EARLY DAYS: "Play, Relate, Communicate"
A Center Based Delivery of the Early Start Denver Model
Program Design Requirements

Program Description

Treatment philosophy and description. The treatment to be delivered is the Early Start Denver Model (ESDM; Smith, Rogers, & Dawson, 2006). This is a model of infant-toddler treatment for autism that is developed specifically for this age group and focuses on parent-child interactions as well as child interventions. The ESDM is based on a fusion of two well known approaches: (1) the Denver Model, a comprehensive intensive early intervention for preschool age children with autism originally developed by Rogers and colleagues, (Rogers et al., 2000), and (2) Pivotal Response Training (PRT). Pivotal Response Training (PRT) involves naturalistic delivery of treatment derived from applied behavior analysis. PRT was developed by Schreibman and Koegel in the 1970's. It involves a naturalistic application of applied behavior analysis to develop language and social skills and has extensive empirical support developed by Laura Schreibman and Robert Koegel in the 1970's and 80's (Koegel, Koegel, & Surratt, 1992; Koegel, O'Dell, & Dunlap, 1988; Schreibman & Pierce, 1993.

The ESDM was developed to address the unique needs of toddlers with autism, and incorporates existing techniques that have received empirical support for improving skill acquisition in preschoolers with autism. The intervention is provided in a toddler's natural environment, the home. This intervention is offered at high intensity (e.g., 25 or more hours per week), consistent with the National Research Council (2001)'s recommendation for intervention for children with autism within this age range.

There are three main goals of treatment for young children with autism in the ESDM: (1) bringing the child into coordinated, interactive social relations for most of their waking hours, so that social attention, imitation and communication can be developed and learning through social experiences can occur; (2) increasing the reward value of social engagement with others by choosing materials, activities, and routines that are enjoyable and interesting for children, by reading children's cues and following children's interests as we choose activities, and by developing play routines that add meaning and predictability for children;

(3) developing play activities into joint activity routines designed to build skills and "fill in" current learning deficits. The main skills that we focus on include teaching imitation, developing awareness of social interactions and reciprocity, teaching the power of communication, teaching a symbolic communication system, teaching more flexible, conventional and creative play with toys, and making the social world

as understandable as the world of objects. Just as the typically developing toddler and preschooler spend virtually all their waking hours engaged in the social milieu and learning from it, the young child with autism needs to be drawn into the social milieu - a carefully prepared and planned milieu that the child can understand, predict and participate in.

The Early Days parent/playgroup model is a 12 week curriculum designed for parents of very young children who have recently been diagnosed with Autism Spectrum Disorder. The program consists of weekly parent education sessions on the teaching techniques utilized in the ESDM and outlined in the manual titled "An Early Start for Your Child with Autism" by Rogers, Dawson, and Vismara. Weekly play group sessions occur simultaneously with the parent education sessions to gain hands-on coaching on the techniques and to encourage practice for parents and peer play for children.

Anticipated Results: Initial outcomes of children receiving the Denver model were published by Rogers and colleagues in a series of papers examining pre-post test data (Rogers & DiLalla, 1991; Rogers & Lewis, 1989; Rogers, Herbison, Lewis, Pantone, & Reis, 1986). Significant accelerations in children's developmental rates were found in several developmental areas, including cognition, language, reduction in autism symptoms, symbolic play, and social engagement. As a group, the children with autism doubled their developmental rates while in active treatment. Four independent replications of the model carried out in rural Colorado school districts (Rogers, Lewis, & Reis, 1987) demonstrated significant accelerations of developmental rates within six months of implementation of the Denver Model. This finding was particularly meaningful in that all of these children had been receiving treatment in the same sites prior to implementation of the treatment model. These studies suggested that the Denver Model has the capacity to affect development in many areas. The replication study also familiarized Dr. Rogers and her staff with the issues of model fidelity, staff training, implementation of intervention, and fidelity measurement issues.

A 2006 study involving the Denver Model (Rogers et al., 2006, see Appendices) used a single subject design and randomized minimally verbal children to either the Denver Model or the PROMPT treatment. The delivery involved one hour of individual treatment and parent training weekly, and daily one-hour home parent practice sessions for 12 weeks. 80% of children acquired functional speech at a frequency of from 10 to 200 words per hour demonstrated in generalized probe sessions involving only natural communication interactions.

In addition, the ESDM has begun to be examined using randomized controlled trials (RCTs) to demonstrate whether the treatment is responsible for the changes in overall functioning (i.e., accelerating learning rates and thus increasing IQ, reducing overall language delay, or decreasing the severity of autism). In a recent study by Dawson et al, 2010, forty-eight 18-30 month olds were randomized into community treatment (i.e., usual standard of care) or the Early Start Denver Model groups.

Evidence from this RCT demonstrated powerful effects of ESDM for increasing children's cognitive, adaptive, and language abilities compared to the community group, who received similar hours of intervention per week compared to the ESDM group. The ESDM group demonstrated large IQ gains compared to the community sample (20 pt gain for the ESDM group compared to 6 points for the community group, Almost 90% of children in ESDM had spontaneous, communicative speech by the age of 3. Longer-term follow- up studies are currently ongoing between University of Washington, University of Michigan, and the UC Davis MIND. Institute to examine whether multisite testing of this approach will establish replicability.

Research on group based delivery of the ESDM is currently being conducted at two separate sites in Australia. Dr. Zierhut spent 18 months at the site in Victoria as the clinical director and overseeing the research effort. Both of these sites have a staffing ratio of 1:4. Findings suggest that the ESDM may be effective when delivered in a group setting (Vivanti, et al., 2012; Eapen et al., 2013).

Role of family. The ESDM has also been tested within a parent delivered approach for toddlers ages 10 months to 35 months. The parent training curriculum of the ESDM addresses the unique needs of children in the 12-24 month period in several ways (Smith et al, 2006). First, the intervention is carried out at home, and the parents are centrally involved in planning and implementing treatment. Second, the intervention is derived from well-replicated developmental research on social, emotional, communicative, and cognitive development in the second year of life. Third, the intervention promotes infant-toddler social engagement and initiative and involves age appropriate activities carried out within joint activity routines. The interventions are delivered in short blocks of time which are easily incorporated into the toddler's and parents' natural caretaking and play routines and have been piloted in a diverse group of families. Thus, the intervention is built to fit into the natural rhythms and patterns of family life for a wide range of families.

Efficacy of this approach was examined in weekly single subject data from both child and parent variables using a multiple baseline design across behavioral responses. A 10 minute parent-child interaction and a 10 minute therapist-child interaction were examined for a) number of child spontaneous words/vocalizations; b) number of child's imitated words, gestures, and actions; c) the number of child disruptive behaviors; d) global rating of Child Attention and Initiations from the Child Behavior Rating Scale, (CBRS; Mahoney & Wheeden, 1998); and e) parents' mastery of the teaching techniques as measured by the Early Start Denver Model Fidelity Scale, (Rogers et al., 2003). Results indicate steady gains in all children's social-communicative behaviors and parents' acquisition of the teaching techniques, coupled with decreases in children's disruptive behaviors. Prior to intervention, all children showed very little communicative behavior, low to moderate levels of child attentiveness and initiation to the adult, and disruptive behaviors (e.g., head banging, biting, throwing toys). Across the course of treatment, all children have shown measurable gains in social-communicative behaviors, increased attentiveness and initiation, and minimal levels of disruptive behavior. These

improvements have been maintained during the three month follow up period. Further, parents mastered the teaching techniques by midpoint of treatment and maintained their mastery across successive sessions, as well as during the follow up period.

Staff ratios. Each parent (s) will be assigned to one group that is led by Dr. Zierhut. The parent education sessions will be offered to primary and secondary caregivers. However, one parent or caregiver will be assigned as "primary" and that adult only will attend the playgroup sessions. The playgroups will be limited to six children and parents. During each playgroup session the "primary" adult is present and there is one trainer and one administrative staff member. The role of the administrative staff person is to assist in taking data on fidelity of parent skills. The ratio of trainer to client should be considered 1:6 as administrative staff is not responsible for client's needs and may not be required to be present during every training session.

Demographics

Participant Demographics. The ESDM is appropriate for children up to age 4. However, it specializes in children in the birth to 3 age range and will prioritize enrollment for children ages 12-36 months of age with a diagnosis of Autism Spectrum Disorder. Both males and females will be recruited, from all ethnic groups and socioeconomic backgrounds. At this time the courses are only available in English, so the parent/caregiver enrolling in the courses must speak and read English fluently. Parent education sessions are weekly for 12 weeks for 2 hours offered in the evenings. Play group sessions are weekly for 12 weeks and will be offered on one weekday morning and one weekend morning for two hours. Parents are required to engage in home practice that includes daily routines that they learn from the ESDM staff.

Exclusion criteria include the following: Non-English speaking parent/caregiver, Any other identifiable genetic condition associated with autism or with mental retardation (e.g. fragile X syndrome, Down syndrome), head trauma, known neurological disease (e.g., encephalitis), or significant sensory or motor impairment (e.g., cerebral palsy). The reason for this is that we do not have a full interdisciplinary team to provide for the additional needs of children with multiple developmental disorders. An abnormal EEG alone or a history of an occasional febrile seizure, without an accompanying diagnosis of epilepsy, will not exclude a child from receiving the treatment. Active parental psychopathology and/or substance abuse will be considered for exclusion only if parents are unable to cooperate with other parents and children in a group setting or if substance use is interfering with care of child and ability to implement program.

Service operating hours. Sessions will be run in 12 week intervals. Up to two

sessions will be run simultaneously. Parent education sessions will be scheduled in the evenings (e.g., 6:30-8:30 pm). Playgroup sessions will be offered on one week day morning (e.g., 9:00-11:00 am) and one weekend (e.g., Saturdays at 9:00am). Dr. Zierhut will be available to meet with parents individually if required on either Fridays, evening or weekends, or by phone.

Geographic Area: The Geographic area served includes El Dorado and Sacramento County (i.e., parents who are willing and able to drive to El Dorado Hills twice weekly or for whom ACRC will assist with transportation).

Capacity: For the first quarter one parent/playgroup (6 clients) will be offered and after it has completed a program evaluation will be conducted (i.e., Dr. Zierhut will conduct parent/client survey and provide documentation to ACRC for review). If it is mutually satisfactory (i.e., between Dr. Zierhut and ACRC) capacity will be extended to two parent/playgoups (12 clients) per quarter.

Referral Process and Assessment

Specific Referral Process: Staff at ALTA Regional Center may refer an infant or toddler who has been diagnosed with Autism to Dr. Zierhut or the Early Days coordinator @ 916- 947-6255 email: dr.zierhut@me.com . If Early Days is contacted directly by a family, they will be redirected to their ACRC Service Coordinator so a referral can be made. The referral sheet provided by ACRC will only disclose the pertinent Public Health Information determined necessary for initial review. The referral will also contain the SC's name, email, phone number and the Supervisor's name.

To confirm the referral, Dr. Zierhut or Early Days Admin Support staff person will contact the Service Coordinator or the family if clarification is needed for information contained in the Uniform Referral Form, additional family information, etc. Through discussion with the Service Coordinator and possibly with the family, Dr. Zierhut will determine if the Early Days parent/playgroup will be appropriate for referred consumer. If a session is underway, Dr. Zierhut will take a wait list for the next available session and communicate this to the family and Service Coordinator. When Early Days sessions are available the SC will be contacted with this information. In the instance of a family on a wait-list, the Service Coordinator will let Dr. Zierhut know if consumer has already been placed in another program, is still in need of services, etc. At this point, the Service Coordinator contacts the family (or if mutually agreed upon by SC and vendor, the vendor can) to confirm family interest and availability to receive services.

Children with an existing diagnosis and their parents will have an intake visit with a Team Leader to assure goodness of fit between program and child/family. Policies and procedures will be explained, and materials provided to families. If further diagnostic evaluation is needed, Dr. Zierhut will discuss this with the Alta Service Coordinator.

Service Delivery

Utilization of planning team: Early Days staff will collaborate with Regional Center through the intake process as described earlier. Dr. Zierhut will attend requested planning team meetings and assist in any appropriate means to transition families to the intensive service provider.

Assessment & Developmental Evaluation: Once a referral is made for an open session or a parent is selected off the wait list the assessment process will commence. This process is to determine fit for the program. The parent will be contacted by Dr. Zierhut or her administrative support staff and an intake assessment which consists of one three-hour appointment will be scheduled. During this appointment, Dr. Zierhut will meet the parent(s) and/or carers for the child and the child. She will explain the details of the program, have the parent sign the parent contract (see attached parent contract) acknowledging the commitment to the program, interview the parent with respect to his or her goals for him or herself (see attached intake interview), and conduct the ESDM Curriculum Checklist. All of this information will be used to determine service plan goals.

The developmental evaluation tool used in the Early Days Parent/Playgroup treatment is the Early Start Denver Model Curriculum Checklist (Rogers and Dawson, 2010). This tool will be completed at the intake evaluation and the end of treatment., 12 weeks later. This tool assesses autism-specific developmental profiles for children in the 8 month to 48 month age range. Children's treatment objectives are developed from this instrument. During the intake a parent interview will be completed in order to determine parent/family goals and child current developmental levels and need areas. Early on in the parent education session, parent/caregivers are taught to develop objectives using the Curriculum Checklist. Parent/caregivers under the supervision of Dr. Zierhut create a treatment plan containing approximately 10 short term objectives and the related teaching steps. These will be written in a treatment plan and given to the Service Coordinator. The objectives will be active for 12 weeks. Parent/Caregivers will be encouraged to take data daily on these objectives. Data will be sampled during playgoup session and the Curriculum Checklist will be administered at the end of treatment in an exit interview to document progress.

Evidenced based teaching methods/curriculum: The Early Start Denver model is a manualized and evidence based curriculum (described above). The published manuals that are utilized include "Early Start Denver Model for Young Children with Autism" by Rogers and Dawson and "An Early Start for Your Child with Autism" by Rogers, Dawson and Vismara. In order to employ these methods, specific training and certification is required. Dr. Zierhut has been Certified as a clinician for direct delivery and as a parent and professional trainer since 2007. Re-certification is

conducted every two years and Dr. Zierhut is currently undergoing re-certification with Dr. Sally Rogers at the MIND Institute.

The playgroup session structure: begins and ends with a group greeting routine during which the children and parents/caregivers transition to the therapy space, greet and sing a song, change clothes (e.g., take off shoes, put on slippers). Then the dyads engage in joint activity routines in 6 designated play spaces which alternate between object-based routines and sensory social routines. The coach moves from play spaces to offer hands on suggestions and feedback on the teaching topic. The coach maximizes child motivation and attention by varying the activities between the table and the floor, between quiet and active episodes. Learning opportunities occur approximately every 10–15 seconds during treatment interactions, based on our fidelity studies. Transitions between activities are responsive to children's needs for a change and are carried out in a thoughtful and organized fashion that fosters child independence, motivation, and choice. During a transition, children move towards an interesting activity rather than being led or directed to a bare space and waiting for an activity to be presented. In a group environment, a child may not be ready to transition to the next play space within a given time frame. If this occurs, the dyad has the option to move into a transitional play space for a short time or joining the next dyad to engage in peer play. The coach will assist the parent in making these decisions. Each 15 minutes, play spaces are rotated and data is recorded on the fidelity sheet or child data sheet.

Joint activity routines are the vehicle for teaching. A joint activity routine involves a series of interactions between child and adult that allow for a shared activity to be begun, developed, elaborated, and completed. Inside a joint activity, objectives from at least two different developmental domains are taught. A joint activity routine typically lasts from two to five minutes and involves multiple acts from both therapist and child. The activities are generally chosen by the child, though the adult may offer choices, and the child's initial choice and the adult response to that choice mark the first "round" of interaction in the activity routine. The materials used are typical playthings, not adult-constructed materials, and generally involve several pieces and several different actions, in order to foster multiple communicative rounds, imitative rounds, and increasing cognitive complexity as the activity develops through theme and variation. The toys may be the child's toys at home, or toys brought in by the adult for the treatment session. Both are always available. In this format, interspersed of mastered activities and learning objectives is easy to accomplish and maximizes motivation and interest. As child interest wanes, cleanup occurs, involving more rounds on interaction, and a new choice is made, beginning the next joint activity routine.

List of supported studies (2013-2010):

Vismara, L.A., McCormick, C., Young, G.S., Nadhan, A., & Monlux, J. (accepted). "Preliminary findings of a telehealth approach to parent training in autism". *Journal of Autism and Developmental Disorders*.

Eapen, V, Crncec, R & Walter, A, 2013, 'Clinical outcomes of an early intervention program for preschool children with Autism Spectrum Disorder in a group setting', *BMC Paediatrics*, vol. EPUB, 10.1186/1471-2431-13-3

Dawson, G., Jones, E., Merkle, K., Venema, K., Lowy, R., Faja, S., Kamara, D., Murias, M., Greenson, J., Winter, J., Smith, M., Rogers, R., & Webb, S. (2012). Early behavioral intervention is associated with normalized brain activity in young children with autism. *Journal of the American Academy of Child and Adolescent Psychiatry.*

Rogers, S.J., Estes, A., Lord C., Vismara, L.A., Winter, J., Fitzpatrick, A., Guo, M., & Dawson, G. (2012). Effects of a Brief Early Start Denver Model (ESDM)–Based Parent Intervention on Toddlers at Risk for Autism Spectrum Disorders: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry.*

Vivanti, G., Dissanayake, C., Zierhut, C., Roger, S.J, & the Victorian ASELCC Team (2012). Brief Report: Predictors of Outcomes in the Early Start Denver Model delivered in a Group Setting. *Journal of Autism and Developmental Disorders. DOI 10.1007/s10803-012-1705-7*

Vismara, L.A., Young, G.S., & Rogers, S.J. (2012). Telehealth for expanding the reach of early autism training to parents. *Autism Research and Treatment*.

Rogers, S. J., & Wallace, K. S. (2011). Intervention for infants and toddlers with autism spectrum disorders. In D. G. Amaral, G. Dawson, & D. H. Geschwind (Eds.), *Autism spectrum disorders* (pp. 1081-1094). New York: Oxford University Press.

Vismara, L.A., Young, G.S., & Rogers, S.J. (2011). Community dissemination of the Early Start Denver Model: Implications for science and practice. *Topics in Early Childhood Special Education.* doi: 10.1177/0271121411409250.

Dawson, G., Rogers, S.J., Munson, J., Smith, M., Winder, J., Greenson, J., Donaldson, A., & Varley, J. (2010). Randomized, Controlled Trial of an Intervention for Toddlers With Autism: The Early Start Denver Model. *Pediatrics*. doi: 10.1542/peds.2009-0958

Parent Training Curriculum: Parent training is a key feature of the ESDM. Dr. Zierhut has been engaged in parent training since 2007 via a 1:1 delivery. She then tested a group delivery of the parent training format in two separate parent groups in 2011-2012. There are 12 teaching topics that comprise the ESDM parent curriculum. They are as follows:
(1) Step into the Spotlight: Capturing Your Child's Attention
(2) Find the Smile!: Having Fun with Sensory Social Routines

(3) It Takes Two to Tango: Building Back and Forth Interactions
(4) Taking Bodies: The Importance of Nonverbal Communication
(5) "Do What I Do!": Helping Your Child Learn by Imitating
(6) Lets Get Technical: How Children Learn
(7) Writing ESDM Objectives
(8) The Joint Attention Triangle: Sharing Interests With Others
(9) It's Playtime!
(10) Let's Pretend
(11) Moving into Speech
(12) Putting it all Together

Sample weekly schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week: Intake	Intake: ESDM CC 6:00-8:00	Intake: ESDM CC 5:00-7:00	Intake: ESDM CC 9:00-11:00	Intake: ESDM CC 5:00-7:00	Intake: ESDM CC 5:00-7:00	Intake: ESDM CC 9:00-11:00	
Week 1	Parent Education Session: Attention 6:30-8:30 pm		Playgroup: Attention 9:00-11:00 am			Playgroup: Attention 9:00-11:00 am	
Week 2	Parent Education Session: SSR 6:30-8:30 pm		Playgroup: SSR 9:00-11:00 am			Playgroup: SSR 9:00-11:00 am	

Parent Participation and Contract: Parents must attend and complete the intake evaluation (Intake Interview attached) prior to the program and the exit interview. Parents will be required to attend parent education and Play group sessions for 12 weeks. Parents will be given a schedule and a copy of the attendance policy (stated below). Parents are required to engage in home practice that includes daily routines that they learn from the ESDM staff. They will be given short assignments that will be partially completed in parent education sessions and at home. Parents will be asked to sign a contract outlining participation expectations.

Team Meetings: Dr. Zierhut (trainer) will meet with administrative staff person at the sixth week to examine parent skills (fidelity) and child data. Prior Parent training research and clinical experience has shown that most parents are utilizing techniques within an 80% level of fidelity by the sixth week. Parents who are not

meeting this expectation will be discussed for consideration of further support and if needed the ACRC service provider will be contacted to discuss concerns.

Evaluation and reporting procedures: Evaluation occurs twice upon Intake and Exit of program utilizing the ESDM Curriculum Checklist, a published tool that is developmentally sequenced and utilized to assess all areas of development from ages 0-48 months. Parent treatment fidelity will be assessed weekly in at least one activity during the playgroup session. The Parent treatment fidelity tool is the same tool that is published in the ESDM manual and has been utilized in every parent training study to date. The manual skills checklist will also be used as a parent self-evaluation tool and shared with parents during a training session. There are two anticipated reasons the curriculum may have to be modified to meet the consumer/families needs, (1) the child has extensive behavior problems that impact the ability for the parent to use the teaching methods and/or work well within the group environment. There are two options to address these issues that have been employed by Dr. Zierhut successfully in the past, one is to move the "let's get technical" topic to earlier in the program to help parents understand the ABC of behavior and give them the tools to develop a behavior plan and practice utilizing this plan with coaching earlier in the program. The other option is to move into 1:1 coaching modality for the parent/caregiver and child until the dyad is able to return to the playgroup. Dr. Zierhut will make herself available for 1:1 sessions as needed. The other reason adaptations may be needed is (2) Parent skill does not reflect improvement indicating a lack-of-fit for the group environment format. Dr. Zierhut will discuss with the Service Coordinator any concerns about lack of fit if parent child fidelity has not shown any improvement by the 6th week of the session. Options and recommendations from the Service Coordinator will be considered and if appropriate shared with the parent/caregiver.

Brief reports outlining child goals and steps, data towards mastery and mastered objectives will be provided upon exit. These reports will be written following ACRC's report writing requirements attached to this outline and are to be turned in fifteen days prior to the expiration of the POS or five days prior to the PTM (whichever comes first)

Exit Criteria

Ending intervention program. This is a time-limited (3 months) treatment which should naturally transition into an intensive intervention or school based program for the child. As long as the parent feels the program is benefiting them and/or their child the family is welcome to continue, even if the parent is not meeting "fidelity" within the six or twelve week timeframe (this is not necessarily shared with the parent, if parents ask for their fidelity scores, scores can be made available but this is a part of their clinical record). If progress is demonstrated it is a parent choice to continue the program. The family has the right at any time to terminate their participation in this program. Some families may choose to exit prematurely if

intervention commences and scheduling conflicts arise. Parents may also decide that this is not a good fit for their family (i.e., treatment philosophy). The only time Dr. Zierhut would recommend termination is if the parent is not compliant with the expectations of the program (see above- parent contract) and or if the parent has an active mental health or substance abuse history that is disruptive to the other clients. This rare and unlikely situation (i.e., parents are screened by ACRC) would be discussed in advance with the ACRC service coordinator. If a parent terminates for any reason, we will support the family during this transition.

Transitioning to other services. If the child is age 33 months or older upon entry to this program, the Early Days and Alta staff will meet together with the family to discuss transition to school-based services. Early Days will work closely with Alta during this phase (if requested) to assure continuity of services and smooth transitions.

Attendance Policy

Attendance requirements. Families that participate in the Early Days program will be asked to agree to the following: (1) to attend weekly parent and playgroup sessions; (2) to carry out the home activities weekly; (3) to keep the required written data from the home activities; and (4) to attend all evaluation sessions. Parents will be given a schedule of sessions when the 12-week treatment sessions start. Session schedules will be posted on the Early Days website and on the door of the office. Parents will be reminded by text message and phone call once per week. If 3 consecutive therapy sessions have been missed, Dr. Zierhut will speak to the family about whether they wish to continue treatment. Two make-up sessions per quarter will be offered. If a family misses any single session, Dr. Zierhut will contact the family immediately and offer the next available make up. She will encourage attending sessions and help the family to review the topic covered during the missed session. The Alta service coordinator will also be informed about the family's decision. In the event that 3 consecutive unplanned absences occur then contact will be made to The ALTA Service coordinator as per ALTA guidelines.

Grievance Procedure

Policy and procedure. For questions or concerns, families and Alta service coordinators will be given a written document with policy and procedures that will include the phone numbers of all personnel. Any grievances that are reported will be handled within 48 hours immediately with documentation in the child's file. All information will be kept confidential and will not affect the families' right to treatment. Any grievances that are reported to Early Days staff will be handled immediately with documentation in the child's file and reports to the Alta Service Coordinator. The policy document will be reviewed with the family prior to starting services and will be reviewed annually by Dr. Zierhut for effectiveness.

Program Evaluation – Method for Quality Assurance

Early Days will undergo an Annual Review (w/in each fiscal year) to assess program effectiveness with a written evaluation design specifying: our Program's objectives and purpose of evaluation, Aggregate data on progress of consumers in program which will include Child Data from Curriculum Checklists at intake and exit, and parent data from fidelity taken throughout the course of the program (minimum 3 times). Parent data will indicate the ratio of parents at fidelity to growth on child objectives.

This review will be submitted in writing and sent to Alta California Regional Center (a copy will be placed in vendor file). This program evaluation will also be maintained by Dr. Zierhut for review by the regional center and Department

Organizational Structure

*(*1) Program Director: Dr. Cynthia Zierhut, licensed psychologist, staff psychologist at UCDavis MIND Institute. She is responsible for all aspects of the program and conducts all parent/playgroup sessions. Dr. Zierhut has considerable experience in early autism treatment as well as in child clinical treatment more generally, and in clinical work with families of young children. She will supervise the child and family treatment. (2) Administative Support person will be responsible for scheduling and data taking. This position will be supervised by Dr. Zierhut. The person in this positions will have college degrees or college training in psychology, education, communication, or some related field, at a minimum and will have previous experience delivering individual intervention to young children with autism. This role will receive in depth training in ESDM before they begin to take data on parent skills or children's objectives. This role will be carefully supervised throughout their work on the project.

Program Director:. All aspects of the evaluation and treatment program will be conducted by Dr. Cynthia Zierhut. She will have several responsibilities on this project. First is quality control. She will be responsible for assuring that all evaluation and the treatment components of this program are implemented with uniform high quality procedures. She will be responsible for maintenance of progress data regarding children and providing reports to Alta as requested. She will also report all significant incidents to Alta. She will keep a database of all children's progress data as measured by the ESDM CC and will be able to generate reports from this database at any time. She will also be responsible for assuring that all paper files for clients are secure and that confidentiality is protected. Finally, she will gather and review parent satisfaction data at least annually, and share all significant concerns with the Alta Service Coordinators. Finally, she will assure that all administrative staff are properly trained.

Staff Training Plan

Staff training plan: The administrative support person will be provided a job

description outlining the job requirements as well as a copy of this program design and related materials for the program. This position requires training in ESDM in order to assist the Program Director in completing fidelity checks on parents and child data during sessions. This individual will be required to complete 160 hours of training, if they have no prior ESDM background. They will have on- going extensive supervision including; weekly supervision, bi-weekly reliability checks and supervision. This person will also be trained on client's rights, developmental disability service system, consumer safety procedures, and policies/procedures of vendor program as developed by ACRC.

Amount, type, and frequency of training. Once the admin support person has completed their initial 160 hours of training, has passed the exams, and has established reliability in child and parent data taking, this person will take data weekly in sessions. This role will be spot checked regularly to examine their skills. Inter-rater Reliability on the parent fidelity and child data sheet is defined as 85% agreement.

Process for Program Design Modification

Dr. Zierhut shall notify Alta California Regional Center 30 days prior to any change in ownership, location, license, certificate, registration, credential or permit, or any modification to the program design or service design pursuant to Section 56712(b), 56762(c) or 56780(b) of these regulations, if applicable and shall notify the Alta California Regional Center and all user regional centers, in writing, at least 60 days before discontinuing provision of services. (Title 17, Section 54330)

Appendices:

1) Dr. Zierhut Resume

2) Fidelity measures (Parent Manual Skills Checklist) parent coaching

3) ESDM Curriculum (A) Checklist and (B) Descriptions

4) Sample Data Sheet

5) Sample progress report