mation, nor is it likely that we will be able to prove these scales valid and reliable given the current strategy.

Our goal is to have all the FCM categories tested for validity and reliability by the end of 1998, and then revise the scales as necessary. Work on revising the adult scales will begin shortly as will work on the scale for children (kindergarten to age 18).

In addition, once regular data collection is underway, we anticipate having in-depth modules for use by clinicians who specialize in one or more areas. For example, if you focus on voice, there would be an additional set of FCMs that related only to voice which measured functional changes on a number of additional dimensions not available in the general scale.

Editor's Note

The Task Force on Treatment Outcomes and Cost Effectiveness is seeking the help of Special Interest Divisions in several areas:

1. *to maintain the bibliography on treatment efficacy and add new lists;*
2. *to identify sites which have large populations falling in one of the categories listed on Table 1 to do validity and reliability studies; and*
3. *to identify specialty areas where FCMs should be developed and to recommend people to help develop additional modules for use by clinicians.*

Any affiliates of Special Interest Division 1 who are interested in helping out in any of these areas or have suggestions/comments regarding these issues, please share your ideas on Division 1's listserv or contact Herbert Baum at ASHA (301)897-0133 or hbaum@asha.org.

Mona R. Griffer

Early Intervention Chat Corner

Interview With Louis Rossetti on the State of Early Intervention Service Delivery as We Approach the 21st Century

Welcome Special Interest Division 1 affiliates to the first of our Early Intervention Chat Corners!

In today's world, early interventionists are forever challenged with changing health care systems, federal and state legislation, and increasingly varied roles and responsibilities in clinical service delivery and working with the families of young children who have special needs. We are fortunate to have as our first guest, Louis M. Rossetti, Director of the Communicative Disorders Program at the University of Wisconsin at Oshkosh. Rossetti, an internationally recognized clinical scholar, teacher, and author, offers his perspective on current trends in Early Intervention (EI) service delivery as we approach the 21st century.

1. **MG:** What current trends in EI service delivery do administrators, direct service practitioners, and university faculty need to be concerned about as we approach the 21st century?

   LR: There are two significant trends to be concerned about. The first is the transdisciplinary nature of the EI service delivery process. What we have become increasingly aware of over time is that it really doesn't matter who provides the intervention because of the tremendous overlap in training and knowledge. Effective early interventionists must be able to cross disciplinary boundaries. University programs must provide opportunities in both the academic and clinical arenas that enable preservice clinicians to do so. After a 10-year history of EI service delivery, we are finally getting the message that we cannot empirically support one discipline's involvement over another's prior to the age of 15 months of age. Therefore, we must garner from each discipline the very best early intervention principles and practices, and acknowledge that the overlap of skills is considered best practice, and will continue to be throughout the 21 century.

   The second important trend is the acknowledgment that home-based services are preferable for children under the age of 1 year. We are continuously moving in the right direction in regard to this naturalistic model of service delivery.

2. **MG:** What is the state of EI service delivery in the United States as compared to other countries, based on your experiences?

   LR: We are the envy of the world, comparatively speaking. Most areas of the world follow a medical model in regard to disabilities. In countries such as Great Britain, Canada, Finland, and the Scandinavian regions, diagnostics drives intervention. In the United States, early interventionists are regarded as educators, and as such, we are not diagnostically driven.

From a national perspective, if I were to rank the United States on a scale of 1-10 in terms of overall early intervention services, they would earn a rating of 7 in regard to being in full compliance with the nature and spirit of P.L. 101-476 (IDEA). The reason for this is that there continues to be a critical shortage of highly qualified early intervention personnel throughout our country.

3. **MG:** How has managed health care impacted on EI service delivery in the United States? Have reimbursement patterns changed? If so, how and to what extent?

   LR: In regard to managed health care, it really depends on who is the primary provider of birth-to-3 services in each state. If the public school system in the state is the primary provider, such that they are billing for early intervention services for children birth-to-3 with special needs, then it is highly unlikely the private agencies, hospitals, or private practitioners will be reimbursed for those services. However, if the public schools are not the primary early intervention service providers, generally reimbursement can be received for established-risk conditions that constitute a medical necessity as opposed to at-risk conditions.

   Presently, in the United States, 35+ states have the Department of Education (DOE) as their lead agency. It makes a great deal of sense to have DOEs serve as the child-find network in the state because of the national recognition that public schools have with families. This does not mean, however, that all public school systems are necessarily doing the best job at providing early intervention services. That really depends on whom the lead agency in each state is distributing their funding to and establishing contracts with in regard to the provision of early intervention services. Once again, this is highly variable across states due to previously mentioned factors (e.g., the transdisciplinary nature of the early intervention process and the availability of highly qualified early interventionists).

4. **MG:** How well do you think university preparation programs are doing in regard to providing preservice clinicians/educators with specialized academic and clinical training in regard to EI service delivery? What factors do you see as continuing to challenge clinical educators, administrators, and students in university settings? What opportunities are offered at the Communication Disorders Program at the University of Wisconsin at Oshkosh to prepare undergraduate and/or graduate preservice clinicians to work effectively with infants and toddlers who have special needs and their families?

   LR: I visit at least 15-20 university campuses a year. Generally, I have found that educational and clinical training programs are doing a poor job, primarily because of one reason. Faculty are no longer clinically active. In my opinion, PhD faculty abdicate their right to talk about clinically relevant information if they don't provide direct clinical services. I often suggest to students to think twice before attending a graduate program in which the doctoral level faculty are not clinically active. Preservice clinicians need the clinical expertise that faculty have to offer. The best way to teach this is through a mentoring process.

   The biggest challenge facing clinical educators today is developing efficacious clinical programs and communicating effectively with parents and caregivers. Family members continue to report that professionals do not listen to them.

   There is a strong emphasis placed on pediatrics in our clinical training program at UW—Oshkosh. Sixty-five percent of our clientele are children. Our students receive extensive clinical training with young pediatric populations from day one. Jack Kile and I believe in the mentoring approach to graduate clinical education, such that we do nothing in the clinic without having students look over our shoulders. There are numerous opportunities afforded to our students for on-and-off campus clinical practica experiences in neonatal intensive care settings and infant-toddler early intervention programs. In addition, I teach a course entitled "High-Risk Infants," which every student has the opportunity to take.

5. **MG:** What kind of academic and clinical continuing education opportunities do you feel ASHA and State Speech-Language-Hearing Organizations should be providing to better prepare professionals who are interested in providing early intervention services?

   LR: The best thing that could be done is for speech-language-hearing, physical and occupational therapy, psychology, education, and medical state and national professional organizations to join

together and offer transdisciplinary continuing education courses that involve a hands-on clinical component. Topics that should be emphasized include effective assessment and intervention techniques and effective involvement of parents and caregivers in the early intervention process.

6. **MG:** What factors should be considered when determining the efficacy of EI services?

   LR: There are four important factors to consider in regard to efficacious EI service delivery. They include:

   - Child change, which may not be the most effective measure of efficacy.
   - Curricula efficiency in regard to program content, format, and style.
   - Family efficacy such that family members feel their needs are being met and that they are listened to and valued throughout the early intervention process.
   - Cost efficacy such that we develop cost-effective approaches to providing early intervention delivery.

7. **MG:** Why is active, ongoing family involvement so critical to the EI assessment and intervention process?

   LR: We know that two factors contribute to the efficacy of our services. One is the age of identification. The other is caregiver involvement.

8. **MG:** Many practitioners and administrators have used the terms interdisciplinary and transdisciplinary interchangeably to describe their team models. Do you agree that these terms are synonymous? If not, how do you differentiate between these models of disciplinary teaming?

   LR: These are definitely not synonymous terms. The best measure is to observe a practitioner and not know their primary academic discipline. It takes at least a 2-year process to develop transdisciplinary skills. The best way to do this, once again, is through a mentoring process.

In closing, I would like to thank professor Rossetti for sharing his views. We look forward to other early intervention topics of interest in subsequent editions of our newsletter. If you would like to submit a topic for consideration in our Early Intervention Chat Corner, please post your suggestions on our Division 1 listserv or send them to:

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Division 1 Affiliates

ASHA Convention Help Needed

At this year's annual ASHA Convention in Boston, the special interest divisions will have a display in the exhibit hall. We are seeking interested and motivated individuals who could help staff this booth during the Convention's exhibit hours. If you would like to participate, please send a note, including your name, address, phone and email address to **Brian Shulman, Special Interest Division 1, Language Learning and Education, ASHA, 10801, Rockville, MD 20852.** You will be contacted at a later date to schedule a convenient time to staff.