Chance Elevator Encounters and Tenacious Champions

Collaborative Referrals Between Child Welfare and Early Intervention

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Abstract
This article spotlights Colorado and Rhode Island's collaboration efforts on the Keeping Children and Families Safe Act (PL 108-36, 2003), which reauthorized the Child Abuse Prevention and Treatment Act (CAPTA, 2018) and Part C of the Individuals With Disabilities Education Act (IDEA, 2018). These two key pieces of federal legislation require collaboration between state early intervention systems for infants and toddlers with disabilities and their families and welfare programs that focus on prevention and treatment of child abuse and neglect to be effective. From these state examples, we highlight both barriers to and facilitators of successful collaboration across the two programs.

Samantha, 24 months old, had very limited language skills. She had been removed from her home and was living with her aunt following a substantiated case of physical abuse. Her case worker was concerned about her language and overall development and referred her to the early intervention (EI) program. However, the EI program had only limited procedures in place for following up on referrals from the local child welfare program. The referral was included in a printout that was sent electronically once a month to the local EI program. The EI service coordinator made several attempts to reach Samantha's aunt, but was unsuccessful. Samantha's case closed, and she received no evaluation or services from the EI program. (Box 1 contains selected data about child maltreatment rates in the United States.)

Sharing information and data across EI and child welfare programs can be successful when an effective process exists for collaboration across the two programs (Mapes & Mitcheltree, 2019). This article describes how Colorado and Rhode Island, recognizing the need to improve connections for children such as Samantha, successfully implemented systems change at the state and local levels to increase the

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Box 1. National Data About Child Maltreatment for Federal Fiscal Year 2017

- There were 674,000 victims of child abuse and neglect in US (2.7% higher than Federal Fiscal Year 2013)
- More than ¼ of victims (28.5%) were younger than 3 years old
- Infants have the highest rate of victimization (25.3 per 1,000 children of same age in the US)
- Slightly higher victimization rate for girls (51.0 %) than for boys (48.6%)
- Highest rate of victimization rate is for American-Indian or Alaska Native; African-American children had the second highest rate

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). *Child maltreatment 2017*. Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

number of referrals to EI for families involved in child welfare. Their stories illustrate how their journeys improved the rate of viable referrals between EI and child welfare over the past several years.

Research Findings and Legislation

The risk for child maltreatment is higher in younger children, and highest for children under 1 year old (Wildeman et al., 2014). Researchers also know that the statistics on children with disabilities are hard to obtain but that these children are at least 3 times more likely to be abused or neglected than children without disabilities (Jones et al., 2012; Perrigo, Berkovits, Cederbaum, Williams, & Hurlburt, 2018). They also know that the consequences of child maltreatment for infants and young children are dire and can lead to disabilities, including alterations to brain structure and changes in the ability to process information (Jones Harden, Buhler, & Parra, 2016). In the last several years, opioid and alcohol use in pregnant women has skyrocketed, which increases the risk of child maltreatment in children younger than 1 year old (U.S. Department of Health & Human Services, 2019).

Two key pieces of federal legislation address the need for collaboration between state EI systems for infants and toddlers with disabilities and their families and welfare programs focused on prevention and treatment of child abuse and neglect: (a) the Keeping Children and Families Safe Act (PL 108-36) reauthorized the Child Abuse Prevention and Treatment Act (CAPTA) and (b) Part C of the Individuals With Disabilities Education Act (IDEA; see Table 1). CAPTA (Child Welfare Information Gateway, 2019) requires that states have in place procedures for referring children under 3 years old involved in substantiated cases of child abuse or neglect to Part C EI for screening or evaluation for eligibility. IDEA requires states to outline their policies and procedures for referrals of a child involved in a case of substantiated abuse or neglect, or prenatally exposed to illegal substances, and to coordinate with child protection, child welfare, and the provisions of CAPTA. In 2016, CAPTA legislation added requirements that child protection have policies and procedures to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder.

The Part C IDEA legislation is a complex undertaking, and states have been working hard to implement all parts since the EI was passed in 1986 (Hebbeler, Spiker, & Kahn, 2012). States face many challenges that need effective leadership, thoughtful inclusive planning, accurate data, and strong cross-agency collaboration (Division for Early Childhood, 2016). One problem, for instance, is that little is known with regard to how the child welfare system provides services to children with disabilities, in part because CAPTA does not require states to collect and report data on children who are maltreated based on disability (Lightfoot & LaLiberte, 2006). Therefore, just knowing how many children are served through IDEA EI programs does not reveal how many children with disabilities are in the child welfare system. Cross-system collaboration is recognized as an essential piece to meet the needs of young children with disabilities who experience abuse, neglect, or both; however, barriers to this collaboration remain (e.g., lack of collaboration and shared information across agencies, limited awareness of the signs of disability by those in the child welfare system, and limited awareness of the signs of maltreatment in young children by EI professionals; Corr & Santos, 2017).

Table 1. Federal Legislation Supporting Young Children Who Are Maltreated

Child Abuse Prevention and Treatment Act (CAPTA, 2018)	Part C of the Individuals With Disabilities Education Act (IDEA, 2004)
• Provisions/procedures including referral of a child under 3 years old who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals With Disabilities Education Act • Policies/procedures including appropriate referrals to child protection service systems and for other appropriate services to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder	State policies and procedures that require the referral for early intervention services for a child under 3 years old who is: • Involved in substantiated case of child abuse or neglect; or • Identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure

Another barrier is that child welfare and EI are separate systems with different local systems and have very different roles and responsibilities. The role of child welfare is to protect the child, which could include removal of the child from the home when necessary, but it does not focus on the child's development. The role of EI is to work with the family to improve the child's overall developmental functioning. Early interventionists work with the family to accomplish these goals. Both programs may use similar language, such as the term "assessment," but the terms may have very different meanings. These differences can be confusing for families and lead to mistrust of agencies that contact them (Corr & Santos, 2017). The timeliness of referrals and the onset of services can be delayed or derailed. This article describes how two states are working to break down these barriers.

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The role of early intervention is to work with the family to improve the child's overall developmental functioning.

Colorado's Story

Colorado's journey toward engaging in an iterative, relationship-based, data-driven process of systems change began with an elevator ride. Both EI Colorado and the Division of Child Welfare are housed in the same building of the Colorado Department of Human Services. In 2013, the possibility of increasing collaborative efforts started when a state EI staff member and the child welfare CAPTA administrator happened to ride in the same elevator. An invitation to discuss respective programs over coffee followed, and a multiyear effort to build coordination across the child welfare and EI systems began. Although the meeting in the elevator was accidental, it was the hoped-for result of careful planning for broader early childhood collaboration and the foresight of state leaders to create a new agency structure. That new structure facilitated the co-location of EI and child welfare in the same overarching state agency and in the same building. Prior to this co-location, efforts to set up a meeting had been ongoing for 2 years without progress. (See Box 2 for an overview of how children are served in Colorado.)

At the time of the elevator ride, only 30% of the referrals from child welfare were being received by EI (nonpublic state database, Colorado Department of Human Services, 2015). Within 3 years, collaboration and communication between EI and child welfare were so successful that 100% of referrals out of child welfare were received by EI.

How Colorado Found Success

So, what happened in those 3 years that made a difference? Multiple changes occurred which allowed the two agencies to become successful collaborators.

Building Relationships

Making and maintaining connections with those interested and passionate about the work is an integral component of success. Staff members from both agencies were committed to building cross-agency relationships at all levels beginning with that chance elevator encounter. First, a multidisciplinary CAPTA workgroup was created. The CAPTA workgroup served as the foundation for relationship-building, which included state- and local-level personnel from child welfare and EI, as well as partner agencies who conduct evaluations, and other key stakeholders, such as universities. The group began by updating the state-level Memorandum of Understanding (MOU) to outline roles and responsibilities of the two agencies to support implementation of federal and state requirements, including policies, procedures, coordination of training, and evaluation of activities. This state-level MOU also serves as a template for local programs to use for the local-level MOUs. The CAPTA workgroup also created a Frequently Asked Questions (FAQ) online tool to support clear expectations, shared language and definitions, and a common understanding around policies used in child welfare and EI. EI and child welfare staff also began conducting joint technical assistance visits. The MOU

Box 2. The State Landscape in Colorado

State agencies: Early Intervention Part C and Child Welfare Systems. Both programs are housed within the Colorado Department of Human Services.

Local agencies: There are 20 local service areas for early intervention (EI). Colorado has a state-supervised, county-administered child welfare system. Child welfare services are administered by 64 county departments of human/social services. Child Find evaluations are primarily conducted by 178 school districts.

Number of children:

In 2018:

- EI served more than 15,000 children. Annual growth has been around 6%.
- Child protective services assessed 11,000 allegations of abuse and/or neglect of children less than 3 years old, and 600 of these allegations were substantiated.
- The total number of referrals through the Child Abuse Prevention and Treatment Act (CAPTA) was 2,184, and of those 374 children were served by EI.

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Early interventions's primary focus is on intervening as early as possible to promote positive developmental outcomes for children, while child welfare's first concern must be the safety of the child.

and FAQ are core components of the joint visits to promote collaboration and understanding of one another's work.

State program staff members continue to interview well-performing counties and EI programs to identify best practices to share statewide through webinars and workshops. EI and child welfare professionals continue to raise awareness about EI at conferences where child welfare groups make up the primary audience.

Using Data to Inform Decisions

Having the right data and using it played a critical role in Colorado's successes. Initially, EI set out to increase the number of completed evaluations for children referred through CAPTA. However, the data showed that first it was necessary to address the number of referrals being received by local programs. When EI started to review the CAPTA referral process in 2012, only the data reported by the local EI programs was accessible. The EI statewide data system showed that a total of 820 CAPTA referrals had been received. This was only 30% of the 2,728 children under 3 years old with substantiated incidents of abuse, neglect, or both for the same year (non-public state database, Colorado Department of Human Services, 2015). EI ultimately wanted to determine the percentage of children completing eligibility, but this initial data showed they first needed to ensure referrals were being made by county departments and being received by EI. The number of CAPTA referrals became a shared performance measure. Both EI and child welfare were responsible for achieving the goal and reporting on progress monthly. This responsibility led to a shared commitment by both agencies to invest staff time in the development of activities to increase the number of referrals at several points to 100%.

The collaboration was achieved in part through a new statewide EI data system which made it easier to extract data and match it with data from the child welfare data system. Matching the data provided the ability to look at child-specific referral information in real time to better inform decision-making. Monthly monitoring of data and reporting to leadership in the Colorado Department of Human Services increased visibility, awareness, and accountability.

However, even though the increase in CAPTA referrals was successful, there was little change in the number of children reaching the evaluation process. It remained in the 20% to 40% range. So, child welfare and EI worked together to identify trends and test strategies at the local level to increase family participation in evaluation activities. Some strategies included adjusting the timing of referrals to EI and increasing understanding of EI by reworking the messages families received. For example, now after a referral has been made, the referring case worker is required to call the local EI agency to see if they have been able to contact the family and to provide a letter to the family that describes EI services. This follow-up helps to ensure that the family knows about EI services and has been contacted by the EI agency. These new activities are being tracked and reported monthly, and it is anticipated that there will be increased participation in EI as a result.

Engaging in an Iterative Process

Colorado uses an informal iterative process to provide a structure for testing changes to their referral system to identify where further adjustments need to be made. Strategies are tried, data are revisited, and adjustments are made. For example, when the Colorado CAPTA workgroup created the FAQ tool, they started with a draft that was shared with local agencies to solicit feedback. After four or five iterations, it was published on a website where ongoing updates can easily be made. To increase visibility and access, the online document will be moved to a website that specifically houses training materials.

One of the lessons learned by the state staff is the need to be persistent and not give up because it gets hard; they succeeded because they were willing to try another angle when something didn't work. While progress was made because of the systems changes that were implemented following that chance elevator meeting, new challenges and changes inherent in state government have emerged. For example, a breakdown in data system functionality temporarily disabled the automation of referrals, temporarily resulting in a significantly lower referral rate. In addition, changes in key leadership created the need to revisit communication activities to preserve cohesiveness in messaging between child welfare and EI and to ensure collaborative efforts were not lost.

Identifying Barriers to Success

In its implementation of relationship building, data review, and iterative change processes, Colorado has experienced three types of barriers, as discussed in the following sections. Colorado is actively working to identify solutions to address these barriers.

Differing and Competing Agency Requirements

Requirements that differ across agencies present challenges. First, the requirement to have MOUs differs by agency; MOUs

are required for local EI programs but not for local child welfare agencies. Therefore, it is often difficult for the local EI agency to get the local child welfare agency to create an MOU and agree upon common practices. Second, EI's primary focus is on intervening as early as possible to promote positive developmental outcomes for children, while child welfare's first concern must be the safety of the child. The need for EI and why the referral is being made are not always understood by child welfare workers, and with so many competing and often urgent priorities, a referral to EI can seem less important to the child welfare case worker. This lack of prioritization can lead to a lag in sending referrals to EI. To reduce the issue, a greater shared understanding of the roles and responsibilities of EI and child welfare workers is needed between the two agencies.

Family Considerations

Not surprisingly, EI has experienced difficulty locating and contacting families due to the challenges often faced by the families involved with child welfare (e.g., frequent moves, inconsistent availability, changing phone numbers). Once located, families often are not interested in being involved with another program coming from the same agency as child welfare, even if the program is free and voluntary. Fear related to not knowing who is calling or at the door may be a large factor. Surveys of local EI programs have shown that following up on a CAPTA referral takes more than twice as long as following up on referrals from other sources and doesn't often result in completion of an evaluation. On average, a general referral takes 45 minutes to an hour to complete, while a referral from CAPTA can take upwards of 5 hours. Furthermore, the CAPTA referral is less likely to result in a completed evaluation. Currently, of the children referred through CAPTA, only 40% are ultimately found eligible for EI (non-public state database, Colorado Department of Human Services, 2018).

Resource Issues

To place these efforts into context, EI and child welfare do not work in isolation. Many other agencies, such as early childhood programs or physicians, also conduct developmental screening activities. Public awareness about EI and child welfare is crucial but labor intensive. Similarly, coordinating efforts across multiple agencies, while necessary, also takes a great deal of time and resources. In addition, staff turnover in both EI and child welfare creates the need for ongoing training cycles and continuous technical assistance within and across programs.

Ensuring Success Moving Forward

While Colorado is proud of the strides made, there continues to be a need for a strong focus on state and local level processes to support a higher level of engagement of families in both systems. A combination of iterative, relationship-based, data-driven activities will continue to drive the work forward, but strategies to enhance awareness of the benefits of EI must be conveyed to professionals and families alike. Conversations that began in an elevator are now being moved to the best "elevator pitch" our programs can collaboratively develop.

Photo courtesy of Haidee Bernstein

Many agencies, such as early childhood programs or physicians, conduct developmental screening activities.

Rhode Island's Story

Collaboration, relationships, perseverance, and having tenacious champions for family and child well-being created Rhode Island's recipe for success. Rhode Island's story began in 2005, when members of the Rhode Island Early Intervention oversight group (the early intervention Interagency Coordinating Council) formed a child welfare subcommittee to develop a plan of action in response to provisions and procedures required in both CAPTA and Part C of IDEA. The visionary goal of these Rhode Island pioneers was to build a cross-agency process to identify and create a successful pathway for infants and toddlers in the child welfare system to either a developmental screening or, if a developmental concern already exists, directly to Part C EI for an eligibility evaluation.

The subcommittee felt strongly that changing the landscape and messaging about developmental screenings for this population was an investment requiring collaborative efforts across state departments and decision-making through collection and analysis of data. The subcommittee participants were selected for their interest and capacity as Rhode Island stakeholders serving vulnerable infants and toddlers and included representatives from Rhode Island's (a) Department of Health; (b) Department of Children, Youth and Families (non-public state database, Rhode Island's child welfare agency); (c) Executive Office of Health and Human Services infant/toddler service providers; and (d) parent representatives. As the focus of the group evolved over more than a decade, additional participants joined to offer skills and experience

relevant to emerging issues. (See Box 3 for an overview of how children are served in Rhode Island.)

Using Our Data to Inform Our Decisions

As a first step, the subcommittee gathered existing referral and developmental screening data to obtain baseline information for this population. The subcommittee accessed and analyzed the required data, including data from Rhode Island Kids Count, Rhode Island Department of Health First Connections program, EI, and CAPTA. The initial analysis revealed that only 13.5% of the CAPTA population had a documented screening (Rhode Island KIDS COUNT, 2005), and information on referral status communications between child welfare and EI were almost non-existent. This reality led to several strategies, beginning with the creation of a single CAPTA referral liaison position in 2006, funded by the child welfare agency and co-located at both a central regional child welfare office and one of the EI provider sites. The CAPTA liaison serves as the point person for communication between child welfare staff and EI providers. In this role, she refers CAPTA children from child welfare to EI and ensures that data about the referral process is shared. In addition, the subcommittee developed a new state-level CAPTA policy change that addressed practices and included:

- a procedure added to the existing protocol within the child welfare investigation process to gain consent and refer infants and toddlers for a developmental screening or EI eligibility evaluation,
- a standardized form with accurate information that allowed the EI program to effectively communicate and engage the designated caregiver (biological and/or foster parent), and
- a process that closes the loop by providing the referral status of each child to child welfare.

The child welfare referral liaison was provided access to the EI data system and can now track the status of EI referrals.

The statewide technical assistance program for EI, in collaboration with the CAPTA referral liaison, supported the implementation of this process through the creation of statewide structural supports (i.e., trainings and guidance documents) for child welfare and EI direct care staff. These new supports included: (a) a training curriculum for child welfare staff with topics about EI services and philosophy, developmental screenings, and guidance for the new EI referral process; and (b) a training curriculum for EI staff with topics on understanding child welfare investigations, engaging caregivers, and ensuring referral status data are provided to the child welfare agency. In addition, the child welfare agency used federal grant funds to create an early childhood resource specialist position to act as a representative of the child welfare agency for state-level meetings and workgroups in 2012. After the initial federal funding, the child welfare agency chose to maintain this position through state funds, recognizing the impact that investigations, placement, and reunifications have on Rhode Island's most vulnerable children. The data showed that after 5 years of implementing the new processes, referrals from child welfare to EI increased, but leveled out at a steady referral rate of about 60–65% in 2016 (non-public state database, Rhode Island Department of Children, Youth and Families, 2016).

In 2014, the subcommittee began a Continuous Quality Improvement project to improve referral rates. The first step included a mapping exercise outlining the current referral process to pinpoint potential barriers. This visual map allowed the subcommittee to take a step back from practice and identify potential gaps in the process that contribute to children not being referred. The mapping activity revealed two barriers to the process: (1) during an investigation, local child welfare agencies either did not collect consent from the biological parent for the referral to EI, or the parent refused consent; and (2) the referral status data from both the developmental screening program and EI were inconsistent, making it difficult to follow up with families to ensure engagement. EI outcomes and developmental screenings were kept in separate databases, making it difficult to match up and account for every child.

Changes Made to Address Challenges

These eye-opening revelations recharged the subcommittee to make changes to the current policy using an impact matrix activity (Langley, Moen, Nolan, Norman, & Provost, 2009), a process to identify strategies that will have a high impact of change with the least amount of effort. To address the consent issue, the child welfare early childhood resource specialist

Box 3. The State Landscape in Rhode Island

State agencies: Part C is housed in the Medicaid Division of the Rhode Island Executive Office of the Early Intervention Interagency Coordinating Council Child Welfare Subcommittee in the Rhode Island Department of Health and Human Services. Child Welfare is housed at the Rhode Island Department of Children, Youth, and Families.

Local agencies: Rhode Island has nine local early intervention (EI) Part C programs that conduct their own eligibility evaluations, four regional child welfare offices that provide Child Abuse Prevention and Treatment Act referrals, and five agencies that provide First Connection services that conduct developmental screenings.

Number of children:

- In 2005, only 13.5% of children of substantiated cases of abuse and/or neglect were referred for a developmental screening (Rhode Island KIDS COUNT, 2005).
- In 2018, of the 980 children younger than 3 years old who were involved in indicated cases of abuse or neglect (Rhode Island KIDS COUNT, 2019):
  - 645 (66%) were referred to First Connections for screening
  - 43 (4%) were already enrolled in EI
  - 229 children were referred directly to EI, and 171 (74.7%) of these were evaluated, found eligible, and engaged in EI services.

investigated CAPTA-related referral protocols and found that other states require only referral notification for parents, rather than formal written consent. This small but important discovery led to a change in the child welfare referral form's consent language to allow child welfare to document that notification was provided. Child welfare staff were provided with training and guidance materials to reinforce and ensure that parents are informed about their child's referral for a screening or eligibility evaluation. To ensure that outcome of the referral to EI is communicated to the child welfare agency, language on the child welfare referral form now requires EI providers to return the form to the CAPTA referral liaison with the referral status.

In 2015, the subcommittee used continuous quality improvement Plan-Do-Study-Act cycles (Taylor et al., 2014) and tracking tools to pilot the new policy to inform parents of the referral through a partnership with a local EI site. The process was tested and revised until the subcommittee had a final CAPTA referral policy ready for state approval that defined the population, who would initiate and track the process, and clarify EI intake, eligibility, and transition around child welfare's role for children in substitute care. MOUs, interagency agreements, training tools, and guidance documents were developed and ready for full implementation. Despite the collaborative efforts to improve the CAPTA referral policy, changes in Rhode Island State Department leadership and senior-level state staff greatly slowed the momentum to fully adopt these improvements. In fact, it was almost 2 years later, in 2017, that the newly appointed child welfare director finally approved the new policy and allowed its full statewide implementation in June 2017.

The state data showed the effectiveness of the changes. In 2017, child welfare successfully referred 82% of the infants and toddlers with substantiated cases for a developmental screening or an eligibility evaluation, and that number improved to 93% in 2018 (non-public state database, Rhode Island Department of Children, Youth and Families, 2018, 2019). Children with a known or highly established condition were referred directly to EI while children without a known or highly established condition were referred for screening. In 2018, of the 203 children that were referred from child welfare directly to EI, only 5% were lost to follow-up, while 75% were screened for eligibility, with most of those being eligible for EI (non-public state database, Rhode Island Executive Office of Health and Human Services, 2019). The remaining children were still in the eligibility process when these data were examined.

Ensuring Continued Success in Rhode Island

Although great progress has been made, the subcommittee is looking to the future to ensure continued success in this collaborative process and to take next steps to think about how to successfully engage families involved with child welfare in EI services to achieve positive outcomes for these children and their families. Other next steps include identifying and implementing strategies and activities to increase EI providers' understanding of social–emotional development to better meet the needs of this population and to continue ongoing communication and collaboration between all agencies that serve infants and toddlers in the child welfare system.

Photo courtesy of Haidee Bernstein

Change is driven by data, and an effective process is often reached by a commitment to ongoing continuous improvement.

What Can Be Learned From Colorado and Rhode Island?

Researchers know from the literature that children with disabilities have a higher likelihood of abuse and neglect. They also know that rates of maternal addiction and babies born addicted are on the rise, placing the babies at risk for developmental delays and social–emotional problems. These problems necessitate the need for establishing and maintaining linkages between EI and child welfare agencies. Developing these linkages takes leadership and staff time, persistence, and creative strategies. The data systems often need to be revised or built to offer viable data linkages. What can be learned from Colorado and Rhode Island about how to do these things?

Establish a Process That Is Supported Through Data

Data sharing is critical to interagency collaboration. Implementing change at state and local levels requires accurate data from both EI and child welfare starting at referral, continuing through evaluation, and then serving the child and family. Strong data informs programs about the strength of the processes and supports that are in place.

Understand That Relationships Are Key

To solve problems in cross-agency systems building at the state and local levels, staff at each level need to be committed to working together to achieve mutual goals. It is important for state and/or local staff to be intentional in developing plans for establishing, maintaining, and sustaining ongoing communication and collaboration surrounding current and potential referral issues. To build these relationships, interagency collaboration needs to be a priority.

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Implement Joint Leadership Commitment and Joint Planning

To build cross-agency policies and procedures at both the state and local levels, agency leadership must provide support for this work that includes long-term commitments to meeting shared goals. Furthermore, it is important to establish joint planning committees, document policies and procedures, and understand the cultures of different agencies and other activities that collaboratively develop common purposes, language, and expectations, with clearly articulated benefits established for all participants. Different state agencies often have differing priorities and requirements that guide and dictate how they work with children and families. Staff working across agencies need to understand these considerations and differing perspectives when working on joint initiatives. Finally, staff and leadership changes are inevitable; therefore, planning for change is key.

Provide Ongoing Communication and Training

The iterative development of joint policies and procedures to be used across agencies or programs will take time to implement. To ensure successful implementation to achieve the intended goals, well-planned ongoing training and guidance documents for all staff across both agencies at the state and local levels must be developed.

Be Data-Driven and Implement an Iterative Process

Throughout this article, we have emphasized that change is driven by data and that an effective process is often reached by a commitment to ongoing continuous improvement. Collect data, see if it is working, tweak, revamp. This is a time-consuming process, but ultimately the time spent will be worthwhile.

Conclusion

Connect child welfare with EI through a doable and effective referral process that is feasible to implement. Making this connection requires identifying and putting in place the appropriate set of supports at both the state and local levels. States need to design the process and implement supports to ensure consistent implementation. These supports include policies, guidance documents, MOUs, training and training materials, data systems, and access to data, personnel, and other information. Some supports are provided once, and some are ongoing. Documenting change will reduce the disruptions caused by staff, including leadership and turnover.

The systems change processes in Colorado and Rhode Island show that state leaders and staff need to be tenacious in this collaborative work. Once groundwork is established, state staff must be committed to seeing the cross-agency work as a continuous process that needs to be monitored through data. Adaptations and changes in policies and procedures are based on what they see in those data. And finally, celebrate successes along the way!

Learn More

Early Childhood Technical Assistance Center
https://ectacenter.org/topics/earlyid/capta.asp

Center for IDEA Early Childhood Data Systems (DaSy Center)
https://dasycenter.org/?s=CAPTA

https://www.colorado.gov/CDHS/CW/devscreen

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Kathleen Hebbeler, PhD, a senior principal education researcher with SRI International, has extensive experience in research and evaluation of education, health, and social programs for young children with disabilities and their families. She has directed large-scale projects involving quantitative and qualitative methods for federal and state agencies and private foundations. Currently, Dr. Hebbeler co-directs the Center for IDEA Early Childhood Data Systems (DaSy Center) that provides technical assistance on the collection and use of data to early intervention and preschool special education state agencies.

Jennifer L. Kaufman, MEd, is the Rhode Island Part C coordinator at the Rhode Island Executive Office of Health and Human Services. She has worked for more than 25 years in the early childhood field with the past 18 years in the area of early intervention. As the Part C coordinator, she has dedicated her energy to ensuring that all Rhode Island families with infants and toddlers eligible for early intervention, especially those involved with child welfare, are identified, referred, and engage in family-centered quality services.

Darlene Magaw, MS, has been employed by Community Care Alliance for the past 35 years. Her current position is the division director for Family Support Services, which includes a variety of early childhood programs (i.e., early intervention, First Connections and Healthy Families America,

Youth Success), and Family Support Center that serves more than 4,000 households annually with basic needs assistance. Ms. Magaw obtained a bachelor's degree in social work from Rhode Island College and a master's degree in psychology from Brown University. Her civic involvement includes serving on the leadership boards for the George Wiley Center and the North Smithfield Food Pantry. She is currently the co-chair of the Family Community Advisory Board for the Northern Region FCCP Family Visiting Advisory Board and facilitates the Interagency Coordinating Council sub-committee on the Early Intervention and Department of Children Youth and Families collaboration.

Evelyn F. Shaw, MEd, is a technical assistance specialist at the Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill, working for more than 30 years on a number of projects related to young children with or at risk for disabilities. As a technical assistance specialist, she has expertise in early identification and on issues related to child find including children with prenatal exposure to substances, children who are maltreated, and use of data to target improvements.

Lorendia K. Schmidt, MSW, LSCW, CACII, is the organizational support manager at the Division of Child Welfare, Office of Children, Youth & Families, Colorado Department of Human Services. She has worked in the field of social work since 2002 and obtained her master's in social work from the University of Denver in 2008. She is a licensed clinical social worker and is a certified addictions counselor. Ms. Schmidt previously served as the Child Abuse Prevention and Treatment Act administrator for the state of Colorado. She currently manages the Organizational Support Unit which oversees the Child Welfare Training System and Colorado's Comprehensive Child Welfare Information System. Her experience includes child welfare practice, mediation for domestic relations court, substance-abuse treatment and case management for juveniles and adults on probation, program/grant management, and home visitation.

Donna Spiker, PhD, is a senior early childhood researcher in SRI International's Education Division. Dr. Spiker is a nationally known developmental psychologist with extensive experience leading many state and national early childhood evaluations, needs assessment, and technical assistance projects. Many of these projects focused on early intervention and preschool special education, early care and education, and school readiness programs and services for infants and young children and their families. They have included children with disabilities, children living in poverty, diverse groups such as native Americans and dual language learners, and underrepresented groups such as young children in foster care and new immigrants. Currently, Dr. Spiker co-directs the Center for IDEA Early Childhood Data Systems (DaSy Center) that provides technical assistance on the collection and use of data to early intervention and preschool special education state agencies.

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