focusing on the needs of families that have children with special needs. As an academic unit in a comprehensive state university system, the personnel, accounting, and internal program reviews of the universities provide fiscal and programmatic accountability. In addition, the home universities provide access to expert

resources, library resources, student training opportunities, technical resources, as well as a variety of other programs and logistical resources which benefit the program.

The Consortium members are part of a national Association of University Centers for Excellence in Disabilities (AUCD). This a national network of over 67 such centers located in major universities across the United States. Members of the Association have many professional relationships which plan, share, conduct, and evaluate research, interdisciplinary training, and model service programs. Most formal relationships are established with memorandums of agreements or by subcontracts and contracts between and among members. For additional information about the AUCD, please see the website <http://www.aucd.org/template/page.cfm?id=24>

For the ICP, the Center for Persons with Disabilities at Utah State University is the prime contractor and takes financial and administrative responsibility for the project. Subcontracts are negotiated with the Institute for Human Development at Northern Arizona University and the Center for Development and Disability at the University of New Mexico. Consortium members participate equally in planning and structuring the program. Common procedures are designed and utilized, and a common data base is used for reporting program activities. ICP staff meetings are held at least monthly. One or two each year are face to face, the other meetings are held by teleconferencing and/or internet conferencing. This is the standard form of establishing formal relations between AUCD members. During this reporting period the ICP consortium members met in Albuquerque for a retreat to discuss programmatic issues of the new Statement of Work

3. Program Description: Major roles of organizations and staff. The overall mission of the ICP is to take children as referrals, assess them, and move them into a treatment, therapy, or intervention program with the goal to resolve the problems they are experiencing. At

the present time, 60% of all clients tracked in the system have been moved to a treatment and/or therapy program to address their needs. About 30% are still in the process of assessment, treatment planning, and follow-up. Many have completed the recommended intervention and are closed or inactive cases.

ICP services can be broadly broken into two main categories. (a) direct services to clients and families, and (b) training and technical assistance.

A. Direct services to clients and families. This services generally falls into three categories: pre-assessment, assessment, and post-assessment.

1. Pre-assessment may include:
 - a) Establishing relationships and soliciting referrals from local service agencies including IHS clinics, Head Start, preschools, BIE schools, etc.
 - b) Ensuring that the requested services do not supplant what another program has responsibility for or is already providing
 - c) Reviewing referral information, collecting and reviewing educational and medical history, completing a developmental screening, and/or consultation interviews with parents and local service agency staff as needed. This process ultimately leads to the determination if and what additional assessment is needed and the best strategies to use for the assessment.
 - d) Organizing the assessment team, which typically includes the family, and may include personnel from the referral source or other agencies.
2. Assessment may include:
 - a) Using a multidisciplinary or interdisciplinary approach to complete a formal assessment that could include the administration of standardized intellectual, language, achievement, developmental, or behavioral tests, as well as interviews and observations. The assessment may also include modeling strategies to assist families and other team members to address the child's needs.
 - b) Debriefing with the family to provide preliminary results and recommendations
 - c) Preparing the assessment reports and recommendations to be disseminated within 15 days to the people or agencies identified by the family.
 - d) Developing a plan of action with the team depending on whether or not the child is eligible for services. If eligible, another meeting will be scheduled to develop a plan (see below). If ineligible for services, ICP may offer post-assessment supports to the family where appropriate.
3. Post-Assessment may include:

- a) Coordinating and meeting with the team to develop an educational plan, at which time the responsible agency will indicate the services and service coordination that will be provided to the child and family when applicable.
- b) Contacting the family following the meeting to determine if they were satisfied with the assessment process and if services have been initiated. If services have not been provided ICP staff will work with the family and the responsible agency to determine what the barriers are. If all other resources have been exhausted ICP staff will continue to look for available resources and may be available to provide direct services until another provider is available.
- c) Closing the child's file if the family reports that all services are being provided and no other ICP support is requested.
- d) Scheduling with the family to provide ongoing supports that may include interim direct services to the child, service coordination, and/or technical assistance to support the family in addressing the child's needs. Technical assistance may also be provided to relatives, child care providers, and other service providers to assist them in meeting the goals and needs of the child.

The ICP staff provides a great deal of post-assessment service, much of which is not captured in the current data base. ICP staff may seek specialized consultation from other ICP staff, university colleagues, or IHS physicians for problems such as feeding and swallowing, nutrition, sensory issues, or other specific medical conditions. Expertise from many sources, many of them informal, is utilized to meet the needs of the child and family being served by the ICP staff.

B. Training and Technical Assistance

For reporting purposes the term training is defined as a presentation that requires planning, involves an agenda, and is presented in a formal way. Technical assistance is more informal and utilizes the expertise of a specific individual or team, without the use of supporting props. It may also include the dissemination of information regarding the ICP. Technical assistance has been grossly under reported due to the fact that it is a more informal process that may constitute anything from a short phone call with a provider who needs information about a specific topic to a more lengthy consultation with a family regarding a specific topic during an assessment.

Requests for training and technical assistance often come as a result of ICP staff working with local service agencies serving children referred for direct service. The staff and directors of Head Start, preschools, or BIA schools may request a workshop on a specific topic or procedure, or information on how to work with a specific problem. The staff from other service programs are often invited to attend such trainings and workshops. Sometimes ICP staff are asked to address only one or a limited number of topics as part of a larger in-service workshop. Training workshops for paraprofessional staff and parents are also frequently requested, especially in areas

where a lack of service professionals necessitates increased involvement by paraprofessionals and parents.

4. ICP Staff Participation and Multi-disciplinary Teams. After a client or family has been referred and assessed by ICP staff, interagency conferences are held with appropriate local service programs to develop treatment, intervention, and therapeutic plans. A major part of this planning is assigning a specific agency or organization the responsibility to provide the recommended treatment. In most instances, the ICP staff broker the recommended treatment and then monitor to ensure that such services are provided. ICP staff are often asked to participate in IEP meetings and to assist in the development of appropriate instructional and therapeutic programs in the schools, Head Start, IHS clinics, etc. Much of the work of the ICP staff is in the context of the multi-disciplinary or interdisciplinary training where the expertise of team members from ICP as well as from other service agencies be brought to bear on the needs of the child and family.
5. Home-based model utilized and accommodations for appropriate testing and assessment. As suggested by the literature, children and especially young children should not be challenged with unfamiliar settings or distractions when being evaluated, and they should not be asked to perform the same discreet activities for each evaluator. For these reasons, evaluations by ICP staff are often conducted in the home or the most logical community-based facility such as a child-care center or school. This does not presuppose that some services are not better situated for clinical settings, especially when specialized equipment is needed. However, if specialized equipment is needed, it is usually for the purpose of a post-operative rehabilitation rather than routine therapy.

The home-based model for conducting evaluations, conferences, and follow-up is the preferred approach for ICP staff. Some clients are assessed in the University Centers

or IHS clinics. Some families choose to come to the University Centers for therapy. This is more common for the UNM where families tend to come to Albuquerque for a variety of purposes and can arrange to participate in therapy at the same time. When assessments, therapy and follow-up are conducted in the University Centers, students have the opportunity to observe and sometimes participate on traditional multi-disciplinary and interdisciplinary teams.

6. Assessment in the clinical environment. In keeping with the premise that ICP services should be provided, to the extent possible, in the homes and community of the children and families referred, assessment and therapeutic equipment, including materials, assistive technology, etc., is often transported to the home or community of the child. Where this is not possible, due to the nature of the therapeutic equipment, such as physical therapy and rehabilitative equipment, arrangements are made to have the child seen in one of the several IHS clinics or hospitals where such equipment is available or to transport them to the University Centers.
7. ICP staff work in relations with IHS clinical staff for assessment and follow-up activities. The majority of the referrals to the ICP come from IHS clinical staff. (See table __, page __.) Most IHS referrals to ICP ask specifically for diagnostic information on the child's learning or development, speech and language acquisition, social or emotional problems, or other difficulties within the school and learning environment.

In addition to the referral form itself, ICP staff generally contact and interview IHS clinical staff and then proceed with the assessment and evaluation of the child and family. Written reports are then returned to IHS clinical staff, and arrangements are made for treatment, planning, and interpretation of findings. A significant part of treatment planning is identifying the agency or organization that will provide the direct

intervention. Many times this is one of the hospitals or clinics of IHS. Once the IHS clinic, school, or other community resource has accepted responsibility for the child, ICP staff follow along to ensure the treatment planning process is being provided as planned and to monitor results. In the event there is a breakdown in the prescribed treatment, a follow-up treatment planning conference is scheduled.

8. ICP staff working relationship with BIE schools and public schools. One of the major roles of the ICP is to provide assessment and recommendations for children's Individual Education Plans (IEP). Forms and procedures for referring children to the ICP are circulated to all BIE and public schools in the catchment area. Contact is made with BIE and public school administrators individually and during conferences alerting them as to the availability of ICP services.

Public and BIE schools receive federal funding under IDEA and, as such, are required to provide appropriate diagnostic and intervention services of children with disabilities. Public and BIE schools routinely request services from ICP to address gaps in the services they can provide, which are the result of limited staff, staff vacancies, or special unique problems that children experience. When BIE and public school children are referred, a supplanting check is required to ensure that the services requested are not duplicative or supplant services the school is required to provide. ICP services to BIE and public school children include assessments and recommendations for treatment planning, participation in the Individual Education Plans, technical assistance to parents, teachers, and training in specific problem areas as requested by the school. In some cases, memorandums of understanding have been negotiated between participating schools and the ICP. Appendix A, Item ___ provides a list of some of the public schools

and BIE schools with which the ICP has worked during the past six months, indicating location, contact persons, etc.

9. ICP coordination with early intervention programs. A significant number of ICP referrals come from children in preschool, early intervention, and Head Start programs. Most of the children referred by the IHS clinics are involved in early intervention programs, and their referrals are jointly submitted. On the Navajo reservation, most of these referrals go through the Navajo Nation's Growing in Beauty program which serves a screening function, ensuring that appropriate data is prepared and submitted to complete the referral process. The Hopi Office of Special Needs provides this service for the Hopi Tribe. Pauline Hunter, Director of Growing in Beauty, serves on the Community Advisory Board. Eva Sekawumptewa and Sandra P. Ami from the Hopi Office of Special Needs also serve on the Board. The ICP staff work closely with Carol Wilson, the IHS Head Start Coordinator in disseminating the information through workshops, presentations, and demonstrations on ICP services. In addition, the ICP staff work with the state agencies of New Mexico and Arizona that serve Native American children with disabilities. Table ____, page ____ presents information on referrals on Children, Youth, and Family Division in New Mexico and other early intervention sources in Arizona.

10. Explanation of service trends and why some services are the most frequently requested. As indicated in Table 4, the most frequent diagnostic and treatment service requested focuses on speech and language development.

Speech and language is clearly the most frequent reason children are referred for services from ICP. This is consistent with Arizona state data which indicate that roughly 75% of children ages birth to three who are referred to early intervention are referred due to language delays. Depending on the areas where they are served, 60-85% of these

children have speech therapy written into their service plans. Case management is the next most frequently provided service, and it is a service that is increasing as ICP staff tend to provide more post-assessment follow-along. Many local service agencies experience difficulty providing the services and/or the service coordination.

Developmental or educational evaluation services are the third most frequently requested service. This has also increased as the Growing in Beauty program responsible for this service does not currently have the capacity to meet the needs. Difficulty with language is often the first problem that parents and child service workers recognize. After language difficulties are confirmed or ruled out, other assessment services are pursued.

It should be noted that the staff of the ICP included one of the very few fully certified bilingual speech/language clinicians. As a result some referring agencies refer specifically for the assessment service of Chris Vining.

11. Information on referrals – how cultivated, tracked, and expected outcome.

The ICP staff undertake a variety of activities to generate referrals from local service organizations and IHS Clinics. Brochures are sent to organizations periodically and handed out at IHS clinics. Brochures and referral forms are carried by ICP staff when visiting community programs for follow-up or assessment where they are left with parents, teachers and administrators. When workshops, presentations, and demonstration are given, brochures and referral information are distributed. Head Start programs are a significant source of referrals. Often they are sent through the IHS clinics and/or Growing in Beauty. The project is working with Cheryl Wilson the IHS Head Start Coordinator.

The referral category of “Other” includes sources which may be outside the catchment area or for children or families which have moved in. It may also include

referrals from private programs and physicians and sometimes referrals that have had to be resubmitted because of delays on incomplete information.

Once a referral is received, the ICP staff generally contact directly the parents of the child referred and the referral agency to discuss the presenting problem and the need for the ICP services. The referring agencies typically indicate the need to provide a non-available diagnostic or intervention service as the expected outcome of the referral process. Referral agencies expect technical assistance and/or recommendations derived from assessment or from the expertise of the ICP staff to provide assistance to the family in meeting the needs of their child and/or the service agency, classroom or clinic.

12. List of contacts, names of persons and programs which have referred children and families to ICP during the past six months. Appendix A, Item ___ provides a list of programs and persons who have referred or requested services from ICP during the past six months.
13. Data reported on activities undertaken during the past six months. The narrative section of this report focuses on those activities undertaken by ICP that occurred during the past six months during the period of this semi-annual report. Background information on the ICP is contained in Appendix A, Item 4.
14. Provide a map indicating number of clients and locations for each of the subcontracts. In Appendix A, Item ____, a map is provided outlining the geographic catchment area served by the Indian Children's Program. Superimposed on this map are the locations in which referrals have been received and services provided, reflecting the distribution of services and where services are concentrated.
15. Types of technology and data being transferred. Within the last few years, cell phone and internet coverage on the Hopi and Navajo reservations as well as other locations in the

catchment area have expanded significantly. Using technology has facilitated family referrals, scheduling appointments, obtaining referral information, and submitting reports, recommendations and intervention materials. In addition, data on service and training provided by NAU and UNM is transferred to the USU in an "ACCESS" data base by using the internet.

16. Community Advisory Board representation. The ICP Community Advisory Board was organized with representation as specified in the contract. See Appendix A, Item _____. It has been difficult to maintain appropriate representations from the three agencies required in the contract. The specified representative is sometimes overburdened with assignments. Sometimes the agency is organized differently. This necessitates the assignment of some other person to represent that agency. Work has been ongoing to ensure proper representation on the Board. Commitment and communication with Board members has been maintained.

17. Summary of recent Board meetings. During the past six months, the Community Advisory Board has not met. Information on recent activities was presented in the 2nd Semi-Annual report and includes minutes of the first two meetings, recommendations, agendas, etc. The next meeting is scheduled for July 21. The agenda will focus on the FASD Study and ICP program evaluation strategies. This will be a face-to-face meeting and will provide opportunities for feedback and suggestions and recommendations from Board members as to strategies to improve the relevance of ICP services. The Advisory Board receives and reviews the monthly activity reports and the semi-annual reports. Board members are often contacted individually to solicit their observations and suggestions about ICP services. They are encouraged to contact the Project Director

and/or program coordinators in New Mexico and Arizona with input and suggestions for improving the program.

18. Types of training ICP provides and efforts of training evaluation. Training and technical assistance are major activities of the ICP. Approximately half of ICP staff time is devoted to training, technical assistance, technical consultation, parent training, and similar activities.

The most comprehensive reporting of training activities is presented in the monthly activity logs on training and technical assistance. These logs detail each event, the topic presented, participants, and relationship with collaborators. Training and technical assistance is summarized in Table 11, page ____.

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topics as part of a larger in-service workshop. Training workshops for paraprofessional staff and parents are also frequently requested, especially in areas where a lack of service professionals necessitates increased involvement by paraprofessionals and parents.

Technical consultation refers to a service in which a child is referred to the ICP, the ICP staff meet with the family and/or local service agency, and together it is determined that the presenting problem or problems can be addressed without conducting a formal assessment. The ICP staff may provide some assistive technology or an instructional procedure for the parents or local program staff to use. Technical consultation may involve suggestions for behavior management, a more appropriate class placement, or referral for some other service to better address the presenting problem. In certain incidences the child's presenting problem is resolved in the intervening time between the submission of the referral and the pre-assessment interviews with the family or local program, thus removing the need for further intervention by ICP staff. When technical consultation is provided the ICP staff always conduct follow-up to ensure the child's problems are appropriately addressed and further intervention is not needed.

19. ICP training staff and other organizations collaborating with training. All of the ICP staff participate in various training activities. In addition, ICP consultants provide training as requested in their areas of expertise and within funding limitations. Periodically, special arrangements are made by ICP staff to bring in experts from the participating universities or state agencies to address specific topics or the needs of specific audiences of local service agencies in the catchment area.

Much of the training provided by ICP is in collaboration with other agencies. The transfer of money back and forth between collaborators is seldom necessary; participating

agencies share costs by providing space, released time for staff, and parents' transportation, instructional information, and participating in the presentations.

Detailed information on community training and technical assistance is provided in the ICP monthly activity logs where each training event is identified, along with the location, topic presented, requesting agency shared resources, and descriptions of the participants. This information is summarized in Table 11.

20. Types of instructional materials utilized by ICP staff. A great deal of instructional materials, progress charts, workbooks, and illustrative material is prepared and utilized by the ICP staff. Much of this material is used in technical assistance with families, either individual families or small groups of families. Other materials are used in presenting small technical assistance activities or workshops to teachers in preschools, Head Start, or school programs. Some material is used to work with clinicians in the IHS clinics, and instructional strategies and materials are provided to them to address specific learning or developmental problems. A listing of some of the more commonly used instructional materials and strategies is presented in Appendix A, Item 7.
21. Information provided by the ICP to address parenting and social supports. Providing advocacy and a social support system for parents is beyond the scope of the ICP program. Families needing social supports are generally referred to parent support organizations and groups such as "Raising Special Kids (RSK)", "Parents Reaching Out (PRO)", or "Education for Parents of Indian Children with Special Needs (EPICS)." A variety of other parent support and social support programs are available in each state, often focusing on the needs of the specific problem entity such as mental health, a specific disability or age category. Parents are referred to these programs to help them acquire the social supports that they need.

22. Skills and information provided to parents. Training and technical assistance is provided to almost every parent whose child receives an evaluation from ICP staff in the form of recommendations, information materials, and modeling activities. The parents of children referred are involved in each step of the assessment and intervention process. This typically focuses on recommendations that build the confidence and capacity of families to address the child's specific needs. For example, during this reporting period, a family indicated during the assessment they would like to transition their daughter from the tube feeding to oral feeding. ICP staff made preliminary suggestions to the family during the assessment and followed up with the child's physician to evaluate the viability of this request. Other examples include the family's choice concerning traditional Native American treatment and medicine. The ICP physical therapist may consult with the child's physician to determine if physical therapy would be indicated and then explain and work with parents in defining the difference between tradition and Western medicine. Physical therapists may model positioning techniques that the family might use. Parent training may take place in the home or in the community service agency (Chapter Houses, Head Start, school classroom). Where possible, we draw together parents that need similar type training to improve efficiency. Speech therapists often teach parents and other family members how to stimulate speech sounds, correct errors, and set up situations that encourage correct pronunciation. Advocacy training is often requested by parents. For a more complete view of the parent training, the reader is referred to the ICP monthly activity logs on community training and technical assistance for the months of October through March.
23. Updating the ICP Website and information regarding the utilization and evaluation. At this point, work is ongoing in revamping the ICP website. Todd Wiesenberger has been

assigned as Webmaster and is currently in the process of redesigning and adding new information to the website. Information will be collected as to its utilization and evaluate its effectiveness. Included on the ICP website will be the ICP monthly activity reports of direct services and training and technical assistance, along with a calendar of training events.

24. Types of assessments provided by ICP staff. ICP staff utilize a wide variety of assessment and evaluation instruments including cognitive, psycho-educational, and neuro-psychological batteries. Assessment instruments targeted to the assessment and evaluation of speech and language are used extensively as are occupational therapy and physical therapy assessment instruments. A list of the assessment tools administered and utilized for ICP staff is provided in Appendix A, Item ____.
25. Utilization of paraprofessionals for community activities. Paraprofessionals working in the local service agencies carry out a significant teaching, management, and supervisory responsibility in the ICP catchment area. While generally working under the supervision of professional staff members, paraprofessionals are in direct contact with children and thus are vital to the mission of the agency and its stability. Some paraprofessionals have formal training and certification, while others obtain training on the job.
- Paraprofessionals are included in almost all training events provided by the ICP (see table 11). Professionals often receive formal credit for ICP-provided training, which helps them eventually achieve certification.
26. Translation of acronyms used in this report. In Appendix A, Item 9 is a list of the acronyms used in this report along with their translations.
27. Measurements of project outcomes and impact. Both formal and informal measurements are taken to determine the progress of children served by the ICP. Formal measures of

outcomes and impact are obtained by the administration of standardized tests and assessment instruments. Consumer satisfaction questionnaires and evaluation information are routinely collected from parents. This data is analyzed and used to determine project outcomes and impact. Project outcomes are also evaluated as cases are closed and referring agencies evaluate their satisfaction with the ICP services provided. Satisfaction and outcomes are further reflected as various service agencies take responsibility for providing the therapy or intervention recommended from ICP assessments and treatment planning.

The review and discussion of improving ICP outcomes and impacts will be a topic of discussion at the upcoming Board meeting schedule July 21.

28. Summary of ICP activities and accomplishments for the last six months. The six month summary will be prepared and distributed as specified in the contract. The summary will be submitted to the Project Officer for approval and focus on the last six months. Included will be recommendations for improving the delivery of services drawn from evaluation data and input of the Board during the past six months.
29. Update on Fetal Alcohol Syndrome assessment and related activities. During the last two meetings of the Community Advisory Board, there have been lengthy discussions on Fetal Alcohol Syndrome Deficit issues. These discussions have focused on the development of an assessment instrument to be administered to health providers, social workers, educators, health agencies, families and tribal leaders and how to plan and integrate this into an FASD prevention system. The FASD assessment instrument has been developed by Dr. Kodiluwakku (Kodi). Kodi has been working with a small advisory group in designing and carrying out the study. Dr. Esposito, Mr. Cooyate, and

Louise Askkie of the Community Advisory Board have been working on this issue. This study will be a major presentation at the next Advisory Board on July 21.

30. Utilization of project information and data and the trends observed from such data. The data presented in Table ___ pp. ____, is similar to that seen and reported in previous years. In an effort not to duplicate other services in the catchment area, ICP focuses on gaps in services. Such gaps often occur because service agencies are unable to hire specific specialties or to maintain the staff they have. Other problems that occur focus on specific problem entities that children have (e.g., Autism, FASD, etc.). For the past several years, there has been an increase in the number of requests for training and technical assistance. This past six months has been reversed, partly at the recommendation of the ICP Advisory Board, which recommended additional emphasis in assessment and providing direct services to children and families. During the past six month period, there has been an increased number of children served, and the technical assistance and training activities have been downsized in response to staff time limitations. As reflected in the data, the ICP has tried to pick up problems as early as possible, focusing on preschool and early education activities.

For the most part, the trends seen from examining the data are not clear. ICP addresses only a small number of the needs in this service area and interacts with many other much larger staffed and funded programs. Abstracting trend data from the limited amount of information collected, thus, presents some risk. Furthermore, the services provided by ICP are primarily referral driven. Thus, the referring agency determines what services they are going to request. These are most often those they cannot provide themselves due to limitations of staff or other resources. These limitations change

periodically due to changes in staff and services within the catchment area. As such, it is risky to project changing trends in services from the ICP data.

31. Changes in significant project personnel. During the past six months, there has not been a significant change in the personnel on the ICP project. Those individuals providing clinical and specialized services have continued to provide such services. There have been slight changes in the amount of time devoted to specific tasks and the expanded utilization of consultants in specific areas.
32. Definitions of terminology in charts and tables, pre-assessments, supplemental checks, evaluation assessments, family follow-up, technical consultation, and interagency meetings. Appendix A, Item 10 provides definitions of terms that are used in the tables and charts of the ICP program.
33. Descriptions of levels of follow-up. The ICP staff conducts a variety of follow-up activities. Most follow-up activities focus on the needs of clients previously assessed and their families. Some follow-up is short and simple; others involve technical assistance and lengthy explanations and training.

Family follow-up may include meeting with the family to review the results of an assessment to assist with the development of recommendation and treatment intervention plans. It may include providing technical assistance to assist families and providers with the implementation of treatment plans. Follow-up also includes post-assessment contact to determine if the appropriate agency has initiated services for the child. If not, ICP staff will contact the responsible agency to determine the reason for the delay. Depending on the reason for a delay in service implementation (e.g., no providers are available, no funding is available, etc.) ICP staff may assist the agency by filling in as the service provider until the appropriate agency can assume responsibility.

The ICP staff have tried to conceptualize a system whereby levels of follow-up could be identified and activities codified consistent with these levels. Although a fair amount of thought and discussion has been give to this activity, nothing has been materialized to the point that it can be utilized. This will be an ongoing activity for other periods of the project.

34. Data to be included in ICP semi-annual report tables on services provided, location, findings, special activities, etc. Information points 36-49 in the Statement of Work address specific data to be collected and reported on ICP activities. This data is presented in the following tables. This data is discussed in the narrative information following each table.