THE Early Intervention Teaming Handbook

The Primary Service Provider Approach

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Foreword by R.A. McWilliam

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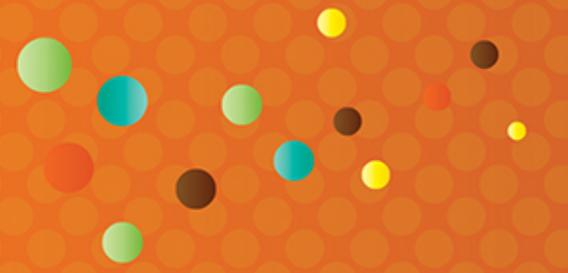## The Primary Service Provider Approach

by

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and

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The individuals described in this book are composites or real people whose situations are masked and are based on the authors' experiences. In all instances, names and identifying details have been changed to protect confidentiality.

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About the Authors

M'Lisa L. Shelden, PT, Ph.D., has a doctoral degree in special education from the University of Oklahoma. She also has a bachelor's degree in physical therapy from the University of Oklahoma Health Sciences Center and a master's degree in early childhood special education from the University of Oklahoma. Dr. Shelden currently serves as Director/Researcher of the Family, Infant and Preschool Program in Morganton, North Carolina. She works alongside Dr. Rush providing ongoing technical assistance to statewide early intervention programs to implement evidence-based early intervention practices in natural settings. Dr. Shelden has 29 years of experience as a physical therapist and special educator. In addition, Dr. Shelden received a 2000 National Institute on Disabilities and Rehabilitation Research Mary E. Switzer Merit Fellowship. She is a graduate fellow of ZERO TO THREE: National Center for Infants, Toddlers, and Families. Dr. Shelden has coauthored several articles related to early intervention teamwork, writing individualized family service plans (IFSPs), coaching, and supporting young children with disabilities and their families in natural learning environments. She has also written a chapter related to physical therapy personnel preparation and service delivery and coauthored a book entitled *Physical Therapy under IDEA* (McEwen, Arnold, Jones, & Shelden; American Physical Therapy Association, Section on Pediatrics, 2000). Dr. Shelden coauthored (with Dathan D. Rush) *The Early Childhood Coaching Handbook* (Paul H. Brookes Publishing Co., 2011) as well as a chapter on using a primary coach approach to teaming in *Working with Families of Young Children with Special Needs* (McWilliam; Guilford Press, 2010). Dr. Shelden has made numerous presentations nationally on the topics related to IFSP development and implementation, transition, inclusion, evaluation and assessment, coaching, primary service provider approach to teaming, and natural learning environment practices.

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Chapter 1

Introduction to a Primary Service Provider Approach to Teaming

In 1990, 200 early intervention providers from across the state had been invited to a meeting to learn more about a teaming model that was to be implemented statewide in programs serving infants and toddlers receiving services as part of the new Part H of the Individuals with Disabilities Education Act (IDEA) of 1990 (PL 101-476). Participants were members of existing teams that included psychologists, social workers, child development specialists, speech-language pathologists (SLPs), and newly added members from the disciplines of occupational therapy and physical therapy, which were required through Part H. The participants were already a bit unsettled because most had recently been reassigned in whole or part from providing center-based therapies to children from the ages of preschool to adolescence to now focusing on children from birth to 3 years of age as guided by the new federal regulations and an overarching notion of family-centered practices, which they believed they were already doing. Now the state was telling them how they were to work together as a team and that one member of the team would be the primary service provider (PSP) for the family. The audience was ready to fight for their professional identity and ethics. Many of the participants in attendance felt that the state was yet again trying to cram another program with more regulations and requirements down their throats. The prime difference this time, however, was that the state was trying to tell professionals how they were to provide their services. They felt the state was crossing a line and they were not willing to passively sit by and be told how to practice their chosen professions.

Ironically, the room in which the meeting was being held was tiered with stadium-type seating. Like a gladiator being thrown to the lions in ancient Rome, the early intervention program director entered the room and approached the microphone. She made a few brief remarks about the federal regulations in Part H, requirements for teaming, and best practice in early intervention involving the use of a transdisciplinary model of service delivery. She stated that this would be the first of several meetings designed to help providers learn how to use this model. Silence. Her comments were followed by a brief introduction of the speaker—a physical therapy faculty member from the largest state-funded university.

A speech-language pathology services supervisor who had been tapped to serve as one of the first SLPs to work in the new Part H early intervention program seated himself with a group of his colleagues, which consisted of other SLP supervisors from around the state and some of the individuals that he supervised. They had been anticipating this event for weeks and were clearly not on the side of supporting this "misguided" idea.

Even before the start of the meeting, the banter among the SLP and his colleagues was intensifying. "If I'd wanted to be a physical therapist, I would have gone to physical therapy school." "How am I expected to teach someone everything I learned about communication intervention in graduate school?" "I don't want to be held liable if someone does something

wrong and a child is injured." "Well, as a speech-language pathologist, I'm not about to stretch a child to do his exercises." "I'm just not going to do it!"

The speaker, a skinny little physical therapist with mismatched earrings and red Converse high-top tennis shoes, approached the podium seemingly unaware of the intense feelings of the audience surrounding her. The participants sat quietly and focused while she went through her presentation, trying to make her case for a transdisciplinary model of service delivery in the early intervention program. As she reviewed the other models of service delivery, some of the audience members recognized that they had been using a multidisciplinary model of service delivery whereby they met weekly to report about children on their caseload, but typically did not receive feedback, information, or support from other team members. Outside of the team meeting, each service provider worked independently on separate treatment plans.

After the morning break, the audience members could contain their angst no longer. In fact, most had really been unable or unwilling to listen to what the speaker had said prior to this time because they had such intense preconceived notions about what she was going to say that conflicted with their personal values and beliefs about how they should work with young children. The first words out of the speaker's mouth once everyone was settled back in their seats were, "Does anyone have any questions about what I have shared so far?" Hands shot up across the auditorium. Some people, unable to precede their words with a raised hand, yelled out their questions and concerns.

"What research do you have that says this is what we should be doing?"

"Why is this so much better than what we already do?"

"If a child has severe disabilities, then don't more therapists naturally have to be involved?"

"Maybe this can work for children with mild disabilities, but I can't imagine how it would work for children with multiple and severe disabilities or children with autism."

"Yeah, maybe if the child only has speech issues and the speech-language pathologist is the primary provider, then it might work."

"What are the liability issues of having a speech-language pathologist do occupational therapy?"

"What if a parent wants all of the therapists involved, wouldn't we be violating family-centered practices if we tell them they have to pick just one?"

"This sounds unethical and against my practice act. What do the professional organizations have to say about all of this?"

"One specific service delivery model isn't the best option for every family. Why can't teams decide which service delivery model to use? After all, we are professionals!"

"This sounds like watered-down service to me. Is the state trying to save money or something?"

"Yeah, it makes me think you believe that just anybody can come in and provide services to the children. Are you trying to minimize the need for specialized therapists?"

Many of the questions were followed by applause from the audience. One by one, the speaker addressed each of the questions and concerns as she continued through the presentation and showed videotape of what assessment and intervention using a transdisciplinary model looked like.

At the end of the day, one of the SLPs turned to her supervisor and asked, "What do you think about all of this?"

"I'm not sure. She made some interesting points. I've been concerned about all of the people coming and going from the families' homes. It seems like such a disruption in their lives. I didn't hear her say that the physical therapist would be doing speech and the speech-language pathologist would be doing occupational therapy. I heard that we need to work more closely together on the goals for the child and family and we need to change what we do when we are with the family in their home or community. From what she said, it sounds like other

team members can go with the primary person if there are questions. I mean, it wouldn't make sense for them to need to go every time, but…"

"I hear what you're saying, but I think it's going to be a huge change for all of us."

"I don't disagree with that. I think I need to read the handouts more carefully and look up some of these reference articles that she gave us. You know, people can get research to back up just about any position they want to promote. I need to read some of this for myself. If I need to rethink how I have been practicing or if I can even improve my practices a little bit to have better results for children and families, then I'm willing to do that. I don't quite understand why the federal government, the state, and some of the researchers in these articles would be promoting this if it was such a bad thing to do."

"I don't know either."

"Maybe they're paying her big bucks to do this."

Both of the SLPs looked at each other simultaneously and said, "Not!"

"With the hostility in this room, I'd say she earned whatever she got."

"I'd say so."

The speech-language services supervisor struggled with the questions and what the physical therapist (PT) had shared during the presentation. He searched to find any available written information about the practices in order to help him better understand the rationale and research. If this type of teaming model really was the way in which early intervention should be provided to infants, toddlers, and their families, then he wished for a comprehensive resource that would explain how to operationalize these practices, beginning with a synthesis of the available research followed by how to prepare a program for this type of team-based approach to procedures for how to operationalize these practices in real early intervention programs.

The speech-language services supervisor's journey to understanding a PSP approach to teaming in early intervention began in 1990. He served on a team with the PT who provided the initial statewide training on a primary provider approach. Together, they have continued to work together to better understand how to use evidence-based practices in early childhood intervention to support the growth and development of young children and families via a PSP (e.g., primary provider, primary coach, team lead, lead provider, team liaison, key worker), as well as how to support other early intervention team members in using these practices. So far, their journey has taken them from the homes of families with whom they have individually worked to most every state in the country and abroad as they continue to define, refine, and examine the effectiveness of a primary provider teaming model. Many viewpoints, perceptions, and misperceptions exist about using a PSP in early intervention, as experienced by the SLP in this partnership.

The purpose of this text is to provide a common definition, characteristics of the practice, and implementation strategies for using a PSP approach to teaming within the context of evidence-based practices in early childhood intervention. This information is based on research in how people learn, early childhood intervention, family-centered helpgiving, and team-based supports as operationalized through the authors' more than 25 years of experience in the fields of physical therapy, speech-language pathology, early childhood special education (ECSE), and early intervention as well as the experiences of early intervention teams using these practices across the United States and beyond.

A BRIEF OVERVIEW OF COMMON TEAMING MODELS

Using teams comprised of individuals with a variety of expertise and knowledge in the field of early childhood intervention has been a consistent component of education legislation (Individuals with Disabilities Education Act Amendments [IDEA] of 1997 [PL 105-17]), recommended practice documents (Sandall, Hemmeter, Smith, & McLean, 2005), and theoretical and research literature since the late1980s (Antoniadis & Videlock, 1991; Briggs, 1997; Nash,

1990; Woodruff & McGonigel, 1988). Bell (2004) stated that a survey of U.S. organizations indicated that more than 48% use teams of some sort. Acknowledging the large amount of work contributed by teams in the workplace is commonplace in business and industry (Cohen & Bailey, 1997; Hoegl & Gemuenden, 2001), as well as in educational (Flowers, Mertens, & Mulhall, 1999) and health care contexts (Borrill et al., 2001; West et al., 2002).

Several different teaming models for providing early childhood services have been suggested in the literature. The multidisciplinary, interdisciplinary, and transdisciplinary team approaches are three models of team interaction that have been readily discussed. The approaches differ based on the level of team interaction, parental involvement, the assessment process, and intervention methods (Fewell, 1983; Haynes, 1976; Peterson, 1987; Woodruff & McGonigel, 1988).

A *multidisciplinary approach* to teaming has been defined as a group of professionals who work independently and interact minimally with each other (McGonigel, Woodruff, & Roszmann-Millican, 1994; Woodruff & McGonigel, 1988). Each member of the team performs a separate evaluation and writes an individual report, including discipline-specific goals. Each practitioner then performs intervention at separate times and focuses on the remediation of the weaknesses noted during the evaluation (McGonigel et al., 1994; Rush & Shelden, 1996). When a multidisciplinary team functions in this manner, team members view the child based on identified deficits from their own discipline's perspective and children receive discipline-specific interventions that may result in overlaps and gaps in services (Giangreco, 1986; Orelove & Sobsey, 1996).

Compared with a multidisciplinary approach to teaming, interdisciplinary teams have more interaction among the team members on an ongoing basis. Each team member continues to perform a discipline-specific evaluation and write discipline-specific goals. The team meets to discuss the results of each evaluation and develop an intervention plan (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Team members provide intervention services at different times and discussion among team members occurs primarily at team meetings (Fewell, 1983; Peterson, 1987; Rush & Shelden, 1996). The primary purpose of team meetings in an interdisciplinary approach is for each discipline to report on child status.

Several authors described transdisciplinary services as a team of professionals who work in a collaborative fashion (Garland, McGonigel, Frank, & Buck, 1989; Haynes, 1976; McGonigel et al., 1994; York, Rainforth, & Giangreco, 1990). The professionals share the responsibilities of evaluating, planning, and implementing early intervention services for infants and toddlers. Families are integral members of the team and practitioners value the family's involvement in all aspects of early intervention. One person is chosen as the PSP for a child and family in a transdisciplinary approach. Other team members provide support to this individual through consultation regarding strategies to specifically include during interventions with the child and family. This approach decreases the number of professionals with whom the family is in contact on a regular basis (McGonigel et al., 1994; Woodruff & McGonigel, 1988).

Members of a transdisciplinary team must first develop competence in their own skill areas and then expand their knowledge by learning to observe development and provide intervention in areas outside their own discipline. As a practitioner's skills improve, team members engage in role release of intervention strategies from their disciplines to the other team member so the PSP has the necessary skills to work with the child and family (Briggs, 1997; Woodruff & McGonigel, 1988; York et al., 1990).

The stages of transdisciplinary team development involve six steps, according to Haynes (1976) and Woodruff and McGonigel (1988). Role extension is the first step and refers to professional development activities including, but not limited to, self-study, workshops, conferences, and university coursework intended to deepen one's knowledge in his or her own discipline (e.g., a PT attending a course on lower extremity splinting for infants and toddlers with low muscle tone). Role enrichment is the second step and involves individual team members developing an understanding of the terminology and core practices of the other disciplines on the team. This

can happen through conversations at team meetings, journal club review and discussion, and sharing information via a resource library. Role expansion is the third step and occurs based on individual team members' acquisition of enough information to make informed observations and program decisions outside of their own disciplines. Role exchange is the fourth step of transdisciplinary team development and occurs when team members have adequate knowledge of the theories, methods, and procedures from other disciplines to incorporate them into their own intervention process while working alongside or with the other team member. For example, role exchange occurs when an SLP is implementing newly acquired positioning techniques during a joint visit with the team's PT. Role release is the fifth step and occurs when a team member is fully functioning in the role of PSP and implements intervention methods typically associated with another discipline with accountability to the team member from the associated discipline. Role support is the sixth and final step of transdisciplinary team development. Role support occurs when the PSP needs support of a specific discipline because intervention strategies are complex, new, or require the direct involvement of a particular discipline. For example, consider a situation in which a child needs to learn how to use a walker and is currently being supported by an occupational therapist (OT) as the PSP. The PT would provide support to the child, OT, and family by teaching the child how to safely and successfully use the walker.

Three fundamental differences exist between transdisciplinary teams and the other commonly referenced models of team interaction. First, one team member is chosen as the PSP in a transdisciplinary team and has consistent interaction with the child and family (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Second, members of the transdisciplinary team must collaborate to meet the needs of a child and family (Garland et al., 1989; McGonigel et al., 1994; Rush & Shelden, 1996; Woodruff & McGonigel, 1988). Third, transdisciplinary team members must commit to teaching, working, and learning across disciplinary boundaries (McGonigel et al.,1994; Woodruff & McGonigel, 1988).

AGREED-ON TEAMING APPROACH IN EARLY INTERVENTION

Using a PSP is most commonly associated with a transdisciplinary model of team development in which one member of the team is chosen to serve as the PSP to work directly with the child. A distinguishing feature of transdisciplinary teamwork is the concept of role release, or teaching the skills traditionally associated with one discipline to another team member who functions in direct service capacities with the child (Woodruff & McGonigel, 1988). The need for a teaming approach using a PSP is based on the fact that focusing on services and multiple disciplines implementing decontextualized, child-focused, and deficit-based interventions has not proven optimally effective (Campbell & Halbert, 2002; Dunst, Bruder, Trivette, Raab, & McLean, 2001; Dunst, Trivette, Humphries, Raab, & Roper, 2001; McWilliam, 2000). Using a PSP has been identified as a practice that can be used effectively with young children and their families (American Occupational Therapy Association [AOTA], 2009; American Speech-Language-Hearing Association [ASHA], 2008a, b; Pilkington, 2006; Sandall et al., 2005; Section on Pediatrics of the American Physical Therapy Association, 2010; Vanderhoff, 2004; Workgroup on Principles and Practices in Natural Environments, 2007b).

The American Occupational Therapy Association web site (http://www.aota.org) includes a document on transdisciplinary teaming, which discusses the role of the OT and use of a "primary interventionist" for supporting young children and their families in natural learning environments (Pilkington, 2006). More specifically, the document details information about how the OT serving as a coach and working as a transdisciplinary team member exemplifies several key principles of occupational therapy practice. Pilkington also referred to the importance of the OT going into the home "bare-handed (i.e., no toy bag) bringing the practitioner's therapeutic use of self to all team and family interactions, coaching and guiding rather than directing and doing" (Pilkington, 2006, p. 12).

The web site of the Section on Pediatrics of the American Physical Therapy Association (http://www.pediatricapta.org) contains a fact sheet on team-based approaches used by PTs. Transdisciplinary teaming and use of a PSP is specifically cited as a "recommended practice in early intervention settings" (Section on Pediatrics of the American Physical Therapy Association, 2010, p. 2). The fact sheet states that the

> Role release and delegation of intervention strategies can be both ethical and legal and exist within the scope of physical therapy practice. The American Physical Therapy Association's Guide to Physical Therapist Practice provides instruction for coordinating, communicating, and documenting patient/client-related interventions. In other words, PTs may teach others activities or intervention strategies. (p. 2)

In 2008, ASHA put forth three documents regarding the roles and responsibilities of SLPs in early intervention. The documents include a position statement, guidelines, and a technical report. Each of the documents indicates that the SLP may practice within a transdisciplinary model and serve as the primary provider "based on the needs of the child, relationships already developed with the family, and special expertise" (ASHA, 2008b, p. 16) of the practitioner. Due to the emphasis on team interaction, members of transdisciplinary "teams benefit from joint professional development and can enhance each other's knowledge and skills as well as through role extension and role release for specific children and families" (ASHA, 2008b, p. 4).

The Division for Early Childhood of the Council for Exceptional Children recommended practices document (Sandall et al., 2005) puts forth a transdisciplinary service delivery model in which a PSP supports the child and family as the preferred teaming strategy in early childhood intervention. The document further states that using multiple providers is not recommended. In fact, rotating multiple practitioners in and out of a family's life on a regular basis has been found to negatively affect family functioning (Dunst, Brookfield, & Epstein, 1998; Greco & Sloper, 2004; Law et al., 1998; Sloper, 2004). Furthermore, using a PSP minimizes any negative consequences of having multiple and/or changing practitioners (Bell, Corfield, Davies, & Richardson, 2009; Dunst et al., 1998; Law et al., 1998; Shelden & Rush, 2010; Sloper, 2004).

Prior to 2007, the National Early Childhood Technical Assistance Center (NECTAC) formed the Workgroup on Principles and Practices in Natural Environments to develop agreed-on practices for supporting infants and toddlers with disabilities and their families. Specifically, the workgroup was charged with reaching consensus on the mission, key principles, and practices for providing early intervention in natural environments. The workgroup was comprised of individuals representing multiple perspectives including state-level policy makers, Part C coordinators, faculty from institutions of higher education, ECSE researchers, early intervention practitioners, and parents, as well as state and national training and technical assistance providers representing all of the key disciplines involved in early intervention (i.e., ECSE, occupational therapy, physical therapy, psychology, service coordination, speech-language pathology). The workgroup created three documents:

1. *Agreed Upon Mission and Key Principles for Providing Early Intervention Services in Natural Environments* (http://www.nectac.org/~pdfs/topics/families/Finalmissionandprinciples 3_11_08.pdf)

2. *Seven Key Principles: Looks Like/Doesn't Look Like* (http://www.nectac.org/~pdfs/topics/ families/Principles_LooksLike_DoesntLookLike3_11_08.pdf)

3. *Agreed Upon Practices for Providing Early Intervention Services in Natural Environments* (http:// www.nectac.org/~pdfs/topics/families/Agreeduponpractices_finaldraft2_01_08.pdf)

Table 1.1 summarizes the mission and seven key principles developed by the workgroup. Principle 6 states, "The family's priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support"

Table 1.1.   Agreed upon mission and key principles for providing early intervention services in natural environments

Mission
IDEA Part C early intervention builds upon and provides supports and resources to assist family members and care givers to enhance children's learning and development through everyday learning opportunities.
Key principles
Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts.
All families, with the necessary supports and resources, can enhance their children's learning and development.
The primary role of a service provider in early intervention is to work with and support family members and care givers in children's lives.
The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles, and cultural beliefs.
IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities.
The family's priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations.

From Workgroup on Principles and Practices in Natural Environments. (2007b, November). *Agreed upon mission and key principles for providing services in natural environments*. Available at http://www.nectac.org/topics/families/families.asp; reprinted by permission.

Key: IDEA, The Individuals with Disabilities Education Act Amendments of 1997 (PL 105-17); IFSP, individualized family service plan.

(Workgroup on Principles and Practices in Natural Environments, 2007b, p. 7). Principle 6 also delineates concepts that support using a primary provider such as formalized communication mechanisms, opportunities for joint visits, and shared responsibility for achievement of individualized family service plan (IFSP) outcomes.

A transdisciplinary model of teaming was first introduced into the literature by Haynes (1976). The original intent of this teaming model was to provide efficient patient-focused services to remediate deficits in a variety of locations. This approach was originally adopted by many early intervention teams in the late 1980s as a recommended practice in early intervention. In this text, we put forth a refinement of the transdisciplinary approach to teaming and the use of a PSP as it applies to Part C early intervention. In our experience, if teams are not using a multidisciplinary or interdisciplinary approach, then they refer to their teaming model as a PSP approach. In fact, we attempted to change the nomenclature and identify a "new" name for a teaming approach that used a PSP coaching-interaction style and focused on supporting family members and teachers to promote child learning through everyday, interest-based opportunities. We began using the term *primary coach approach to teaming* (Shelden & Rush, 2007, 2010) because commonly used definitions of the transdisciplinary model of team interaction lacked the essential elements of a focus on the adults in the child's life instead of a sole focus on practitioner–child interventions, as well as how to interact with and support the adults in a way to promote confidence and competence in using everyday life activities as the venue for learning, growth, and development. In yielding to the terminology most commonly used in early intervention, PSP, this text intends to provide a common definition for the field, practice characteristics, and detailed information on how to operationalize this teaming approach. Regardless of the terminology used, the field of early childhood intervention has moved beyond the use of a pure transdisciplinary model of team interaction.

Woodruff and McGonigel (1988) provided a table that compared the elements of practice of multidisciplinary, interdisciplinary, and transdisciplinary models of team interaction. They compared how teams conduct assessment, develop and implement the service plan, communicate with one another, involve parents, participate in staff development, and guide philosophy. We offer an additional comparison of a PSP approach to teaming in Table 1.2. More specifically, a PSP approach to teaming differs from a transdisciplinary service delivery model in that the PSP is not asked to engage in role release and take on the role of practitioners from other disciplines involving specific techniques targeted at skill development, but rather become an expert on a family's and child's activity settings, routines, and interests in order to promote

Table 1.2.   Models of team interaction

	Multidisciplinary	Interdisciplinary	Transdisciplinary	Primary service provider (PSP)
Assessment	Team members conduct separate assessments.	Team members conduct separate assessments.	Team members and family conduct joint assessment.	Fewest number of service providers needed participate in the assessment based on improving the child's participation across activity settings and learning opportunities.
Parent participation	Parents meet with team members individually.	Parents meet with entire team or a representative of the team.	Parents are full, active members of the team.	Parents and other care providers are equal team members.
Service plan development	Team members develop separate, discipline-specific plans.	Team members develop separate, discipline-specific plans but share them with each other.	Team members and family develop joint plan based on family priorities, needs, and resources.	Outcomes/goals are developed based on improving the child's participation across activity settings and learning opportunities.
Service plan responsibility	Team members are responsible for their discipline-specific plan.	Team members share information with each other about their part of the plan.	Team members are jointly responsible and accountable for how the PSP implements the plan.	Team members are jointly responsible and accountable for how the PSP implements the plan.
Service plan implementation	Team members implement their discipline-specific plans.	Team members implement their portion of the plan and incorporate other sections where possible.	A PSP implements the plan with the family.	Team members provide coaching to the PSP to effectively implement the plan across activity settings and care providers.
Lines of communication	Informal	Occasional case-specific staffing	Regular team meetings to exchange information, knowledge, and skills among team members	Ongoing interaction among team members for reflecting and sharing information occurs beyond scheduled meetings.
Guiding philosophy	Team members recognize the importance of information from other disciplines.	Team members are willing to share and be responsible for providing services as part of the comprehensive service plan.	Team members commit to teach, learn, and work across traditional discipline lines to implement a joint service plan.	Service and care providers engage in learning and coaching to develop the necessary expertise to improve the child's participation across activity settings and learning opportunities.
Staff development	Independent and discipline specific	Independent within and outside of own discipline	A critical component of team meetings for learning across discipline boundaries and for team building	Team members implement an annual team development plan to identify any gaps in skills and knowledge and improve expertise across disciplines.

From Early intervention team approaches: The transdisciplinary model by G. Woodruff & M.J. McGonigel (1988) (p. 166) in J.B. Jordan, J.J. Gallagher, P.L. Huntinger, & M.B. Karnes (Eds.), *Early Childhood Special Education: Birth to Three.* Copyright 1988 by The Council for Exceptional Children. Reprinted with permission.

parent mediation of child participation in everyday activities. For example, for a child who is having difficulty walking on his own and has an IFSP outcome targeting playing with his twin brother in the backyard, many team members across all disciplines would be equipped to support the parents in promoting the child's interest and success of playing with his brother. If, however, the child needed foot splints to support his success in this interest-based activity

setting, then the PT (PSP or not) would be responsible for either constructing or assisting the family in acquiring the needed assistive technology.

In a PSP approach to teaming in early intervention, the PSP acts as the principle program resource and point of contact between other program staff, the family, and other care providers (i.e., the team). The PSP mediates the family's and other care providers' skills and knowledge in relation to a range of needed or desired resources (i.e., child learning, child development, parenting supports). A PSP approach to teaming is characterized by the team members' use of coaching practices to build the capacity of parents, other primary care providers, and professional colleagues to improve existing abilities, develop new skills, and gain a deeper understanding of how to promote child learning and development within the context of interest-based, everyday learning opportunities (Dunst, Bruder, et al., 2001; Rush & Shelden, 2005; Shelden & Rush, 2007, 2010). Using a PSP approach to teaming does not equate to only one practitioner supporting a child and family nor does it imply any prescription for frequency and intensity of service provision. In this approach to teaming, the child and family have access to any and all team members as needed via joint visits with the PSP and team meetings. Determining frequency and intensity is an IFSP team decision based on many factors rather than the perception that frequency and intensity equals the amount of service provision delivered by one member of a multidisciplinary or interdisciplinary team (e.g., 1 hour per week).

Whereas Woodruff and McGonigel (1988) described the six linear phases of transdisciplinary team development, the process in a PSP approach to teaming is based on four foundational interdependent components:

1. Role expectation

2. Role gap

3. Role overlap

4. Role assistance

> ### 🏃 Remember
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> The primary service provider approach to teaming is based on four foundational interdependent components: 1) role expectation, 2) role gap, 3) role overlap, and 4) role assistance.

These components refer to individual team member involvement when using a PSP approach as opposed to the discipline represented by each person.

Role expectation refers to three minimal areas of competency when practicing in Part C and using a PSP approach to teaming. The first expectation is that each team member will be an evidence-based practitioner. This includes being knowledgeable of the evidence to support practice in his or her own discipline, early intervention (Part C federal regulations and the mission and key principles for providing early intervention in natural environments), and early childhood development (beyond the areas of development typically associated with a particular discipline). The second expectation is that every team member is competent in providing parent and parenting support. *Parent support* is defined as assisting families related to identification, use, and evaluation of needed resources such as transportation, housing, crisis intervention, and medical services. *Parenting support* involves evidence-based information, techniques, strategies, and approaches that assist parents in meeting identified needs related to topics such as toileting, supporting positive behavior, helping a child sleep through the night in his or her own bed, and/or expanding a child's repertoire of foods. Finally, the

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> Role expectation includes three minimal areas of competency. Each team member will be
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> 1. An evidence-based practitioner
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> 2. Competent in providing parenting and parent support
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> 3. Able to mediate parents' and care providers' abilities to support child learning and development

third expectation is that all team members know how to mediate parents' and care providers' abilities to support child learning and development by using evidence-based adult learning and interaction methods (e.g., coaching) (Rush & Shelden, 2011). The Role Expectation Checklists (Appendix 1A) may be used by practitioners to conduct self-assessments of current knowledge and skills related to preparedness for working on teams providing Part C services using a PSP approach to teaming. The Role Expectation Checklists—Administrator's Guide (Appendix 1B) can be used by team leaders and supervisors to help structure an interview for a new staff member or contract provider, conduct orientation, and identify professional development needs of team members.

Role gap occurs when the PSP or another team member realizes that the primary provider does not have all of the needed knowledge and skills to adequately support a child's learning or implement necessary parent/parenting supports. This may occur at the time in which the PSP is being selected or while serving as the PSP for a particular child and family. Individual practitioners may opt out of serving as the primary provider when role gap occurs as the PSP is being selected, or the individual practitioner and team may determine that role gap will be bridged through role assistance from other team members. Role gap may also occur while a practitioner

> **Remember**
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is serving as the primary provider. This might occur when a child makes substantial progress in a particular developmental area or when a parent encounters a new or unexpected situation requiring knowledge and expertise beyond the primary provider's training and experience. The team has two options to consider when the primary provider is in this circumstance. First, other team members provide role assistance to the primary provider. This could occur during a team meeting, join visit, colleague-to-colleague coaching opportunity, or formalized training event. Second, replace the PSP with another team member. Changing the PSP is the option of last resort (see Chapter 5). Due to the relationship-based nature of early intervention, this option should be considered only when role assistance is determined to be inadequate because of the significance, urgency, or seriousness of the situation. Another role gap that a team may experience is when the entire team is lacking an area of expertise or knowledge (e.g., assistive technology alternatives for a child with hearing impairment or vision loss). In these limited instances, the team must identify an external resource to support the PSP, child, and family. This can be achieved through contractual arrangements or by tapping another early intervention team member within the program or region with the needed expertise. The team's long-term development plan should include formalized training opportunities for an individual team member or entire team to obtain the necessary information to fill the role gap.

Role overlap is when multiple team members feel confident and competent to fill the role of the PSP for a particular child and family. Role overlap maximizes flexibility and efficiency for teams in selecting the PSP. For example, when identifying the most likely primary provider for an infant with Down syndrome whose mother is challenged by feeding him, many team members would have the knowledge, skills, and expertise necessary to support this child and family with role assistance from other team members as needed. When role overlap occurs, role assistance would most likely take the form of colleague-to-colleague coaching

> **Remember**
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opportunities, conversations during team meetings, and joint visits with the family. Role over-lap occurs more frequently as team members work together for longer periods of time. This occurs not necessarily because team members are releasing or exchanging intervention techniques or strategies, but due to collective experience implementing evidence-based practices in early intervention and shared conversations at team meetings, observations during joint visits, and supporting one another over time.

Role assistance is 1) the ongoing direct support provided by the team or a specific team member to the PSP and 2) focused learning opportunities for the team at large and individual team members filling an identified role gap. Role assistance is provided through regular team meetings, joint visits between the PSP and another team member, colleague-to-colleague coaching conversations, and coursework, training, and other professional development activities. Role assistance should be provided when any team member identifies that additional support is needed. Role assistance is required if an evidence-based intervention is perceived to be too complicated, new, or beyond the scope of practice of the PSP. This is not to say that any time a PSP feels uncomfortable or challenged that a joint visit is required. Role assistance, however, should be prompt and could be in the form of a one-to-one or small-group conversation, a joint visit, coaching during a team meeting, or additional in-depth training for an identified role gap situation. See Chapter 6 for more information about joint visits.

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> Role assistance is
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> - The ongoing support provided by the team or a specific team member to the primary service provider
> - Focused learning opportunities for the team at large and individual team members to fill an identified role gap

A PSP approach to teaming differs from a transdisciplinary or other approach to teaming in which one practitioner serves as the liaison between the family and other team members (Woodruff & McGonigel, 1988) by an explicit focus on the multiple individuals (i.e., parents/care providers and children) in the environment, the content of intervention (i.e., natural learning environment practices—everyday activity settings, child interests, parent responsiveness), the type of interactions (i.e., coaching practices), and the interconnectedness of all team members (i.e., PSP approach to teaming) regarding their role in promoting parent-mediated child learning and development. Figure 1.1 illustrates the similarities and differences of the four components of a PSP approach to teaming and the six stages of transdisciplinary team development. Role expectation includes the stages of transdisciplinary team development referred to as role extension, role enrichment, and role expansion. Role expectation in the PSP approach to teaming includes Stages 1–3 of the transdisciplinary teaming process and refers to the minimum expectation that all early interventionists have a mastery of evidence-based practices in early childhood across developmental domains and a detailed understanding of the roles and basic practices of other disciplines working in early intervention. The PSP approach to teaming does not involve or include role exchange or role release to implement deficit-based and skill-focused intervention methods typically associated with another discipline. Instead, practitioners using a PSP approach to teaming identify role gap and role overlap situations and recognize the need for role assistance (i.e., discipline-specific expertise), which is known as role support in the transdisciplinary teaming process.

EVIDENCE-BASED DEFINITION OF A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

In light of information and resource documents from AOTA, American Physical Therapy Association, ASHA, Division for Early Childhood, and the Workgroup on Principles and Practices in Natural Environments and as required by Part C, early childhood practitioners

Transdisciplinary team development process	≠	PSP approach to teaming process
Role extension refers to professional development activities including, but not limited to, self-study, workshops, conferences, and university coursework intended to deepen one's knowledge in his or her own discipline. Role enrichment involves individual team members developing an understanding of the terminology and core practices of the other disciplines on the team. Role expansion occurs based on individual team members' acquisition of enough information to make informed observations and program decisions outside of their own disciplines.	→	Role expectation refers to three minimal areas of competency when practicing Part C and using a PSP approach to teaming. 1. Evidence-based practices ▪ Own discipline-specific evidence-based practice ▪ Early intervention regulations/mission and key principles ▪ Early childhood evidence-based practices including typical development across all developmental domains and the roles and basic practices of other disciplines working in early intervention 2. Parent support 3. Adult interaction/adult learning
Role exchange occurs when team members have adequate knowledge of the theories, methods, and procedures from other disciplines to incorporate them into their own intervention process while working alongside or directly with the other team member.	🚫	Role gap is the circumstance in which the PSP or another team member realizes that the primary provider does not have the needed knowledge and skills to adequately support a child's learning or implement necessary parent/parenting supports.
Role release occurs when a team member is fully functioning in the role of PSP and implements intervention methods typically associated with another discipline with accountability to the team member from the associated discipline.	🚫	Role overlap is the situation in which multiple team members feel confident and competent to fill the role of the PSP for a particular child and family.
Role support occurs when the PSP needs support of a specific discipline because intervention strategies are complex, new, or require the direct involvement of a particular discipline.	→	Role assistance is 1) the ongoing direct support provided by the team or a specific team member to the PSP and 2) focused learning opportunities for the team at large and individual team members to fill an identified role gap.

Figure 1.1.   Comparison of the transdisciplinary team development process and the primary service provider (PSP) approach to teaming process. (*Source:* Woodruff & McGonigel, 1988.)

are faced with the task of reconceptualizing their roles with families of children with disabilities from independent, child-focused interventionists to members of family-centered teams using a PSP. An interdependent team of highly qualified practitioners is more likely to support families in a manner that will build their capacity to confidently and competently promote the growth and development of their children.

A PSP approach to teaming is implemented when an early intervention program is identified as a formal resource for early childhood intervention and family support, and the program employs or contracts with practitioners with diverse knowledge and experiences to support the child's parents and other primary care providers. Using a PSP approach to teaming is not intended to limit a family's access to a range of supports and services, but instead to expand support for families of children with disabilities. The PSP is the lead program resource and point of contact among other program staff, the family, and other care providers (i.e., the team). The PSP mediates the family's and other care providers' skills and knowledge in relation to a range of priorities and needed or desired resources. The operational definition of a PSP approach to teaming is

> An established team consisting of multiple disciplines that meets regularly and selects one member as the primary service provider who receives coaching and support from other team members, and uses coaching as an interaction style with parents and other care providers to support and strengthen their confidence and competence in promoting child learning and development and obtaining desired supports and resources in natural learning environments. (Shelden & Rush, 2010, p. 176)

The operational definition of a PSP approach to teaming is the requirement of a geographically based team consisting of individuals representing multiple disciplines, in which one member is selected as the PSP, receives support from other team members, and provides support to the parents and other care providers using coaching and natural learning environment practices to strengthen parenting competence and confidence. A geographically based team is a group of early intervention practitioners consisting minimally of an early childhood educator or special educator, OT, PT, SLP, and service

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> A geographically based team is a group of early intervention practitioners minimally consisting of an early childhood educator or special educator, occupational therapist, physical therapist, speech-language pathologist, and service coordinator(s) responsible for all referrals to an early intervention program within a predetermined area defined by zip code or other geographical boundary.

coordinator(s) responsible for all referrals to an early intervention program within a predetermined area defined by zip code or other geographical boundary. A specific child's IFSP team is composed of members from the geographically based team.

PRIMARY SERVICE PROVIDER APPROACH WITHIN THE CONTEXT OF RECOMMENDED EARLY CHILDHOOD PRACTICES

Although a PSP approach to teaming may be used in isolation as part of early intervention under Part C, the law requires that services be provided in natural learning environments and the focus of intervention is on supporting parents and other care providers in confidently and competently promoting child learning and development. This text focuses on using a PSP approach as one of three key components of an evidence-based approach to early intervention. The other two components are implementing natural learning environment practices or, more specifically, using child interests and everyday activity settings as the contexts for learning, and coaching as the strategy for building the capacity of the important adults in the child's life (see Figure 1.2). Enhanced capacity of parents and other care providers in early intervention includes both global child and family outcomes. Desired child outcomes include

Evidence-based practices in early intervention

Primary service provider teaming practices

Natural learning environment practices

Participation and competence

Coaching practices

Figure 1.2.   Evidence-based practices in early intervention.

supporting child learning, promoting positive social relationships, and providing opportunities for children to learn and use appropriate behaviors to meet their needs. Family outcomes in early intervention involve assisting parents in understanding their children's strengths and needs, knowing their rights and how to advocate effectively, helping their children learn and develop, ensuring availability of family support systems, and gaining access to desired resources in their community (Early Childhood Outcomes Center, 2005).

Natural Learning Environment Practices

Under Part C, the content of the intervention must be evidence based and provided in the natural learning environments of eligible infants and toddlers (Workgroup on Principles and Practices in Natural Environments, 2007b). Natural learning environments are the locations where children would be if they did not have disabilities. Natural learning environment practices are those practices that support parents of children with disabilities and other care providers in understanding the critical role of everyday activity settings and child interests as the foundation for children's learning opportunities (Dunst, Bruder, et al., 2001). Activity settings include, but are certainly not limited to, taking a walk, eating a snack, going down a slide at the park, feeding the cat, making dinner, riding in a car, watering the garden, and fishing with Grandpa. Using these practices also supports parents and other care providers in recognizing and using child interests as a means for capitalizing on the number and variety of learning opportunities that naturally occur in the lives of all young children. *Interest-based learning* is defined as children's engagement in activities and with people and objects they find interesting, fun, exciting, and enjoyable (Dunst, Herter, & Shields, 2000; Raab, 2005). For example, when a child is involved with objects (a favorite spoon) or people (brother or sister) that he or she finds interesting, research shows that the child will be more motivated to pay attention longer, resulting in positive benefits related to child learning (Dunst et al., 2000; Raab, 2005).

Most practitioners are trained to determine a child's delays in skill development and then either directly attempt to remediate the deficits through practitioner–child interventions and/or teach parents strategies to work on delayed or absent skills within a daily routine or activity setting. For example, if a child lacks head control, then a practitioner might recommend more opportunities for "tummy time" throughout the day and teach the parent ways to help the child tolerate being on his or her stomach for longer periods of time or encourage the child to push up on extended arms. Conversely, a practitioner that understands that child participation in activity settings is early childhood intervention spends time with the parent observing and identifying the child's interests and existing opportunities for expression during which the child has an inherent opportunity to learn and practice new skills. Consider an example in which a practitioner learns that a child loves to lie on her daddy's stomach while he watches his favorite sports teams on television (i.e., activity setting/child interest). The practitioner encourages the father to continue this activity, discussing all the valuable learning opportunities the child experiences by participating in this interest-based activity setting on a regular basis (i.e., every evening and multiple opportunities on the weekends). If the father is interested and willing, then the practitioner also discusses with him ways to involve the child further in the activity. The father realizes that another one of his daughter's favorite activities is when they blow raspberries or she tries to imitate exaggerated mouth movements that he makes. While she's on his stomach when he's watching "the game," he blows raspberries and makes silly faces to engage her more or extend the amount of time she's happy in this position. This is an example of a simple, interest-based, responsive strategy the father could easily use to maintain the child's engagement in a fun and interesting activity that would not only lead to improved head control, but also promote the child's social, cognitive, and communication skill development while spending quality time with her daddy in a naturally and frequently occurring context. Evidence-based strategies and techniques are taught by early intervention

team members as parent-mediated tools for supporting child participation in interest-based everyday activity settings.

Coaching Families

Early intervention practitioners should use a capacity-building approach with families of infants and toddlers with disabilities in order to support parent competence and confidence for promoting child learning within the context of natural learning opportunities (Trivette & Dunst, 2007). Capacity building is a process that assists parents in recognizing and taking advantage of everyday activities and situations that have development-enhancing qualities to enhance children's learning (Dunst & Trivette, 2009; Wilson, Holbert, & Sexton, 2006). Practitioners must adopt a method of parent engagement that is consistent with how people learn in order for parents to benefit from early intervention practitioners' use of a capacity-building approach to increase parenting skills and abilities (Donovan, Bransford, & Pellegrino, 1999).

As mentioned previously, coaching is one style of interaction identified as a practice for building the capacity of parents, care providers, and colleagues in early intervention (AOTA, 2009; ASHA, 2008a; Campbell, 1997; Dinnebeil, McInerney, Roth, & Ramasway, 2001; Hanft, Rush, & Shelden, 2004; Rush & Shelden, 2011; Section on Pediatrics of the American Physical Therapy Association, 2010; Trivette, Dunst, Hamby, & O'Herin, 2009; Workgroup on Principles and Practices in Natural Environments, 2007b). Coaching does not mean just telling another person what to do; it is a process that starts with what the other person already knows and does and supports that person according to his or her needs and priorities. Coaching is an interactive process of reflection, sharing information, and action on the part of the coach and coachee used to provide support and encouragement, refine existing practices, develop new skills, and promote continuous self-assessment and learning. Coaching involves asking questions; jointly thinking about what works, does not work, and why; trying new ideas with the child; modeling with the child for the parent; sharing information; and jointly planning next steps (Hanft et al., 2004; Rush & Shelden, 2011). A coaching interaction style is as hands on by the PSP as necessary, but also ensures that what the practitioner is doing and discussing with the parent is meaningful and functional within the context of everyday life and promotes the parents' ability to support child learning and development during all of the times when the practitioner is not present.

Operational Definition of Coaching Practices

The definition of coaching developed and used by the authors focuses on the operationalization of the relationship between coaching practices and the intended consequences, as well as the processes used to produce the observed changes, and is based on a comprehensive review of research on coaching practices. *Coaching* may be defined as

> An adult learning strategy in which the coach promotes the learner's ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement and use of the action in immediate and future situations. (Rush & Shelden, 2005, p. 3; Rush & Shelden, 2011)

The following is a brief example of how a practitioner would engage a grandparent in a coaching interaction. Consider a situation in which a grandmother tells a practitioner that she would like for her grandchild to sit in her highchair during mealtime. The practitioner asks what they have currently been doing during mealtime and how well it has worked. The practitioner and grandmother then brainstorm some ideas, building on what the grandmother has tried, and plan to meet during lunchtime on the next visit. The grandmother places the child in the highchair in the kitchen. The child begins to fuss and cry and reaches out her arms toward

the grandmother. The practitioner asks her why she thinks the child might be crying. The grandmother believes that the child is angry about being in the highchair because she prefers to sit on her grandmother's well-cushioned lap during meals. The practitioner then asks what ideas the grandmother might have to help the child be happier in the highchair. The grandmother says she is not sure and also states, "I think I hold her too much. I really think she's ready to sit in the highchair by herself." The practitioner affirms the grandmother and then asks, "How can we use what you already know about your granddaughter's interests to help her be more content in the highchair?" The grandmother shares that she likes to play with a set of plastic measuring spoons and she sometimes gives them to her when she's cooking. Then the practitioner asks, "Can we try that right now?" The grandmother gives the child the measuring spoons and she calms down immediately. The grandmother states, "I should have thought of this before, but I don't usually give her a toy when she needs to eat." The practitioner affirms the grandmother's concerns about the measuring spoons and asks, "What other ideas do you have?" The grandmother responds with handing the child her favorite spoon and cup and says to the practitioner, "What about just giving her these?" The practitioner agrees that the spoon and cup seem to be working well. The grandmother then states, "Before we know it, she'll be feeding herself." Following the meal, the practitioner and grandmother develop a plan that includes ways for the grandmother to use the child's interests at every meal in ways that won't be distracting to the mealtime routine.

Coaching Characteristics

The characteristics of a particular practice inform a practitioner of what to do to achieve the desired effect. A review of coaching research by the authors suggests that coaching has five practice characteristics that lead to intended outcomes: 1) joint planning, 2) observation, 3) action/practice, 4) reflection, and 5) feedback (Rush & Shelden, 2011).

Joint Planning   Joint planning ensures the parent's active participation in using new knowledge and skills between coaching sessions. The two-part joint plan occurs during all coaching conversations, which typically involve discussing what the parent agrees to do between coaching interactions to use the information discussed or skills that were practiced (Part 1) and planning for the activity setting that will be used as the context for intervention during the next visit (Part 2). For example, as a result of a coaching interaction between a parent and practitioner and a child's love of playing in water, the two-part plan involves the parent's decision to purchase an inexpensive plastic wading pool, fill it up, and play with her toddler in the backyard between visits (Part 1). The next visit will occur in the afternoon when they are playing in the wading pool (Part 2).

Observation   Observation typically occurs by the practitioner directly viewing an action on the part of the parent, which then provides an opportunity for later reflection and discussion (e.g., a practitioner observes a parent moving her child from playing with a favorite toy to the bedroom for a nap). Observation may also involve modeling by the practitioner for the parent. When the practitioner models for the parent, the practitioner discusses what he or she is going to do with the child and asks the parent to make specific observations while the modeling occurs. The practitioner then models for the parent by building on what the parent is already doing and demonstrating additional strategies. Following the model, the practitioner prompts reflection by the parent regarding how his or her actions match the parent's intent, is similar to or different from what the parent typically does, and is consistent with what research informs about child learning and what the parent wants or is willing to try based on the practitioner's modeling (e.g., following further discussion, the practitioner demonstrates preparing the child for the transition from play to naptime by talking about what will happen and offering the child a choice of what favorite snuggly the child would like to take to bed).

Action/Practice   Actions are events or experiences that are planned or spontaneous, occur in the context of a real-life activity, and might take place when the coach is or is not present. The characteristic of action provides opportunities for the family member or care provider to use the information discussed during the coaching interaction. This type of active participation is a key characteristic of effective helpgiving and is an essential component for building the capacity of the person being coached. For example, the parent offers the child a choice of whether he or she wants milk or water during snack time and waits for the child to attempt to verbally respond.

Reflection   Reflection occurs during the visit and follows an observation or action, providing the parent an opportunity to analyze current strategies and refine his or her knowledge and skills. During reflection, the practitioner may ask the parent to describe what did or did not work during observation or action as part of the visit or between visits, followed by generating alternatives and actions for continually improving his or her knowledge and skills.

Feedback   Feedback occurs after the parent has the opportunity to reflect on his or her observations, actions, or opportunity to practice new skills. Feedback includes statements by the practitioner that affirm the parent's reflections (e.g., "I know what you mean") or add information to deepen the parent's understanding of the topic. It also includes jointly developing new ideas and actions. The coach provides feedback by sharing information based on current research from his or her discipline-specific training, professional experience, and input from other team members. Sharing additional information about typical 2-year-old behavior following the parent's reflection on what he or she has tried and found to be either successful or unsuccessful around helping his or her child share favorite toys with a cousin is an example of informative feedback.

PURPOSE OF A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

The fundamental purpose of using a PSP approach to teaming is to enable families to establish and maintain an ongoing working relationship with a lead team member with needed expertise, who then becomes an expert on the "whole" child and family rather than promoting an isolated focus on developmental domains and deficits by each practitioner. The intent of this approach is to promote positive child and family outcomes and minimize any negative consequences of having multiple and or changing practitioners involved in the family's life. Families are faced with varying degrees of consistency of approaches, information, and interaction styles when multiple practitioners are involved (Sloper & Turner, 1992). These circumstances can potentially lead to confusion or conflict, leaving the parent to decide what to do and whom to trust and believe.

BENEFITS OF A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

The relationship between the practitioner, family members, and other care providers is a significant benefit of a team approach that uses a primary provider. The important adults in the life of the eligible child can focus on developing trust, respect, and open communication with one key person instead of having to experience this process with multiple people who have different interaction styles, levels of expertise, and knowledge about the child and family.

Efficiently using family and program resources is another important benefit of a PSP approach to teaming. Using a primary provider allows for increased coordination of supports and services instead of a more fragmented approach to addressing the child and family priorities. For example, in a more fragmented approach, a family could potentially be introduced to three or four practitioners with separate meeting times and reasons for visiting. The parent must then remember who does what (e.g., SLP to work on talking, PT to work on rolling), on

what day and time (e.g., Tuesday at 4:00 p.m. for OT, Wednesday at 9:00 a.m. for SLP), the expectations for involvement during the visit (e.g., observer, active participant), the "homework" to be completed between visits (e.g., practice giving choices, pull-to-stand exercises), what needs to be available for the practitioner or whether he or she brings his or her own toys and materials, practitioner preference for sibling involvement, and how the environment should be set up and maintained while the practitioner is present (e.g., television on or off).

Decreasing both gaps and overlaps in supports and services is also a benefit when using a PSP. Because the child cannot be divided neatly into developmental domains and/or discrete areas of focus by a particular discipline, using multiple practitioners inherently invites redundancy across practitioners to address particular skills. For example, an OT may be working on feeding during her visits, while during separate sessions an SLP also addresses a child's oral-motor abilities as they relate to managing foods. In addition, gaps can occur when multiple providers are involved because of a lack of communication and belief by one practitioner that another practitioner is addressing a particular issue.

Consider a situation in which an early childhood special educator and a PT are both involved with a family providing ongoing services at separate times. The child may need specialized equipment to be able to play with toys or interact more independently with his environment. Each believes the other practitioner will address the assistive technology needs of the child and family, but ultimately neither addresses the need or at best an unnecessary delay occurs in providing access to the needed technology. Multiple practitioners working with a particular family may all recognize signs of maternal depression, but because this issue does not fall clearly within the scope of practice of the disciplines involved, each makes the assumption that someone else will be responsible for addressing the issue either through referral or assisting the parent in gaining access to needed supports.

In contrast, a primary provider is responsible for focusing on the entire child within the context of the family and community. The focus of the primary provider is on parent promotion of child participation within and across family routines and activities rather than an emphasis on practitioner–child interventions to remediate deficits within a particular domain by a specific discipline. For example, in the previous scenario in which multiple providers failed to address the issue of maternal depression, a primary provider would recognize the parent's possible depression and its direct impact on the parent's ability to promote child participation during everyday activity settings. Thus, the primary provider would need to engage the parent in a conversation about the necessary supports and resources the parent could access.

Due to the complexity of working with families from a wide variety of diverse backgrounds, identifying one lead provider from the team diminishes the potential of violating a family's values, beliefs, rituals, and traditions. The advantage of a primary provider is that he or she can focus on the time necessary to embrace the uniqueness of the family situation and respectfully engage in conversations to better understand the family preferences.

ORGANIZATION OF THIS BOOK

This text is intended to be a working guide for how to operationalize a PSP approach to teaming in early intervention and, therefore, features learning tools to assist the reader in applying the content to everyday practice. The content is applicable to practitioners working in early intervention, parents, program administers, policy makers, and higher education faculty and students interested in learning more about teaming. Case studies and scenarios are provided to illustrate and provide examples for how PSP teaming practices are implemented in early intervention. Readers are provided with opportunities to reflect, remember, and take action throughout the text. Reflection opportunities include thinking about current or future practices and applying or using the information learned to build on one's current knowledge and skills. Remember notations contain brief summations of critical points to assist readers in

retaining key concepts. Take action opportunities challenge readers and include ideas for how to put information into action by applying what is being learned to a real-life context.

TERMINOLOGY USED IN THIS BOOK

This book contains terminology that may or may not be familiar to the reader or may be defined by different readers in different ways. The authors have provided definitions of some of the terms used throughout the text to ensure a common understanding.

Blended service coordination: A service coordination model in which an early intervention practitioner also serves in the role as service coordinator (e.g., an OT serves as the team's OT and also provides service coordination).

Caregivers or care providers: This term is used to refer to all individuals other than parents who care for and are important in the child's life. This includes, but is not limited to, grandparents, aunts, uncles, family friends, baby sitters, and nannies.

Child care providers: Individuals who work in child care centers or family child care homes.

Dedicated service coordination: A service coordination model in which a separate individual serves as the service coordinator and solely provides this service to the family.

Geographically based team: A team of practitioners that provide services and supports to children and families within an identified geographic area of the region served by the program, such as a county, specific zip code area, or school district.

IDEA Part C: IDEA Part C (formerly Part H) is the federal legislation that provides regulations for how states provide early intervention services to eligible children from birth to age 3.

Individualized family service plan: The process used to develop and provide appropriate early intervention services for families to increase their capacity to care for their infants and toddlers with disabilities. Family members and service providers work together as a team through the IFSP process. The team plans, implements, and evaluates services tailored to fit the family's unique concerns, priorities, and resources. The IFSP is the vehicle through which effective early intervention is implemented in accordance with federal legislation (Part C).

Interdisciplinary team: Interdisciplinary teams have more interaction among the team members than is typical for multidisciplinary teams. Each professional continues to perform a discipline-specific assessment and write discipline-specific goals. The team meets to discuss the results of each assessment and develop an intervention plan (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Team members provide intervention services during different appointment times, with discussion among team members occurring primarily at team meetings (Fewell, 1983; Peterson, 1987; Rush & Shelden, 1996).

Joint visit: A visit in which a secondary service provider (SSP) accompanies the PSP in order to coach and support when a question or issue is identified by the PSP, family members, other care providers, or other team members. The visit is a joint one because both the PSP and SSP are with the child and family at the same time. The joint visit may also be referred to as a consultative visit, consultation, or covisit, depending on the program or fiscal ramifications.

Multidisciplinary team: Professionals working independently of each other and interacting minimally with other team members (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Each member of the team performs a separate evaluation and writes an individual

report, including discipline-specific goals. Intervention is then performed by each service provider at separate times and focuses on the remediation of the weaknesses noted during the evaluation (McGonigel et al., 1994; Rush & Shelden, 1996).

Parents: The individuals who are directly responsible for the care of their biological, adopted, or foster child.

Practitioner: This term is used to identify staff members or contract providers working in an early intervention program. Practitioners may include, but are not limited to, audiologists, behavior specialists, early childhood educators, early childhood special educators, nurses, nutritionists, OTs, PTs, psychologists, service coordinators, social workers, SLPs, and vision and hearing specialists.

Primary service provider: The one team member selected to serve as the liaison between the family and other team members. This is the person who sees and interacts with a family most often and who is responsible for becoming an expert on individual family priorities, activity settings, routines, and unique characteristics. The PSP assists family members and other care providers in promoting child participation within and across everyday activity settings, addressing parenting issues, and ensuring the family's access to needed and desired resources. Any core team member may be the PSP with the exception of the service coordinator in systems that use a dedicated service coordinator. The person selected to be the PSP is the member of the team who is the best possible long-term match for a child and family.

Secondary service provider: This is a team member that uses coaching to support the PSP, parents, and other care providers directly related to the IFSP outcomes. This support may occur within the context of a team meeting, during a joint visit, or as part of a conversation between meetings and scheduled visits.

Service coordinator: The member of the team responsible for coordinating necessary evaluations and assessments, facilitating the initial IFSP meeting and subsequent reviews, assisting the family in receiving the services and supports described on the IFSP, and ensuring their rights and procedural safeguards.

Teachers: In this text, teachers include those individuals who teach in infant/toddler classrooms.

Team: A geographically based team designed to support children enrolled in early intervention and their families. Teams are not formed around individual children, but consist of representatives from a variety of disciplines that are assigned to provide supports within a given catchment area, geographic region, or zip code. A core team must minimally include an early childhood educator or early childhood special educator, one OT, one PT, and one SLP for approximately every 100–125 children enrolled in Part C. The team must also include a service coordinator who is one of the core team members and also serves as a service coordinator or a dedicated service coordinator, depending on the state's guidelines for service coordination (e.g., approximately three service coordinators for every 100–125 children enrolled in the program).

Team facilitator: A member of the geographically based team who is responsible for conducting all team meetings.

Team meeting: The PSP team meeting is a regularly scheduled (most often, weekly) formal opportunity for colleague-to-colleague coaching and support necessary to build the capacity of parents and care providers to promote child participation and parenting supports across home, community, and early childhood program settings.

Transdisciplinary team: A team of professionals who work in a collaborative fashion (Garland et al., 1989; Haynes, 1976; McGonigel et al., 1994; York et al., 1990) and share the responsibilities of evaluating, planning, and implementing services. Families are integral members of the team, and other team members value the family's involvement in all aspects of intervention. One person is chosen as the PSP for a child and family. Other team members provide support to this individual through consultation regarding activities to include during interventions with the child and family.

CONCLUSION

The purpose of this text is to define a PSP approach to teaming as one component of a three-part approach for providing evidence-based early intervention practices. This three-part approach also includes using natural learning environment practices as the context for intervention and coaching as the style of interaction with the important adults in the child's life. Using a PSP is a key principle identified by the Workgroup on Principles and Practices in Natural Environments of the NECTAC and is recognized by ASHA, AOTA, the Section on Pediatrics of the American Physical Therapy Association, and the Division for Early Childhood of the Council for Exceptional Children as an appropriate teaming approach in early intervention.

The federal regulations for Part C clearly delineate the involvement of teams comprised of individuals from multiple disciplines in the design and delivery of early intervention supports and services. Furthermore, evidence, practical experience, and common sense inform us that having one primary liaison from the team to the family is an effective means of providing supports. This text is designed to assist the reader in operationalizing the research-based characteristics of the practices in early intervention contexts.

This text is intended to provide detailed information in such a way that practitioners and program leaders can consider how their current practices align with the approach described. The information is provided in a manner that could support a program in implementing the characteristics of this practice as well as serve as a resource for family members interested in learning more about the use of a primary provider. This text is also put forth as a resource for higher education faculty to use within and across disciplinary and departmental boundaries in order to prepare graduates to serve on teams in early intervention.

Role Expectation Checklists

Practitioner's name: _____ Date: _____

	Knowledge and skills are characterized by the following:	Yes	No	Examples/notes/plan
Evidence-based practices	Practitioner can ensure that the practices he or she uses from his or her own discipline are evidence based.	Y	N	
	Practitioner has an understanding of Part C of the Individuals with Disabilities Education Act Amendments (IDEA) of 1997 (PL 105-17).	Y	N	
	Practitioner has reviewed the mission and key principles for providing early intervention services in natural environments.	Y	N	
	Practitioner implements practices in accordance with the mission and key principles.	Y	N	
	Practitioner demonstrates knowledge of typical child development across the five domains (adaptive, cognitive, communication, physical, and social-emotional).	Y	N	
	Practitioner demonstrates the ability to assess child functioning across the three global child outcomes (positive social-emotional skills, acquisition and use of knowledge and skills, and use of appropriate behaviors to meet his or her needs).	Y	N	

	Knowledge and skills are characterized by the following:	Yes	No	Examples/notes/plan
Parent support	Practitioner supports family members in identifying, gaining access to, and evaluating informal and formal resources needed to assist them in meeting their desired outcomes (e.g., employment, housing, medical/dental care, transportation).	Y	N	
	Practitioner implements evidence-based parenting support practices to assist family members and other care providers to achieve their desired outcomes (e.g., toileting, helping the child sleep through the night in his or her own bed, providing positive behavior support, eliminating the use of a pacifier, teaching basic nutrition).	Y	N	

	Knowledge and skills are characterized by the following:	Yes	No	Examples/notes/plan
Adult interaction/ adult learning	Practitioner uses methods and strategies when working with the adults in young children's lives that are likely to strengthen individual or family capacity to accomplish the family's desired outcomes.	Y	N	
	Practitioner recognizes and builds on what the family and other care providers already know and are doing related to child learning and parent support.	Y	N	
	Practitioners demonstrate respect for individual adult learning styles, preferred interaction methods, and cultural influences.	Y	N	

Role Expectation Checklists—Administrator's Guide

Practitioner's name: _____   Date: _____

	Knowledge and skills are characterized by the following:	Examples/notes/plan
Evidence-based practices	*Indicator* Practitioner can ensure that the practices he or she uses from his or her own discipline are evidence based. *Administrator probe questions* • What research does the practitioner have to support the practices that he or she uses? • How is the research relevant to children from birth to 3 years of age? • How does the research consider the importance of parents/caregivers and everyday contexts? • How does the practitioner vary his or her treatment methods or strategies with children/families based on current research and the child/family needs, activity settings, and so forth?	
	Indicator Practitioner has an understanding of Part C of the Individuals with Disabilities Education Act Amendments (IDEA) of 1997 (PL 105-17). *Administrator probe questions* • How recently has the practitioner reviewed IDEA Part C regulations and/or state policies and procedures for early intervention? • What were the topics discussed when the administrator, team leader, or supervisor had a conversation with the practitioner about how IDEA Part C regulations and state policies and procedures for early intervention are implemented in the program? • How does the practitioner demonstrate understanding of IDEA Part C? • How does this compare with the practitioner's prior work experiences?	
	Indicator Practitioner has reviewed the mission and key principles for providing early intervention services in natural environments. *Administrator probe questions* • How recently has the practitioner reviewed the mission and key principles? • What were the topics discussed when the administrator, team leader, or supervisor had a conversation with the practitioner about how the mission and key principles are applied in the program? • What is the practitioner's current level of understanding and agreement with the mission and key principles? • How does this compare with the practitioner's prior work experiences?	*(continued)*

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Evidence-based practices	Knowledge and skills are characterized by the following:	Examples/notes/plan
	Indicator Practitioner implements practices in accordance with the mission and key principles. *Administrator probe questions* • How does the practitioner demonstrate practices in accordance with the mission and key principles? • What does the practitioner do when conflicted about implementing practices in accordance with the mission and key principles?	
	Indicator Practitioner demonstrates knowledge of typical child development across the five domains (adaptive, cognitive, communication, physical, and social-emotional). *Administrator probe questions* • How does the practitioner demonstrate knowledge of typical child development across the five domains? • Does the practitioner competently and confidently provide supports to families within the context of everyday activities regarding topics outside of their own area of expertise?	
	Indicator Practitioner demonstrates the ability to assess child functioning across the three global child outcomes (positive social-emotional skills, acquisition and use of knowledge and skills, and use of appropriate behaviors to meet his or her needs). *Administrator probe questions* • What is the practitioner's knowledge of the three global outcome areas and how the global outcomes are used? • How does the practitioner collect and share information related to the three global outcome areas?	

Parent support	Knowledge and skills are characterized by the following:	Examples/notes/plan
	Indicator Practitioner supports family members in identifying, gaining access to, and evaluating informal and formal resources needed to assist them in meeting their desired outcomes (e.g., employment, housing, medical/dental care, transportation). *Administrator probe questions* • What is the practitioner's knowledge about resource-based practices? • What is the practitioner's knowledge of formal and informal community resources? • How does the practitioner build the family's capacity to identify, gain access to, and evaluate resources rather than giving or procuring needed resources for family?	*(continued)*

	Knowledge and skills are characterized by the following:	Examples/notes/plan
Parent support	*Indicator* Practitioner implements evidence-based parenting support practices to assist family members and other care providers to achieve their desired outcomes (e.g., toileting, helping the child sleep through the night in his or her own bed, providing positive behavior supports, eliminating the use of a pacifier, teaching basic nutrition). *Administrator probe questions* • What basic evidence-based knowledge does the practitioner have regarding typical parenting needs for support? • What evidence does the practitioner use for parenting supports? • How does the practitioner implement evidence-based parenting support practices?	

	Knowledge and skills are characterized by the following:	Examples/notes/plan
Adult interaction/adult learning	*Indicator* Practitioner uses methods and strategies when working with the adults in young children's lives that are likely to strengthen individual or family capacity to accomplish the family's desired outcomes. *Administrator probe questions* • What experience does the practitioner have using adult learning methods to support the adults in the child's life rather than only focusing on working directly with the child? • What methods and strategies does the practitioner use to build parent capacity to achieve his or her desired outcomes? • What is the evidence to support the methods and strategies the practitioner uses?	
	Indicator Practitioner recognizes and builds on what the family and other care providers already know and are doing related to child learning and parent support. *Administrator probe questions* • How does the practitioner obtain information about what family and care providers already know? • How does the practitioner use this information to guide the supports he or she provides?	
	Indicator Practitioners demonstrate respect for individual adult learning styles, preferred interaction methods, and cultural influences. *Administrator probe questions* • How does the practitioner gather information about the adult's learning style, preferred interaction methods, and cultural influences? • How does the practitioner use information about adult preferences within the context of interactions?	