

Partners in School: An Example of Care Coordination to Ensure Consistency of Evidence-Based Practices Across Home and School for Youth with Autism Spectrum Disorder (ASD)



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Abstract The Individuals with Disabilities Education Act (IDEA, 2004) and the Every Student Succeeds Act (ESSA, 2015) mandate that families participate in shared decision-making with schools. For youth who receive special education services, such as those who have ASD, having parents and teachers aligned in their practices is even more crucial. Unfortunately, consistency of evidence-based practices (EBP) across home and school is rarely experienced. This chapter describes the development of *Partners in School*, an example of coordinating care between home and school settings for youth with ASD. The goal of *Partners in School* is to ensure that parents and teachers are implementing the same EBPs in the same way (i.e., consistently). It draws from the literature on school consultation, business negotiations, and health communication/shared decision-making. The scientific literature is merged with the perspectives of parents and teachers of elementary students with ASD from a large urban school district. The chapter begins by anchoring this approach on the empirical evidence for family–school partnerships, and then concludes by describing the implications of *Partners in School* for care coordination.

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A family–school partnership can be defined as a student-centered relationship involving close communication and collaboration between parents and teachers, given their shared responsibilities in ensuring the academic, social, emotional, and behavioral well-being of children (Christenson & Sheridan, 2001). The concept of family–school partnerships is grounded in ecological systems theory, which identifies five distinct areas that contribute to development. In this theoretical approach, families or schools are situated in the area characterized by direct contact, called the microsystem. The mesosystem focuses on the relationship between these different systems (Bronfenbrenner, 1992). Difficulties occur for youth when there is incongruity, such as a mismatch between the home and school systems. As a result, various professional organizations (e.g., National Parent-Teacher Association, 2009; State Support Network, 2018) have created guidelines to improve family–school partnerships, focusing on welcoming families, communicating effectively, establishing trust, sharing power, and providing professional development training.

Parents' involvement in their children's education is often based on the opportunities for participation presented by the school staff. The most effective programs targeting family-school partnerships work with parents directly to target specific skills or behaviors (Magnuson & Schindler, 2016). For example, the *Getting Ready for School* intervention targets families from traditionally underserved backgrounds and provides them with weekly workshops to prepare their preschoolers for the transition to school (Marti et al., 2018). Educating parents of developmental milestones may empower them to work with teachers to integrate developmentally appropriate opportunities into their daily routines at home (Magnuson & Schindler, 2016). When a strong family-school partnership is lacking, children may experience inconsistencies between expectations and responses to behaviors at home and at school, leading to higher levels of externalizing behaviors (Daley, Munk, & Carlson, 2011).

A strong family-school partnership is important for all children, and there are many reasons why it is particularly critical for youth with ASD who receive special education services. First, a diagnostic characteristic of youth with ASD is difficulty with change. In the area of restricted, repetitive patterns of behavior, the Diagnostic and Statistical Manual-Fifth Edition (DSM-5), makes references to an "insistence on sameness" and "inflexible adherence to routines" (American Psychiatric Association, 2013). Therefore, discontinuity of experiences across home and school may be particularly distressing for youth with ASD. Second, the challenges associated with ASD are often pervasive across home and school contexts (Azad & Mandell, 2016). For example, youth who struggle to transition from preferred to non-preferred activities often display this rigidity both at home and at school. Third, a comprehensive approach to addressing the needs of youth with ASD requires both parents and teachers to engage in EBPs at home and school, respectively. Accordingly, there has been a trend in the field of autism services toward parent-mediated interventions (Green et al., 2015; McConachie & Diggle, 2006; Oono, Honey, & McConachie, 2013; Rogers et al., 2014) or teacher coaching models (Kretlow & Bartholomew, 2010; Mandell et al., 2013; Wilson, Dykstra, Watson, Boyd & Crais, 2012) to ensure

that the primary stakeholders in children's lives are engaging in scientifically supported practices. Unfortunately, there are limited models that effectively harness the power of both parents and teachers to improve outcomes for children with ASD.

Partners in School Development: Drawing from Multidisciplinary Research

The goal of *Partners in School* is to maximize continuity for children with ASD by ensuring that the same EBPs are used across home and school. This approach establishes bidirectional parent-teacher communication and takes them through a systematic problem-solving process with the goal of duplicating intervention components from the school to the home. To develop this comprehensive model, we drew from several scientific literatures including school consultation, business negotiations, and health communication/shared decision-making.

School Consultation

At the epicenter of school-based consultation models is the concept of problem-solving. There are four essential steps to problem-solving: (1) identifying the problem, (2) determining why it may be happening, (3) developing and then subsequently implementing an intervention, and (4) evaluating the effectiveness of that intervention. In Bergan & Kratochwill's, (1990) model of behavioral consultation (BC), a consultant (e.g., school psychologist) and consultee (i.e., teacher) collaboratively work through this problem-solving sequence to address a student's needs in the classroom.

Sheridan and colleagues expanded BC to include parents in Conjoint Behavioral Consultation (CBC). In CBC, consultants work with both parents and teachers (i.e., as consultees) to problem solve concerns about students. In both BC and CBC, the problem-solving process is implemented through a series of three or more interviews (Sheridan & Kratochwill, 2008). Several randomized controlled trials (RCTs) have confirmed that CBC is effective in improving behavior outcomes for typically developing children (Sheridan et al., 2012; Sheridan, Witte, Holmes, Coutts, et al., 2017; Sheridan, Witte, Holmes, Wu, et al., 2017). More specifically, parents who participated in CBC reported significantly fewer challenging behaviors in children when compared to a control group of parents (Sheridan et al., 2013). Further, students whose parents participated in CBC demonstrated increased "learning related" behaviors, such as following directions and decreased disruptive behaviors, such as excessive motor movement (Sheridan et al., 2017).

School-based consultation for youth with ASD has been led by Ruble and Colleagues (2010). Their approach, titled, “Collaborative Model for Promoting Competence and Success (COMPASS),” includes one preliminary parent-teacher consultation meeting, followed by four teacher coaching sessions. In randomized control trials, COMPASS has shown to be successful in helping children obtain their Individual Education Program (IEP) goals (Ruble, Dalrymple, & McGrew, 2010; Ruble, Dalrymple, & McGrew, 2012). Both CBC and COMPASS are impactful models that have greatly influenced the development of *Partners in School*.

Business Negotiations

The idea of problem-solving in school consultation has many similarities to the concept of negotiation in business. For example, Adair & Brett’s (2005) four-stage model of transactional negotiation includes relational positioning, identifying the problem, generating solutions, and reaching an agreement. During these four stages, negotiators alternate between cooperative and competitive orientations. Business experts suggest that there is a relationship between a negotiator’s emotional state and the outcome of the negotiation. More specifically, positive moods can increase a negotiator’s tendencies to select a cooperative strategy (Forgas, 1998), whereas negative moods can make negotiators more competitive in their preferences (Loewenstein, Thompson, & Bazerman, 1989).

Experiencing positive emotions is related to the idea of a mental model. Based on language expectancy theory (Burgoon, Denning, & Roberts, 2002), a mental model is defined as a cognitive representation of the expected negotiation, which includes the self, the dyadic relationship, attributions about the other person, and knowledge of the bargaining process. Of particular importance is the notion that individuals who modified their initial perceptions (or mental models) did so at the onset of the interaction; otherwise, the fixed assumptions tended to persist throughout the interaction (Bazerman, Curhan, Moore, & Valley, 2000; Thompson & Hastie, 1990). A mechanism to modify these initial perceptions is to engage in positive violations of expectations. Positive violations occur when someone behaves better than expected or when someone initially evaluated negatively behaves according to social norms, cultural values, or situational demands (Burgoon et al., 2002). The negotiation literature suggests that people are more satisfied with a deal, and more likely to follow through with a deal, when they experience positive emotions, particularly at the beginning of the negotiation as a positive violation of their expectations. Therefore, in the *Partners in School* model, positive emotions in parents and teachers are elicited at the onset of their interaction.

Health Communication and Shared Decision-Making

Historically, there is much similarity between the patient-physician relationship and the parent-teacher relationship. Although both of these relationships have been predominately one-sided (Henderson, Hunt, & Day, 1993; Siminoff & Step, 2005; Work & Stafford, 1987), there are recent shifts that encourage a partnership approach. For example, medical-shared decision-making advocates for a *partnership* approach featuring the two-way exchange of information and preferences between patients and their physicians (Charles, Gafni, & Whelan, 1999). As mentioned previously, home-school *partnerships* advocate for a mutually beneficial relationship between parents and teachers around issues of communication, problem-solving, support, and overlapping goals (Christenson & Sheridan, 2001; Sheridan & Kratochwill, 2008).

Similar to business negotiation, experts in health communication have shown that initial experiences influence subsequent outcomes. In health communication, the nature of initial communication exchanges between a physician and his/her patient has a direct influence on patients' choices between treatment options and their subsequent adherence to treatment plans (Siminoff & Step, 2005). Unfortunately, when patients and physicians come together within the health context, their differences are immediately highlighted. When differences are highlighted, this sets the course of the interaction for both parties to solely focus on their own needs. One way to address this problem is to have communicators "discover" their similarities. Creating shared understandings and common interests are key to co-constructing the interaction. In general, people are more inclined to cooperate with other people who they perceive as similar to themselves (Siminoff & Step, 2005). These findings suggest that in the *Partners in School* model, it is necessary to direct parents' and teachers' attention to their similarities given the inclination to focus on their differences.

Partners in School Development: Perspectives of Parents and Teachers of Youth with ASD

Agreement on Concerns

In a previous study, researchers merged the scientific literature described above with the perspectives of parents and teachers of children with ASD from schools in a large urban public school district (Azad, Marcus, Sheridan, & Mandell, 2018). Their initial interest was to examine whether parents and teachers agreed about their concerns for the same child. They interviewed parents and teachers about their top three concerns for the child with ASD, and then subsequently gave them an opportunity to discuss their concerns during a dyad observation. Interview data showed that parent and teacher concerns clustered around eight general areas (e.g., following direction, difficulty transitioning, aggressive behaviors, etc.) Parents and teachers shared the same primary concern 28% of the time. More importantly, 69% of parents

and teachers shared the same top two concerns, even if they were not in the same order. For example, a parent's first concern may have been the teacher's second concern, and vice versa. This finding is encouraging because it suggested that parents and teachers agreed with their concerns when multiple concerns are queried. Unfortunately, during the discussion of their concerns, 49% of the parent-teacher dyads discussed concerns that neither reported as their primary concern; 31% discussed concerns that neither reported as their primary or secondary concern. These findings indicated that although parents and teachers may agree about their concerns, they are unable to communicate about them effectively (Azad & Mandell, 2016). Therefore, in the *Partners in School* model, it became imperative to get parents and teachers talking about their most salient concerns.

Problem-Solving

Researchers were also interested in the extent to which parents and teachers could generate solutions about mutual concerns. Their data suggested that parents and teachers of children with ASD displayed limited use of the core elements of problem-solving (e.g., defining a mutual concern, setting goals, developing interventions to address their mutual concerns, discussing data collection methods), but moderate levels of behaviors that facilitated the problem-solving process (e.g., discussing students' strengths, providing background information about the home or school setting). Parents and teachers also were generally "nice" to each other, referred to as psychological involvement in problem-solving. For example, they communicated in a calm manner and used verbal and nonverbal cues to convey understanding (Azad, Kim, Marcus, Sheridan, & Mandell, 2016). These findings suggested that the *Partners in School* model would need to focus on the core elements of problem-solving with parents and teachers of children with ASD.

Given that this exploratory work was conducted in a diverse urban setting, researchers were interested in whether demographic characteristics of parents or teachers impacted their problem-solving skills. Data showed that lower income parents and parents interacting with white teachers displayed less problem-solving compared to higher income parents and parents interacting with non-white teachers (Azad et al., 2018). Based on these findings, it would be necessary to add explicit strategies that would "even the playing field," allowing parents and teachers equal opportunities to engage in the problem-solving process.

Central Themes

Given the limited work in this area, researchers aimed to gain a deeper understanding of what ideal collaborations would look like between parents and teachers. Content analyses suggested parents and teachers were concerned about different aspects of

communication. Parents were more concerned about the content of their communication with teachers, such as what their child was learning at school (i.e., in order to create similar experiences at home). Teachers were more concerned about the mechanisms of communication and reported feeling frustrated with the communication methods (e.g., written and face-to-face) they attempted to use to stay connected with parents.

Further, parents and teachers did not want to ask the other person to be more involved because of the perceptions of their challenges (i.e., faced by the other person). Both attributed resistance from the other person as a lack of confidence in their own expertise. Although both parents and teachers valued parental presence, teachers wanted parents to be active partners in the education of their children (Azad, Wolk, & Mandell, 2018). These findings suggested that both the content and mechanisms of communication, as well as the expertise of parents and teachers would have to be considered in the *Partners in School* model.

Logistical Needs

Researchers asked parents and teachers how long meetings should be in the *Partners in School* model. For parents, 53.8% of the sample opted for 30–60 min. Approximately 46.2% of teachers wanted 15–30 min meetings. Accordingly, *Partners in School* has both 30- and 45-min meetings. Second, researchers queried about how the meetings should take place with face-to-face, phone, or a combination of these approaches provided as options. Parents wanted face-to-face (54%) or a combination of face-to-face and phone meetings (39%). Similarly, 48.7% of teachers wanted face-to-face meetings and 41% wanted a combination. Therefore, *Partners in School* includes both phone and face-to-face components.

There was also interest in how many meetings parents and teachers would actually participate in across a 10-week or approximately 2-month span, and what time of day those meetings should take place. Parents were variable in their opinions on the number of meetings, ranging from two (i.e., once a month; 23.1%), five (i.e., every 2 weeks, 30.7%), or 10 meetings (i.e., once a week; 17.9%). About half (51.3%) or slightly over a third (35.9%) of the parents wanted these meetings to take place either in the morning to early afternoon, or early to late afternoon, respectively. Many teachers wanted two meetings (23.1%) or five meetings (43.6%) over the course of the 10 weeks. Only a minority (10.3%) wanted these meetings to be after school or in the evenings and more than half (66.7%) wanted meetings to take place at variable times. To accommodate these preferences, *Partners in School* three face-to-face meetings scheduled during the day, and phone meetings scheduled at variable times.

The *Partners in School* Model

Partners in School is a four-step model that occurs over the course of 10 weeks. It is comprised of: (1) an individual pre-consultation phone interview; (2) an in-person consultant-facilitated parent-teacher consultation meeting; (3) implementation of the same student intervention plan at home and at school; and (4) an individual post-consultation phone interview. Pre- and post-consultation surveys are collected after the phone interviews. See Fig. 1 for a visual representation of the model.

Pre-consultation Phone Interview (30 Min)

Parents and teachers participate in a pre-consultation phone interview that is conducted separately with the consultant. The goals of pre-consultation are to: (a) build rapport with parents and teachers; (b) encourage parents and teachers to reflect on the other person's role; and (c) gain child-specific information that would facilitate the in-person consultation. To accomplish these goals, we begin by asking parents or teachers to identify a strength in the other person. In school-based meetings, parents and teachers are accustomed to reporting on the problems that they experience with students (Azad & Mandell, 2016), and therefore, this question is purposely intended to create a positive violation of expectations and trigger a more positive mood.

Next, the challenges faced by the other person are discussed. As mentioned previously, parents and teachers often do not want to ask the other person to be more involved given their (i.e., the other person's) challenges. This approach was a way for parents and teachers to acknowledge the other person's challenges openly, but not let these factors impede their ability to collaboratively work together. After these initial questions designed to build rapport and empathy, parents or teachers discussed preferences displayed by the child at home or school, respectively. *Partners in School* utilizes strength-based student intervention plans given the longstanding evidence of positive reinforcement in shaping behavior (MacNaul & Neely, 2018).

The last two components of the pre-consultation phone interview were related to baseline data collection. Using the eight concerns identified in the exploratory work, parents and teachers selected the concerns that were most relevant for the child. For the concerns that they endorsed, parents and teachers ranked ordered their top three concerns (prior work indicating 69% agreement when multiple concerns, regardless of the order, are queried). For each of the three concerns, parents and teachers rated the frequency and severity of that concern at home or school, respectively. Pre-consultation surveys targeting parent or teacher (e.g., self-efficacy), dyadic (e.g., communication), or child (e.g., behavior problems) outcomes were distributed after the interviews either by mail or in-person at the child's school.

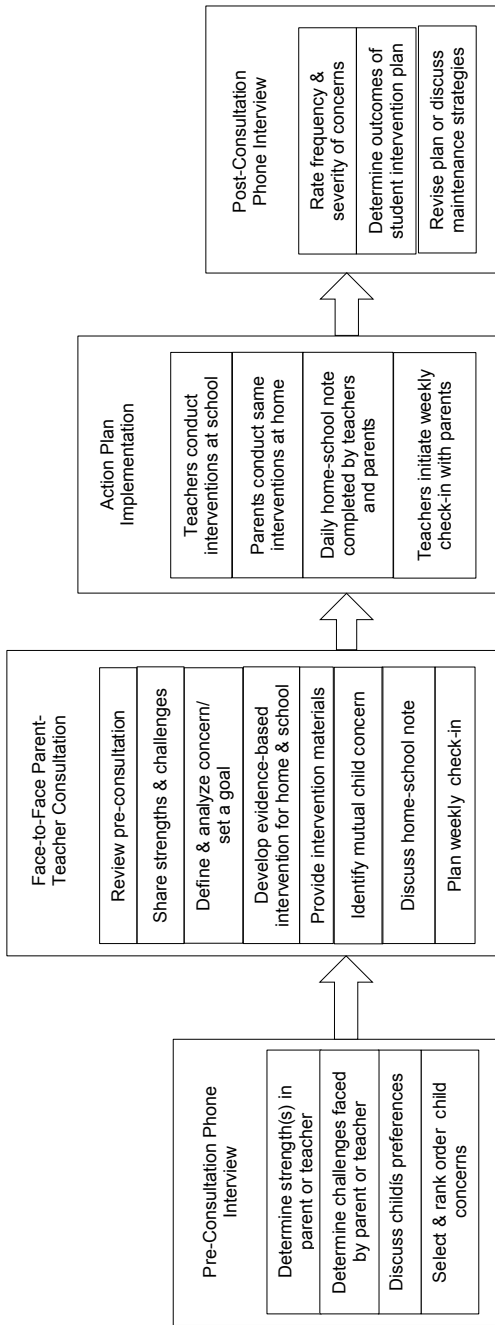


Fig. 1 Visual representation of the *partners in school* model

Face-to-Face Parent-Teacher Consultation (45 Min)

Parents and teachers were asked to bring their pre-consultation surveys to the face-to-face consultation meeting. The goals of the consultation meeting were to: (a) share information gathered during the pre-consultations; (b) collaboratively design an individualized student intervention plan to be implemented in the same way across home and school; and (c) develop a communication plan for parents and teachers to discuss intervention progress. The consultant began this meeting by providing parents and teachers with notes about the information that they shared during their separate pre-consultation phone interview. The initial part of the consultation was prescriptive to allow parents and teachers equal opportunities to speak (given the research showing that low-income parents and parents interacting with white teachers may engage in less problem-solving).

Parents and teachers shared the top three concerns that they identified in the child during the pre-consultation. They reported on these concerns rather than having the consultant report on the overlapping concern because of the emphasis on similarities at the onset of the interaction (i.e., target concern), rather than differences. Next, parents and teachers shared the strengths they identified in the other person with the intention of eliciting positive emotions. They shared their perspectives on the other person's challenges, so neither party would feel guilty about the other's involvement. Both of these brief shares were intended to be positive violations of expectations to alter the course of the discussion into a more cooperative (rather than competitive) interaction.

The next phase of the consultation meeting focused on the core components of problem-solving given that it was the areas where parents and teachers struggled the most. Parents and teachers provided more information on the target concern and set a goal to be achieved at home or school, respectively.

When developing the individualized student intervention plan to address the mutual concern, the consultant merged knowledge on the core principals of EBPs for ASD with the expertise of parents and teachers. Intervention research has established 27 EBPs that lead to positive educational outcomes in children with ASD (Wong et al., 2014). The goal of *Partners in School* is to help parents and teachers implement EBPs, and to do so consistently across settings. This approach is not wedded to a particular evidence-based program (e.g., JASPER [Kasari, Paparella, Freeman, & Jahromi, 2008]; Early Achievements [Landa, Holman, O'Neill, & Stuart, 2011]), rather it capitalizes on the large array of evidence-based approaches available (e.g., prompting, reinforcement, etc.). There were shared and nonshared EBPs in the student intervention plans developed during *Partners in School*. More specifically, all student intervention plans (i.e., the shared aspect) utilized visual supports (Knight, Sartini, & Spriggs, 2014) and positive reinforcement (MacNaul & Neely, 2018) given the evidence-base for these approaches. Other nonshared EBPs were used based on the needs of the student (Azad et al., 2018).

It was essential that parents and teachers felt like equal active partners in the process of developing the student intervention plan. The expertise of parents and

teachers were valued, whether it was about the child's preferences or the different strategies that they previously used to address the mutual concern. All materials needed for the student intervention plan were provided to parents and teachers on the same day to facilitate immediate implementation.

In addition to the student intervention plan, there was a communication plan that parents and teachers co-constructed together. The first component of the communication plan was the daily home-school notes. Teachers were provided with 15 copies of the daily home-school note and a folder to keep the home-school notes in their classroom. Parents were provided with a folder to place in their child's backpack for the home-school notes to travel from school to home, and back to school. Parents and teachers also planned for a weekly check-in using any mode of communication (e.g., call or text) that they preferred.

For each day that the student intervention plan was implemented across home and school, parents and teachers completed a pre-populated home-school note that listed each of the steps in the student intervention plan generated during the consultation meeting. Teachers indicated whether the steps were completed at school and how much progress was made toward the goal. They also signed the form and sent it home to parents. Parents also indicated whether the same steps were completed at home and how much progress the child made toward their goal. Parents signed the form and returned it in their child's backpack to the teacher. A bidirectional form of communication was created to allow both parents and teachers to feel like equal active partners. At the end of the first and second week, the consultant emailed the teacher to remind him/her that it was their day to check-in with the parent. Teachers initiated a weekly check-in with parents using the mode of communication that they agreed upon during the consultation meeting. Teachers were provided with three semi-structured questions for the weekly check-in. At the end of the third week, the consultant collected the home-school notes to graph the student-level data and schedule the post-consultation phone interview. Parents and teachers implemented the student intervention plan in their respective settings for three weeks.

Post-consultation Phone Interview (30 Min)

The goals of the post-consultation phone interview were to discuss (a) the outcomes of the intervention plan; (b) the outcomes of the communication plan; and (c) changes to the student intervention plan or generalization strategies. This interview was conducted with parents or teachers, separately. The consultant began the phone interview by asking parents or teachers to rate the frequency and severity of the top three concerns that they identified during the pre-consultation phone interview. Next, they discussed the student-level data showing how much progress the student made toward their predetermined goal. Parents and teachers provided their perspectives on the communication plan, including the daily home-school notes and the weekly check-ins. Depending on how much progress the student made, the consultant discussed

either alterations to the student intervention plan or strategies to generalize the plan (e.g., to a different time of the day).

Implications for Interdisciplinary Care Coordination

Children and adolescents with ASD require care in multiple settings, with home and school being the settings where these youth spend a majority of their time. Although the accumulated evidence on family-school partnerships suggests that coordinating care between home and school contexts is critical, there are limited empirically grounded approaches that attempt to do this effectively in educational practice. *Partners in School* is an example of how to effectively coordinate care between home and school settings. This approach is grounded in the literature from school consultation, business negotiation, and health communication/shared decision-making. This evidence was merged with mixed-method data from parents and teachers about their agreement on child concerns, the ability to problem solve, and perspectives on their ideal collaborations. Logistical information from parents and teachers also was gathered, and taken into consideration. The goal of *Partners in School* is to synchronize home and school settings, such that parents and teachers are implementing the same EBPs in the same way. Aligning parent and teacher practices increases children's access to EBPs by strengthening intervention dosage, intensity, and impact.

The *Partners in School* model has implications for interdisciplinary care coordination. Research has consistently shown that parents (Vohra, Madhavan, Sambamoorthi, & St. Peter, 2014) and professionals (Golnick, Ireland, & Borowsky, 2009) often report a lack of interdisciplinary care coordination as a major barrier in the provision of high-quality services for children with ASD. For example, Farmer et al., (2014) reported that less than one-third (29.9%) of families of children with ASD received coordinated care. Given that coordinated care across disciplines is difficult to achieve, parents often become the "messenger" by relaying information between professionals (e.g., providing school-based information from teachers to primary care providers). If parents and teachers are not synchronized, it is unlikely that care from other providers (e.g., pediatricians, psychologists, etc.) will be coordinated, and subsequently integrated into a comprehensive treatment plan. Coordinating care between parents and teachers may be particularly important for lower SES parents given that this vulnerable population has a higher risk of lacking interdisciplinary care coordination (Brown, Green, Desai, & Weitzman, 2014). Care coordination between home and school may be the first step in more interdisciplinary care coordination, and ultimately, better outcomes for youth with ASD.

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