



WISCONSIN BIRTH TO 3 PROGRAM

IMPLEMENTING EVIDENCE-BASED PRACTICES IN EARLY CHILDHOOD

INTERVENTION INTENSIVE INSTITUTE



PRIMARY COACH AND TEAMING: Frequently Asked Questions

In April of 2010 and January of 2011, a total of 25 Wisconsin Birth to 3 teams representing all five regions of the state attended two day Intensive Institutes presented by national experts, M^lLisa Shelden, PT, Ph.D and Dathan Rush, Ed.D., CCC-SLP. The Intensive Institutes promoted the study and practice of implementation of the primary coach approach to teaming and the coaching interaction style to build the capacity of the adult learner. Attendance at the Institutes required teams to commit to six months of follow-up activities around coaching practices with families, other team members and peers, including submittal of a minimum of six coaching logs for ongoing TA as they began implementation of the primary coach approach to teaming within natural environments. The Frequently Asked Questions Document (FAQ) is a compilation of the questions and responses that were posted on the *Primary Coach Approach to Teaming Blog* to provide an ongoing dialogue related to processes and challenges in implementation of these practices. Responses were thoughtfully crafted by the Birth to 3 team at Department of Health Services (DHS), Waisman Center Wisconsin Personnel Development Project (WPDP), and RESource, with support and guidance from Shelden and Rush. During the ARRA funded period, there were a total of 3393 hits to this Blog.

Implementation and How to Begin Questions: Page 1
Specific Practice Questions: Page 9
Evidence-Based Questions: Page 21
Billing Questions: Page 25

IMPLEMENTATION AND HOW TO BEGIN QUESTIONS:

Q: How do we think about coaching and contextualized practices from the very beginning of the process, especially when it seems our initial evaluations to determine eligibility are so formalized and skill-based? It doesn't set us up to be routines-based/activities-based from the beginning?

M^lLisa Shelden responds: “ It takes some planning and often a shift of thinking to stay focused on child participation when so much emphasis is placed on evaluation for eligibility that is skill-based. This is why we start with assessment for functional activity settings at the first visit...often before we have verified eligibility. We feel it is worth the time and effort even if the child ends up not qualifying for the program.

The family can be more participative when we're talking about routines and activity settings and it sets the tone for what supports will look like if the child enrolls in our program. If we do find out that the child isn't eligible, then we have more information to help us make referrals to community programs or activities that might be of interest and support to the child and family.”

Q: How do we start? What do we need in place?

The following article *Checklists for Implementing a Primary-Coach Approach to Teaming (Appendix at end)* is a good one for seeing where you currently are in your implementation of these practices, and figuring out what is next. It can be found at http://http://fippcase.org/casetools/casetool_vol5_no1.pdf

Q: How to share with families?

Here is a suggested script:

“I will be your primary contact but I work with a team of specialists who have a variety of backgrounds and qualifications such as special education, early childhood education, occupational therapy, physical therapy, speech-language pathology. I also work with social workers, psychologists, and nurses, so if at anytime we need to talk with them or get information from them or use them, I can pull them in easily. Research in child learning and development has helped us see the value of everyday activities that occur in your home or in your community as sources for children’s learning opportunities. Our approach supports you in finding the best opportunities for promoting your child’s growth and development. These opportunities center around your child’s interests and your family’s everyday activities. Research has shown that, just like adults, children are more likely to pay attention to and learn during activities that they find fun and interesting. (Insert an example relevant to family.) Because you (and other caregivers as appropriate) are an important person in your child’s life, our time together will be spent identifying the things you do or want to do in order to provide your child increased opportunities to take part in activities that he/she finds interesting.”

See the following article, *Script for Explaining an Evidence-Based Early Intervention Model* for more ideas, at http://http://fippcase.org/briefcase/briefcase_vol1_no3.pdf

Q: Any tips on how to suppress a suggestion or change it to be more coaching?

A good way to practice being less directive with families is through the use of coaching logs. When you capture a dialogue that you have with a family in a coaching log, you will be better able to exam how well you listened and reflected with the family. Continue to use reflective questions in your conversations with families, particularly the analysis and alternatives questions. Remember to incorporate action and practice into your visits when the family has ideas. Offer to try something right now with the family to see how it goes.

Q: How do we deal with criticism from families that want B-3 to look like the medical model?

The best resource for guiding your conversations with families can be found in the *Script for Explaining an Evidence-Based Early Intervention Model*

1. http://http://fippcase.org/briefcase/briefcase_vol1_no3.pdf

Key components center around the primary coach developing a relationship with the family to provide contextualized intervention, with both the primary coach and family receiving the support of a full team including the other disciplines. A conversation with a family, describing this way of teaming that centers around the child’s interests and family’s everyday activities might begin with:

- *Even though I will be the person that you will probably see most often, I am a member of a much larger team of highly experienced and skilled professionals. They support me as I work with you. If you and I have a question we can’t answer or need some specific help, then you and I can ask for help from the team. When we ask for support, I can go back and talk with all of the team members during our weekly team meeting or I may talk with one or two of*

them and share what you and I have tried or talked about and get some ideas, or another person from the team may come with me to visit you.

- *You may be wondering or others may ask you why we just have one person who comes to see you on a regular basis. The reason is because the latest research tells us, and families report, that it is more beneficial to have just one person supported by a team of people than it is to have a number of people working directly with you and your child. When a lot of people ask you to do something else or something different, that's time taken away from the things that you and your child enjoy doing or need to do together, or worse, it may mess up your routine and activities. (Shelden, M. & Rush, D., 2008, page 4)*

Q: How is the primary provider determined?

The primary coach is selected based on desired outcomes of the family, rapport/relationship between coach and parent or other primary care provider, specialized knowledge, and/or availability of the coach and family.

See this article: *Checklists for Implementing a Primary-Coach Approach to Teaming*

http://http://fippcase.org/casetools/casetool_vol5_no1.pdf

Q: Can the primary provider switch? When?

Justifiable reasons for changing the primary coach include a request by a family member or other care provider; or when a primary coach believes that even with coaching from other team members he or she would be ineffective in supporting the parent or other primary care providers. More information can be found in the article “Characteristics of a Primary Coach Approach to Teaming in Early Childhood Programs. Found at

http://http://fippcase.org/caseinpoint/caseinpoint_vol3_no1.pdf

Q: How often is the educator the primary provider?

The primary coach is selected based on desired outcomes of the family, rapport/relationship between coach and parent or other primary care provider, specialized knowledge, and/or availability of the coach and family This could be someone from any of the disciplines, as appropriate. Any team member could be positioned to be the primary coach with the knowledge and support from their team members. It depends on staffing and roles that have evolved within your team over the years and the experience of your team members. It also depends on the identified outcomes for the child’s individualized IFSP. It is also appropriate to redefine and strengthen the role of your educator and how the educator’s cross disciplinary background may benefit the team and families.

Q: How do we explain to families why this county does it differently than another county?

The State of Wisconsin does not prescribe a specific approach to providing services, resources and supports to families served by the Birth to 3 Program. Counties have some discretion as long as the requirements of IDEA are met, including provision of early intervention services in natural environments and that are based on individualized outcomes on the IFSP. There is a growing body of research about the most effective early intervention practices. We have recognized, through the research, that increasing the capacity of the adult learner (parent, grandparent, neighbor, and child care provider) has a significantly bigger impact on the child and his or her family.

Wisconsin’s Birth to 3 is allocating ARRA funding to support a statewide quality improvement initiative to assist counties in exploring the implementation of evidence-based practices. Counties are choosing to focus on different aspects of evidence-based practices building from their current capacity and as fits with their priorities as identified in their Budget and Work Plan for their

Consortium. You might explain to families, the county, your agency and community partners that we are discovering more effective ways in which to approach services that better support child outcomes and even more importantly provide better support for the caregiver who is part of the child's everyday routine.

Q: How do we address the medical community about this approach?

Consider modifications of the script available in the following article, *Script for Explaining an Evidence-Based Early Intervention Model* for more ideas, at http://http://fippcase.org/briefcase/briefcase_vol1_no3.pdf
Consider sharing the article with physicians.

Q: How do we make the switch with families who have carved out our one hour visit as our play time with their child, without their involvement?

Conversations around the intentions behind participating in this time together with the family and child will need to occur. Ideas for how to begin these conversations can be found in the following article, "Script for Explaining an Evidence-Based Early Intervention Model" at http://http://fippcase.org/briefcase/briefcase_vol1_no3.pdf
Also consider developing your own "agency script" as a team in the format presented in this article. Remember always to be open and honest with the family regarding the "new" approach. "Family-centered practices place families in central decision-making roles and proactively involve families in acting on their decisions. Evidence now indicates that being treated in a family-centered way results in a number of parent and family benefits. These benefits include, but are not limited to parent and family empowerment, family well-being, positive judgments by parents about their confidence and competence, and positive judgments about their children's behavior (Dunst & Trivette, 1996; Dunst & Trivette, 2005b).

Q: How do we convey that this approach is evidenced based and progressive in thinking without appearing to be critical of neighboring counties not using this approach?

Consider reading the following articles to help you describe the benefit of this approach in increasing the family's feelings of competence and confidence in understanding the child's developmental trajectory.

For more information, see these link

[Parent-Mediated Everyday Child Learning Opportunities: I. Foundations and Operationalization](#)

Carl J. Dunst, Ph.D.

[Influences of Resource-Based Intervention Practices on Parent and Child Outcomes](#)

Donald W. Mott

Carl J. Dunst

Q: Do Rush & Shelden have missed visit policy guides? At what point can you determine that a family does not want to be coached and is not voluntarily interested in the program and it's supports?

Each individual program typically has its own missed visit policy unrelated to the program's or individual practitioner's use of interaction style, teaming model, or type of practices used. The program is voluntary, so families will choose to discontinue for a variety of reasons just as they always have.

Q: How do we use this approach in a child care setting?

The first thing to consider would be the parent's intentions on clarifying what would be useful within the context of the child's day within the care setting, and meeting the child care provider with the parent present initially if possible. Empowering and coaching the teacher within the context of the activities that are scheduled would be the focus. A conversation with the child care provider prior to the visits to clarify the role of the early interventionist while at the child care program would be important, to discuss the way that the early interventionist can join in the activities of interest to coach the caregiver in strategies that would be useful "between visits" on a daily basis. Examples of relevant activities might be sitting at snack to introduce ways to assist a child with self feeding, joining in circle to introduce signs to the child who is just beginning to communicate in this way, playing outside on the large equipment for the child with some mobility challenges. In a child care center, if the caregiver can also alert the co-teacher or aide in the classroom that her/his focus during that time will be more specific to the particular child in the activity he/she is engaged in, the other teacher could offer more assistance in monitoring the other activity centers and groups of children during that time. Obviously, the teacher will have needs to shift her/his attention to the rest of the group as necessary, and flexibility will be important. Communication between the early interventionist, parent and caregiver must also be a system that is in place and working well for this to be effective.

M³Lisa adds: Families must also be included beyond notes at the CC center. We routinely schedule at least a monthly visit with families (in addition to the visits with the child care provider) to support the child and family in the home environment. This is most often an early evening visit. Families could also choose to meet us elsewhere, if preferable..the park, a restaurant, etc.

Q: A team is working hard at writing participation based outcomes, but is finding a struggle with the development of strategies that are not "directive" for the initial IFSP. The team is beginning to get to know the family, has preliminary discussions about routines and activities, but finds families wanting the new service provider to "give us something to do" and the strategies then look more like "homework". Once joint planning begins, the strategies naturally emerge from those joint planning conversations, but how do we think about this for the initial IFSP?

M³Lisa Shelden responds: "The strategy section on the IFSP does present quite a conundrum for teams that have embraced a coaching approach. Again, a very thoughtful question that demonstrates excellent understanding of coaching and natural learning environment practices. As you know, a good coach (using evidence-based practices) would never jump in describing strategies and ideas with a family without first exploring what the family has tried. So, writing an IFSP and then including suggestions in the early conversations feels awkward...and wrong (rightfully so). We've used two approaches in tackling this situation: 1) to write a somewhat generic type of statement that covers the requirement of the IFSP; and 2) Using information gained from the family interview, ABC Matrix, or especially the Interest-Based checklist to write in some strategies that the family is already using that will continue to assist to enhance the child's participation in and across activity settings.

Here is an example of each:

- 1) A statement such as...the primary service provider and family will work together to identify specific strategies to enhance _____(child's name) participation in _____ (name activity setting) using coaching and ongoing assessment. This statement is vague (and somewhat redundant), but will fill in that empty box without violating coaching practices.
- 2) Consider a child with an outcome of...Leo will tell his parents when he is hungry and what he wants to eat and drink using words. Let's say every night before bath time, Leo and his dad have a fun, rough-housing tickle time. During this time, Leo is absolutely having a blast! He is laughing, vocalizing, saying some words, etc. We would all agree that this is a great activity (except maybe

Leo's mom who now has to calm him down for bath and bedtime) that will help promote Leo's ability to use his words to communicate more effectively. So, in the strategy section we could write something like...Mr. Maxwell will continue to have playtime with Leo every night before bath time and encourage his use of his words through modeling short phrases like "more tickle" or "gonna get you."
You can probably tell, our favorite choice is #2"!)"

Q: How does building on interest-based activity settings and learning opportunities differ from “embedding therapy”?

M’Lisa Shelden responds: “When we think about the difference between embedding and building on interest-based activity settings and learning opportunities, the bottom-line is...

1) Is the practitioner looking for a place (time of day, activity setting, etc.) to insert strategies, exercises, drills etc. (kerplunking)?

OR

2) Is the practitioner learning about the child's daily routines, special events, favorite activity settings to assist the parent in supporting the child's participation?

As you know, if the answer is yes to #1 that=embedding.

I think sometimes this concept is so challenging for early childhood practitioners that have previously been center-based...even therapists in clinics, because the notion of a good early childhood program is to embed learning opportunities that are interest-based throughout the day. In preschool programs embedding IS an EBP...but not in homes. Also, even for a good therapist in the past at a clinic...he or she would have planned, fun and engaging activities that target a child's particular needs (based on delayed skills). The big difference is in those situations that child was being handed over to a paid professional to specifically work on enhancing the child's development. In a preschool this is a normalized, natural learning environment. Preschool teachers are paid to provide a development enhancing environments. Going to a therapy clinic or a segregated playgroup or classroom is not a normalized activity and cannot be considered natural. Research has taught us that when we embed in natural settings (with the exception of preschools) we LIMIT learning opportunities. When we're visiting a child in his or her home or child care setting...this is the child's life (or at least a big part of it) all day every day...we must be experts on what the child and family would be doing if we weren't there. We shouldn't go in and disrupt the natural learning opportunities (even if we believe learning opportunities are limited in frequency and intensity) or decontextualize them to focus on a particular skill, when we know their lives are FULL of learning opportunities that promote skill development across ALL developmental domains...we just have to believe this and take the time to look for them. So, instead of embedding therapy or strategies into their day, we'll dig in and really get to know what happens when we're not there, observe and assess how the adults and siblings are promoting the child's participation currently, and then add strategies and ideas for the adults and siblings to consider to continue to enhance, challenge, and promote the child's development.

KEY ELEMENTS:

1) The existing or desired activity setting IS the context for early intervention NOT early interventionists creating activities to promote development of specific skills.

2) Child interests are used as the basis of which activity settings to choose because interest-based will immediately engage the child for longer periods of time NOT early interventionists suggesting development enhancing activities because we know they are good for a child.

3) FIRST, identifying responsive strategies the adults are already using NOT jumping in and directing the parent to try specific strategies the practitioner would (Parents don't want to be therapists), THEN building on the parent's responsive strategies through consideration of new ideas and information.

(1) = Everyday opportunity

(2) = Child Interest

(3) = Parent responsiveness”

Q: For ongoing sustainability, as Pilot Teams complete their final month of coaching log review, what are the conversations on “keeping this going”?

M’Lisa and Dathan recommend continuing these reflective professional conversations at some level in an ongoing manner, though not at the intensity of the six month coaching log practice. Those become particularly valuable when there are new team members, or for supervisors to mentor staff. Use other opportunities to further the depth of the practices, through portfolios, the Abbreviated Practice checklist, conversations with colleagues, etc. to avoid slippage.

Q: How purely do we stick to the model of "when would you like me to come back?" How much flexibility is given to the family and how does this affect the teacher/therapist/service coordinator scheduling and cost-efficiency?

M’Lisa suggests: One of the reasons for using flexible scheduling is cost-efficiency. We have to be flexible. Partnering with families...means partnering. The purpose of using flexible scheduling is not so the family dictates when the visit occurs, but participates in the decisions based upon time needed between visits to try out new ideas, etc., AND also to be reasonable in consideration of constraints on practitioners' schedules and program variables. For example, a mother might say “I’d love it if you could come back on Monday”. The practitioner might say, "I’m back this way on Wednesday, will that work?” The mother could indicate yes or ask if there is any way to accommodate her request. This is a partnership to negotiate what works best considering all of the variables. In the past, the practitioners basically called the shots on their availability.

Q: For frequency, is it permissible to write “up to 12 visits in 3 months” or “10-12 visits in 3 months”? Since the IFSP is a legal document, it seems that the number of visits should be set and families should expect to receive that number of visits from the primary coach, but maybe there is more flexibility with this model and it is okay to have a range of visits?

First, since the IFSP is considered both a legal document and a dynamic document there is an expectation that things will change and that changes will be reflected in an updated IFSP. For an array of reasons, the number of visits cannot be precisely determined ahead of time; rather at the moment in which the document is created, the team is providing a best educated estimate of what will be necessary to meet the outcomes. As needs change, an increase or decrease in visits should be reflected in the IFSP. This must also be discussed with the family so it’s understood that it is about the individual needs and not the number of visits and it is anticipated the number of visits will change over time. It is recommended that providers move away from emphasizing the quantity of visits but rather the quality of visits in order to meet the individual needs of the child and family. Also, consider the use of certain dates (birthday, holiday, family events, etc.) as an end date or when it’s expected an outcome will be achieved and the number of visits anticipated it will take to complete the outcome within the stated time period.

However, there is NOT the flexibility to suggest a range of “2-3 one hour visits per week until Christmas” but rather the anticipated number, such as “12 one hour visits through Christmas of 2011”. Then, when or if necessary, change the number of visits as the need arises. It’s also useful to front load visits and decrease visits as necessary without being “stuck” having to do a certain number each week when it becomes obvious those visits will not be necessary.

Darsell Johns, Part C Coordinator at DHS adds:

The IFSP is scaffolding for the coaching process and we have to carefully construct it so that parents and providers work toward the child's development together. If we are talking about individualized planning then the number and type of visits will depend upon the ongoing progress of the child and family. This provides an opportunity for visits to decrease or increase in relationship to the child and family's progress in between visits.

It may be possible to initially determine a schedule of visits but also engage in a discussion with parents, that the visits may change in relationship to the child and family.

If you begin with more visits up front, you'll need to consider how/when to move toward fewer visits. The key component is being able to begin at a place that is developmentally appropriate for the family and can then create a pathway for coaching to proceed in higher and lower frequencies as needed.

Q: What is the title for the team member who makes a joint visit with the coach and parent to respond to questions and do some coaching? I think that we have heard the terms 'joint visitor' and 'consultant' at varying times.

The person on the team that visits with the family most frequently is the primary coach and the individual accompanying the 'primary coach' is most often referred to as the "secondary coach."

Regarding your question about the term "consultant," here is how Rush and Shelden responded:

Misperception 10: Coaching is the Same as Consultation.

Coaching is 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). Consultation is generally used to help the consultee solve a current problem with the intention that this will help him/her to solve similar problems in the future (Buysse & Wesley, 2005). Consultation in early intervention has most often been associated with classroom-based interventions, whereas coaching is an interaction style that may be used with parents, teachers, and other care providers within any context in which young children may be found. Consultation is typically used to refer to an indirect model of service delivery. Coaching does not differentiate between direct or indirect, hands-on or hands-off intervention.

Q: A parent has a question for the coach that the coach doesn't think she can answer well. She takes the question to the teaming meeting where she receives information from others. When the coach takes this information back to the parent, the parent remains confused and has further questions. With the team available, does it make sense for the coach to ask an appropriate team member to come on a joint visit to respond directly to the parent's question?

Consider the possibility of setting up a call with the parent during the team meeting to allow a dialogue that would lead to better clarification for the family, or even inviting the family to attend a portion of a team meeting if they would be interested. If the family or the primary coach are discussing a need for physical demonstration than a joint visit would be necessary. Another option might be to schedule a phone call with the therapist while the primary coach is already at the home visit

Q: How do we write the team (OT, PT, SLP, and ECSE) onto the Services page, to capture the potential for joint visits?

1. During the development of the IFSP many factors need to be taken into consideration, with the teams' best educated guess as to who will serve as primary coach and also the frequency of any anticipated team members for joint visits. Additional therapists should not be listed as secondary coaches unless the team foresees a strong possibility it will be needed. Rather, it would be best

that they are added at a later date if it's determined necessary. An IFSP is intended to be a working and dynamic document and should be changed, altered and regularly updated (at a minimum every 6 months).

2. To help reduce this, team members should be thoughtful and mindful of what is listed on the IFSP initially. An honest and thorough discussion helps alleviate unexpected changes. As teams develop more cohesively over time this process actually becomes very smooth and simplified. The awareness of individual strengths, relationships, and trust among team members makes this much easier. This does take time and a genuine effort and desire. Consider not immediately jumping to the need for a joint visit but discussing other team alternatives to resolve the issue. If the joint visit is ultimately needed then you would need to implement the process for revising the IFSP, and provide the written prior notice.

SPECIFIC PRACTICE QUESTIONS

Q: Is it ever OK for us to be a resource for toys? I understand that we do not want to be taking in things and then taking them away, but is there a place for something like this?

This depends on whether this is part of a family outcome on an IFSP. Has the team had a resource-based conversation with the family? Has the team considered all the other options, like going to the store with the family to help them think about what toys might be best for their child, going to a Goodwill or a garage sale, helping the family make something at home, researching toys online with a family, or going to a community center, library or play group with a family to see how the child interacts with peers and toys available there.

Q: How do you ensure the focus of intervention on visits stays on the whole child and does not become discipline specific?

If providers are working on participation-based IFSP outcomes within activity settings meaningful to the family (such as “playing out of doors with siblings” or “sitting at the table to join the family for dinner”), a “discipline specific” practitioner such as a PT could be assisting a child with getting down the back stairs to go outside to play, climbing up on the riding toy, tossing the ball to big brother, while engaging in communication with the child, enjoying the activity and/or assisting the parent in soothing the child if the riding toy falls over (social-emotional). The strength of this approach is that working with a child and parent within the context of a meaningful activity allows all of this to happen.

Q: I was wondering about the strategy of following the child's lead and matching their interest/play when the child has ASD. What would you say about following child's lead and responding to their interest when the child is engaged in a negative behavior? or rigid play, or perseverative play?

The purpose for following a child's lead is to engage the child in new learning and discovery. For a child with autism, these leads provide opportunities to expand up on and shape those behaviors into meaningful communication or social engagement. They also provide opportunities to support and nurture the special interest of a child with ASD. We are learning from older children and adults the value of supporting a child's engagement with their special interests --to build on them rather than try to make them go away. For a young child, our observations of what is referred to as "rigid or perseverative play" may serve a variety of purposes for that child (e.g., self-soothing/regulation, self-initiated learning/discovery about a special interest, escaping a challenging situation). The goal would be to figure that out and use that potential. This is where the coaching partnership is essential. An interventionist's role would be to coach families to learn how to recognize what the child is presenting through his or her

interests and behaviors and then to help the parent or other primary caregiver to respond to what the child is demonstrating.

Perhaps redirection into another activity or helping the child accommodate or move away from a distressing situation is called for.

Following are a few current resources you may find useful:

1. Spring 2010 Issue of Early Developments Focuses on Autism Spectrum Disorders
05/27/2010

http://www.fpg.unc.edu/news/highlight_detail.cfm?ID=881

2. Randomized, Controlled Trial of an Intervention for Toddlers With Autism: The Early Start Denver Model. *Pediatrics*.

Dawson, G.; Rogers, S.; Munson, J.; Smith, M.; Winter, J.; Greenon, J.;

Donaldson, A.; Varley, J. (2009).

http://extension.ucdavis.edu/unit/autism_spectrum_disorders/pdf/dawson_rogers.pdf

<http://autismcrisis.blogspot.com/2010/02/very-early-autism-intervention-early.html>

3. PLAY Project: Parent Coaching is also a part of the PLAY project, for which research is underway:

http://www.playproject.org/about_research.php

Q: How does this match with the requirement to individualize, as in the INDIVIDUALIZED family service plan?

1. It is important to remember that practicing coaching and the primary provider approach in early intervention is not a requirement. Many teams and providers are ready and willing to embrace these practices and are vigorously reading the literature/ evidence which support these practices. As teams of providers begin to implement, many success stories are being learned – particularly related to increased parent engagement in the process.
2. When considering the individualized component of primary service provider model, remember that there is a very strong team component. The notion of primary provider does NOT mean that one person alone works with a family. Regularly scheduled team meetings occur, thus giving providers the opportunity to tap into the knowledge and expertise of teammates in order to gain ideas and problem-solve. The scheduling of joint visits with another provider as needed is a critical piece as well.
3. This approach is not necessarily a cost-savings to programs, and does not necessarily mean overall decrease in number of visits.
4. IFSPs are potentially even more individualized when these practices are in place given the strong emphasis on the provider intentionally learning and understanding how a family spends their day with their child. This allows the provider to learn more deeply about what the family likes to do and what they struggle with. Given the depth of information providers can learn about the family's life, IFSP outcomes become much more individualized for that family.

Keep going through the articles at the website <http://fippcase.org/>.

The CASEmakers, CASEinpoints, BriefCASES and CASEtools articles may be of help.

You may also be interested in the article “Tips and Techniques for Developing Participation-Based IFSP Outcome Statements” at http://www.http://fippcase.org//briefcase/briefcase_vol2_no1.pdf

Dathan Rush reminds us: “Coaching, use of natural learning environment practices, and a primary coach approach to teaming are not “service delivery models,” but rather elements of evidence-based practices in early childhood intervention. We are required under Part C to use evidence-based

practices. We have to be sure that “individual” as defined by some providers and families, does not mean the use of preferred practices that may not be supported by research.”

The OSEP /NECTAC document Seven Key Principles: Looks Like/Doesn't Look Like also states in Principle Six: “The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support” and in Principle Seven: “Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations.” You can find this document at

http://www.nectac.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf

Q: What if a family identifies a goal that is dependent on a skill that research has shown requires a certain amount of decontextualized “practice” on the part of a child? Take, for example, a child who has a repaired cleft palate and who is not producing bilabial sounds. The parents would like to be able to understand the child. The child would benefit from skilled intervention to increase production of bilabial sounds. In situations like this, is it appropriate for a therapist to work directly with a child and to provide suggestions for decontextualized repetitive practice so that the child becomes more intelligible?

The following articles may be helpful:

Language Learning in Children Exhibiting Characteristics of Apraxia Using Contextually Mediated Practices

http://www.http://fippcase.org//caseinpoint/caseinpoint_vol1_no3.pdf

Activity Setting Influences on the Early Language Production of a Child with a Cleft Lip and Palate

http://www.http://fippcase.org//caseinpoint/caseinpoint_vol2_no1.pdf

Q: What about when we need to be concerned with the intelligibility of children with apraxia and cleft palate. It is here that the evidence based for parent-implemented responsive teaching seems much less clear to me and the evidence for therapist-implemented, sometimes decontextualized, intervention seems stronger. In these cases, it seems much more appropriate to ensure good child outcomes by providing the evidence based therapist-implemented treatment.

The first question is if intelligibility is the only concern, carefully consider eligibility guidelines and whether the child is eligible for early intervention, or if the nature of the concern could be addressed through pediatric rehab. Suppose the child has intelligibility concerns and other delays and is eligible for early intervention. In this case, coaching parents is extremely critical. If there is specific intelligibility strategies a parent can learn and incorporate into routines, it is the responsibility of the professional to give that knowledge away to the parent in such a way that it makes sense for the parent to incorporate into family life. An ongoing challenge is always finding ways to engage very young children in interest-based activities that allow practice of new skills (within a context), so that numerous opportunities are available.

Q: Why wouldn't the child meet eligibility requirements if intelligibility was the only concern? Couldn't the child qualify under atypical development? And wouldn't it be much better on the family functioning to serve the child in the home rather than suggest that they drive somewhere to get outpatient pediatric rehab?

Some children could qualify due to atypical development. It is important to review the decision making table for risk factors related to expressive delays only, which can be found in *Wisconsin*

Birth to 3 Program: Guidelines for Determining Eligibility at <http://www.waisman.wisc.edu/birthto3/EligibilityGuidelines.pdf> on page 21 of the section titled Guidelines for Best Practices in Determining Eligibility Based on Communication Skills. Chart 1 and 2 of Diagnosed Considerations on Pages 16 and 17 also provide useful guidance.

It is also important to carefully examine justification for informed clinical opinion, which can be found in a NECTAC article on pages 34-37 in the front section of the same document.

From the document, atypical development is described below:

If the results of the formal testing under paragraph (a) 3 closely resemble but do not equal the standard in paragraph (a) 3 for a developmental delay but observation by qualified personnel or parents indicates that some aspect of the child's development is atypical and is adversely affecting the child's overall development, the EI team may use alternative procedures or instruments that meet acceptable professional standards to document the atypical development and to conclude, based on informed clinical opinion, that the child should be considered developmentally delayed.

Note: Examples of atypical developments are asymmetrical movement, variant speech and language patterns, delay in achieving significant interactive milestones such as exhibiting a pleasurable response to a caregiver's attention, and presence of an unusual pattern of development such as a sleep disturbance or eating difficulties.

Q: I would love some clarification on whether using sensory strategies such as brushing, sensory diets and some equipment like weighted blankets and hug vests is contraindicated. This area seemed a bit blurry and I always incorporate these strategies into functional activities for the family, so I am unclear as to why this would be frowned upon.

There isn't a clear easy answer to this question. There is growing research to document differences in sensory processing but there is not yet consensus from the research on the effectiveness of commonly used interventions. There is a need for the research for the evidence supporting sensory intervention strategies. Each of us will need to come to our own conclusion based on the research that is available and your experience. It is important to advise parents that you would like to try a strategy, though there is not yet research to support it. You also need to consider whether these specialized products such as hug vests and surgical scrub brushes are a part of a family's natural environment, and what would be readily available in a particular family's home.. Here is a link to a number of resources that might be helpful:

Posted in link to word document:

- [Sensory Processing Disorder: A call for translational research](#)
- [Validating the diagnosis of Sensory Processing Disorders using EEG technology](#)
- [Effects of sensory integration intervention on self-stimulating and self-injurious behaviors](#)
- [Psychophysiologic and behavioral patterns of sensory processing in children with sensory modulation dysfunction \(abstract\)](#)
- [Developmental sensory disorder: Contributions from a clinical perspective \(abstract\)](#)
- [Sensory gating measured by evoked potentials in children with Sensory Modulation Dysfunction \(abstract\)](#)
- [Twin studies of tactile and auditory defensiveness \(abstract\)](#)
- [Research, summaries and bibliographies Summary of research findings in SPDF](#)
- [Sensory integration/learning disabilities](#)
- [Effects of sensory integration intervention on self-stimulating and self-injurious behaviors](#)
- [A comparison of consultative model and direct intervention with preschoolers \(abstract\)](#)

- Guidelines for Competency in the Application of Sensory Integration Theory
Controversy regarding Sensory integration
 1. The Disorder Is Sensory; the Diagnosis, Elusive - New York Times
Jun 5, 2007 ... A diagnosis of sensory integration problems is not yet generally accepted, expected for three or four years, but the **controversy** is well under way. ... An article in www.nytimes.com/2007/06/05/health/.../05sens.html
 2. Sensory Integration
This site provides information and links to a wide range of web resources www.sensoryinfo.com
 3. Validating the Diagnosis of Sensory Processing Disorders Using EEG Technology (Davies, P.L. & Gavin, W.J., 2007)
www.spdfoundation.net/pdf/davies_gavin.pdf
 4. Lessons Learned: A Pilot Study on Occupational Therapy Effectiveness for Children With Sensory Modulation Disorder (Miller, L.J., Schoen, S.A., James, K., & Schaaf, R.C., 2007)
www.jefferson.edu/JCHP/jshp/ot/documents/Miller_effectiveness.pdf

Q: What is appropriate for a licensed mental health provider in provision of services to the parent/child dyad when the concerns are more complex and may involve post-traumatic stress disorder, deprivation/maltreatment disorder, mood disorders or parent's history of abuse/neglect? How do we address the need to maintain a "safe place" for therapeutic intervention?

If the MH services are considered under the Part C umbrella, then the confidentiality issues would still apply. Respect for privacy issues within the family should always be considered. Also consider what is essential for others on the team to know in reference to the child's progress. For example, if the child is experiencing post traumatic stress disorder and is triggered by bath time due to family violence experienced in a bath situation, it would be essential for a PT to understand this as she helps the family consider safe positioning during bath time. The parent can help make decisions on what the rest of the team may need to know.

M'Lisa Shelden reminds us that the service coordinator could also occasionally be in this position. For example, if the SC has the expertise and the family needs detailed assistance with budgeting...the fewer people involved in those very private conversations would be more respectful of the family - so the SC could schedule separate visits for these supports.

In addition, from the perspective of joint visits, if infant mental health services are being delivered in the context of Part C requirements and as a part of a Birth to 3 team, if the mental health clinician is the primary coach, another person may be coming out on a joint visit in the context of coaching around another area of development and specific questions the family and/or clinician have in reference to the other discipline's area of expertise, which would be the topic of discussion.

If however the mental health clinician was accompanying the primary coach on a joint visit, it would be specific to the questions of social and emotional development concerns, and in support of the primary coach's ability to support the family and the child around these questions. In this situation, the issues raised by the child and/or parent would be relevant for the primary coach to understand and integrate into her work with the family.

As services outside of Birth to 3 are always a family prerogative, if the mental health clinician is working in tandem to but outside of Birth to 3 and Part C services, it would be an "outside"

mental health service and the confidentiality questions would apply, but the individual would not be serving as a primary coach within the Part C realm.

Q: What about how to use the primary coach approach with more involved children?

You are as hands on as you need to be and you provide as many visits as frequently as the team decides based on the child and family IFSP outcomes. The frequency of visits depends upon a family's circumstances, and their expressed feelings of competence and confidence, separate from the severity or complexity of the child's needs. Some children may need more joint visits, and the primary coach may need more support from the team to ensure the family's questions are answered and the specific strategies fit well into the context of the family's everyday routines. Consider that visits may be more frequent as necessary, and are adapted to fit with the family's readiness.

M³Lisa Shelden adds:

“Another aspect is related to the role of supporting parents to support child development, growth, and learning. In the past few months, we've participated in "Lunch & Learn" conference calls with two different states and this was the topic of the calls. We typically share information and stories of experiences that talk about supporting families around how to include their child in their everyday life. Pointing out that sometimes for children with many challenges, life becomes about medical procedures, positioning, medications, suctioning, therapy, etc....and the role of the child in the life of the family is altered to only or largely being about these types of activities. We also make the point that we don't want to belittle the importance of these activities and procedures...that they are a part of the child and family's life and absolutely necessary, but they shouldn't be what life is about. I tell a story about a young child that I worked with who had cytomegalovirus resulting in severe cerebral palsy with quadriplegia. She also had no vision or hearing. When I met the family, their routines were about when therapies would happen (about six hours each week), and administering medications, time off the ventilator, and working with their in-home nursing care staff. The family actually only visited the child in her room...she never left her room. Pretty much, the in-home nurse was dictating what life was like for the child based upon her care routines. When I met the family and asked about what the child liked and what made her happy, they all looked at me like I was crazy. They immediately thought that I did not understand the degree of disability of the child and began to explain to me all she couldn't do. I listened and then shared that I did understand her challenges, but I desperately needed to learn more about what was motivating and interesting to her. The only thing they could come up with was that she liked to be left alone. I shared some information about child learning and we talked awhile and decided to focus on learning more about the little girl's interests. I had learned in training by Kat Stremel (in the 80's) about a strategy in which all of the important people in the life of the child would wear a wristband on our arm. We each then used a specific scented oil on the wristband to help the child identify who was approaching her, touching her, and moving her. I remember just like yesterday that the mom chose peppermint oil. Our strategy was to approach the child and put our wrist next her head in a location where she was sure to "smell" us. It only took a couple of tries and RIGHT away the little girl knew when her mom was next to her. She would smile and rub her face on her mom's arm and move her body excitedly. This was not only fabulous to see in terms of the child's response, but the mother and other family members were ELATED!!! They all began talking and interacting with her more. We learned how to give her choices and anticipated and expected responses from her. All in all, the family really raised their expectations of the child in terms of interaction and intention. Of course, we still addressed positioning needs both for function and prevention, we tried other communication strategies, and fought constant ups and downs related to her medical fragility...but in this journey the child became a real part of the family. She left her room everyday...and even went outside on special occasions. The family also assumed a more appropriate role with the in-home nursing staff in terms of decision-making for the child's activities and participation. I also worked with the nurse

regarding her interactions and engagement with the child. The family was clearly confident about what they wanted for their child AND their family.

This story seems to help practitioners refocus on their role of supporting the family in looking at child participation RATHER than focusing solely on all of the maintenance, prevention, and other procedures the child might need. We cannot do one without the other...life is about more than therapy...therapy should be promoting a happier, healthier, and intensified quality of life defined by the child and family...not replacing it!"

Q: A team is working very hard to write participation based outcomes based on family routines and child interests. The question came up, what if we write an outcome about the child participating at the park by playing with peers and learning to climb on the playground equipment. Does this mean that every visit must then take place at the park until this outcome is met? Are there things we can work on with the family at home that might transfer over to meeting these outcomes at the park, or is this considered "out of context"?

Dathan Rush responds: "What a wonderful outcome! The outcome is just what the IFSP team is choosing to measure. You do, however, want to be sure the context for the IFSP outcome is something that happens fairly frequently. In the sample outcome provided, you would definitely want to have some of your visits at the park, but probably will not go to the park every visit because the family may have other outcomes and/or other activity settings that can serve as the context for your visits and achieve similar results. In this case, the primary service provider and family may focus on other interest-based activity settings that provide the opportunity for the child to play with peers and/or climb around on playground-type of equipment or activities. Depending on the child and family interests, this might include going to a mother's day out group; playing on the swing set in the back yard, building a "fort" in the living room, then crawling and climbing around on it; playing with cousin's at grandma's house, etc."

Q: A Dane Co. team is experimenting with block scheduling. The question came up, how do we revise the IFSP services page when we overestimate the number of visits a primary provider will need to make in order to help the child/family meet IFSP outcomes? What if we estimate it will take 8 visits to meet the outcomes, and then once we begin working with the family, it only takes 4 visits.

Dana Romary responds:

"Knowing the family participated in that conversation makes it even easier because it won't appear as if this decision was made based on what the primary coach wanted without consulting the family. Utilizing Written Prior Notice and then updating the IFSP to reflect the change is, in my opinion, all that is needed."

Darsell Johns adds: "I don't think the proposed services dictate the plan; the needs of the child and family and identified outcomes do, regardless of the form used or policy we are implementing. We want to see the child make gains and should expect that our individualized planning will often lead us down unexpected paths. Documenting the change in an update of the IFSP should be sufficient to demonstrate these gains."

Q: We could use help thinking about how to approach 2 new referrals. The first is a child who has a brachial plexus injury that may require surgery. We would like to introduce a conversation about using a primary coach approach and what birth to 3 services are in context of natural learning environments, but face the dilemma of a communication barrier because the family's primary language is Spanish, a medical team who is insistent that the child needs direct, hands-on and intensive physical therapy, and a family that is reluctant to even participate in Birth to 3. The second is a child who has bi-lateral hip dysplasia. While we do not face a communication barrier with this one we do have to collaborate with a medical team who is again recommending a high level of intensive, hands on therapy. The teams working with these families are really committed to approaching both scenarios with a commitment to using a primary coach style of interaction and

framing up Birth to 3 in the context of natural learning opportunities, but are a bit stuck in where to even begin considering the outside influences they face.

M²Lisa Shelden responds: “ First off...I must say what a thoughtful and mindful presentation of the questions and issues at hand. It is apparent that this team is working hard!!! Let's take scenario one first...A non-English speaking family with a child with brachial plexus injury.

Key points:

1) What is the research related to interventions for BPI?

So, taking the age of the child into consideration, the level and severity of the injury will inform us more about what the medical team has in mind when they are recommending intensive PT. It would also be nice to know if they are considering this child as a candidate for surgical repair of the injury and if so...what timeline they have planned.

Knowing this information would inform us of what type of exercises (yes, I said exercises) we would need to show the family members how to do. Since I do not know the age of the child, I will need to speak generally...as we know, we must prevent any further complications from developing secondary to the injury. So, range of motion of the arm, using what active movement is available, or if this is an older child and some loss of range is present...a plan for increasing those limitations would be appropriate. ALSO...positioning of the extremity is critical. So, if this is an infant, immediately we must move to supporting the parents and other family members regarding how they hold the child when awake and asleep, how they position the child for sleeping when out of arms, how they encourage movement of the arm...etc. In some cases splinting of the hand and extremity would be appropriate...we can do this and support the family in how to apply and remove the splint and how to watch for possible problems with the splint. We would also need to visit the family (always with an interpreter - either formal or informal) with adequate intensity to ensure the family knows how to do ALL of this as a part of their daily routine. So, using our assessment to gather information about the families routines, activities, interests, etc. all still applies. Additionally...identifying child interests and enhancing the child's participation in the identified activity settings is crucial.

2) Who should be the PSP?

We can look at this a couple of ways...If the medical team wants a PT...them assign a PT. We'll also assign our other core team members to help as needed by the PT. OR...the team could follow the regular procedure for identifying who would be the best PSP...for example...if you had an OT that was bilingual...and a PT that was not...(see what I mean). The focus on the child's injury and prescribing a service for that injury is limiting. We are early intervention...we are not going to limit the family's supports to only focus on the injury...that is not early intervention...so we can't and don't want to do that. We are going to consider ALL of the child and family factors and put forth our best option to the family.

In terms of identifying the PSP, as this team knows...they have options...it just depends on which road you and the family want to take.

3) What is intensive PT?

What does intensive PT look like to this medical team? I would ask. Because...what I've described sounds pretty intensive to me.

My point is...don't balk at the notion of intensive PT being prescribed. You might OR might not want to offer up a different PSP, but certainly we can all agree that frontloading services for this family is a must. We have a LOT of support to do and we need to get in there and be responsive to the family's concerns and help them to feel confident and competent about their abilities as well as to RELAX and ENJOY their baby and family.

Don't worry...I'm not going to start up again on scenario 2. The same decision-making process would apply. I hope I also made the point that this isn't so much about what type of teaming approach we use, but IS about our knowledge of evidence-based practices. Early intervention, when evidence-based makes BIG differences for children and families. We understand the medical team wanting to do their job...fix that arm! We happen to have a bigger, more complex job...ensure that family knows how to support their child to maximize the baby's growth and

development AND achieve their family's hopes and dreams. Our work isn't for the faint of heart...we're good at what we do...help the medical team know that you understand what they want and need AND why you can do it better!"

Q: I often do not see children for intelligibility issues before the age of 3; however many parents are very concerned that their children are so difficult to understand. So, in the event a child is considered eligible based on intelligibility, I wonder how you make this most natural. I have been trying to 'set up' situations that contain intelligibility targets within preferred activities - e.g. emphasizing final /k/ in the words 'truck', 'track', 'stuck', 'park', etc. while playing with a child who loves vehicle play. But, not all targets lend themselves as easily. My team and I struggle with the need to make intervention as natural as possible, while still providing appropriate targets at a rate that is considered 'bombardment' and appropriate to speech therapy. What is your view on bringing target cards into the home and incorporating them into preferred activities - e.g. like having the child drive over cards with their truck and say them as they drive over them? Many professionals seem to think of this as a form of assistive technology. Of course, I still see it as vital to work anything brought into the home into a natural activity, explain the purpose, and allow parents to try the strategies.

Dathan Rush responds: "We get this type of question frequently. I think we have similar views on the intelligibility issue for children under three years of age. If you have not already seen it, I would refer you to an article by Alan Kamhi in LSHSS, Volume 37, p. 271-279, published in 2006. The article is titled, "Treatment Decisions for Children with Speech-Sound Disorders." As Kamhi reviews the research, he quotes Shriberg (1997) indicating that 75% of children with speech delay normalize their speech sound production errors by age 6. Of the 25% who do not normalize by this time, 25% normalize by age 9. I use this information to help with my decisions and to share with parents. When parents are particularly concerned, then I go through the process of identifying interest-based activity settings with them and opportunities to promote correct articulation for developmentally appropriate phonemes and phonological patterns.

If a child is eligible for early intervention and has significant intelligibility issues and this is a priority area for the family, then we go through the process of identifying everyday interest-based activity settings for the child/family that provide opportunities for communication. Rather than bring any materials in with us, we would use what they have and work with the parent about how to be responsive to the child. In this situation, that would include identifying target words and sounds that would be part of an activity, and then ensuring that they come up a lot within the context of the activity, thus providing the child with multiple opportunities to naturally use the sound/word/etc. For example, if the child likes books, then we would work with the parent to find books that contain the target sound(s) or talk with the parent and/or model how the target sounds can come up during book reading even if not a lot of them are included in the text of the book. If the child likes to play in the bath, then we would work with the parent to come up with ways the target sound(s)/words to occur frequently during that time. If the child likes books, but the family does not have any or very many, then we would talk about ways for the child to have access to books (i.e., the library). Then we would discuss characteristics of the books that we would look for (i.e., child interest and containing target sounds). In this way, we are building the family's capacity to provide support for the child's articulation when you are not there and using things that they already have or can access easily within the community. "

Q: A pilot team is serving an Amish family that lives some distance away (1 ½ hours) and has selected the SLP as the primary coach. The progress this little gal is making with the integration of sign and her increased communication ability is amazing, and the family concerns have shifted radically to the mobility concerns. The PT has been providing some joint visits around mobility, leading into readiness on the family's part for orthotics and a walker. For a number of weeks, the PT will need to go out regularly to assist with the fitting, and the use of these pieces of adaptive

equipment. The weekly joint visits for a lengthier period of time are burdensome, as a funding source has not been identified to pay for the second therapist.

Questions: Understanding the limits on the change of a primary coach (switching from the SLP to the PT), is it ever acceptable in such a situation to have the PT go out without the primary coach, to concentrate on the current concern? The team describes their intention to embrace the primary coach best practice with fidelity, but finds in the above described scenario a real funding burden.

M'Lisa Shelden responds: "First off, thanks for the thoughtful question. It is very clear that this team is carefully considering the risks and benefits of moving away from one of the implementation characteristics of a primary service provider approach to teaming (i.e., that joint visits must happen on the same date/time). Considering the circumstances and the thoughtful discussion that surrounds this situation, we would support the team in implementing separate visits on a short-term basis. Having separate visits, however, does create more work for both the primary provider and the secondary coach. The PSP will be required to have some additional conversations than would otherwise be necessary...for example, preparing supporting the parent(s) in what will need to be addressed when the secondary coach is there; the debriefing between the PSP and secondary coach about what happened at the visit; and the follow-up conversation with the parent(s) following the debrief. This implementation condition is not intended to place undue hardship on a program...in fact, for the opposite reason - to ensure efficient communication and support across team members. We would also encourage the team to continue to evaluate the situation. This might be one of the rare circumstances over time that may require a change in PSP. For example, if the short-term separate visits end up not being short-term and the SLP is feeling unable to support the family with the support of the PT...the team should then discuss (absolutely including the family) in the pros and cons of changing or not changing the PSP".

Q: Are you using the Primary Provider Model with all families or on a pilot basis? Are you using the Primary Provider Model for medically involved children?

Dathan reminds that this is not a model, but an approach. It is a team approach, where every child has access to multiple disciplines but the one main liaison (primary coach) is surrounded and supported by the other disciplines. All disciplines share some common knowledge, and each practitioner practices within his/her own scope with additional support offered through joint visits. The level of support is defined by the outcomes on the IFSP and identified needs for support from the family and/or practitioner. See the story from page 12 of this document about a young child who had cytomegalovirus resulting in severe cerebral palsy with quadriplegia. This story seems to help practitioners refocus on their role of supporting the family in looking at child participation RATHER than focusing solely on all of the maintenance, prevention, and other procedures the child might need. M'Lisa also cited the research on family-centered care and the need NOT to increase family stress. See citations:

Dunst, C. J., Brookfield, J., & Epstein, J. (1998). *Family-centered early intervention and child, parent and family benefits: Final report*. Asheville, NC: Orelena Hawks Puckett Institute.

Shonkoff, J., Hauser-Cram, P., Wyngarden-Krauss, M. W., & Upshur, C. C. (1992). Development of infants with disabilities and their families: Implications for theory and service delivery. *Monographs of the Society for Research in Child Development*, 57(6, Serial No. 230).

Sloper, P., & Turner, S. (1992). Service needs of families of children with severe physical disability. *Child: Care, Health, and Development*, 18, 259-282.

Q: Have families asked why an OT is providing speech or physical therapy services? Have you felt that you have been asked to provide services outside of your scope of practice?

Let's revisit the understanding about the primary coach's role. The context of everyday activities, which are the focus of intervention, is not divided into domains of development, but fully integrated. The discipline specific practitioner is the facilitator of supports within that context. For parents new to early intervention who begin with this approach, there are typically not questions unless a clinic or physician visit inspires a clarification. Within the activity setting (for example: sand box), whomever is there supports the participation, we all need to know how to do that with the understanding of the basics of development, parents included. The specialized knowledge/information a discipline offers within that context should build capacity and NOT create dependence on the practitioner. It is unethical for the professional to hoard information/keep it to her/himself. Role release looks at what WE should do, how we share information, and who we share information with.

Q: Some therapists have expressed that they feel like they need to be available to families as the primary coach after hours in a few very rare circumstances, such as when working on feeding and transitioning to different foods/solids when choking or aspiration might be of concern.

M'Lisa supports this intention to be responsive to families, and flexibility in scheduling. She also cautioned the flip side about creating dependence versus building capacity, and the need to examine the family's natural "back-up" plan that is not the early interventionist. Balance the heightened sense of responsibility and awareness encouraging flexibility without supplanting the family's natural support systems and capacity.

Q: If an SLP is engaging in an activity-based outcome around playing in the sandbox and the child falls and is injured when she and the parent help the child get into standing while also supporting the child's communication, what is the liability? Is she practicing outside of the scope of practice in assisting the child to move?

M'Lisa and Dathan remind us that the parent's participation in any activity reduces the liability. There are always liability concerns whenever a child may be injured, in every setting, whether home-based or clinic. The question about "practice outside of scope" does not appear to apply in that sand play involves the child moving about whether the practitioner is focusing on language, movement, social engagement, cognitive and learning opportunities, etc.

Q: We have children in our program who have a number of outcomes including one related to feeding, yet the feeding specialist isn't the primary coach. We have weekly team meetings so that the feeding specialist and the primary (and secondary) are able to meet. In our program, due to liability issues, no one but the specialist works on feeding. When there are no motor or sensory issues related to feeding, does the feeding specialist always need to do joint visits?

Response by Becca Jarzynski, M.S., CCC-SLP, Preparing Mentor for the Birth to 3 Crossing Borders Initiative

You seem to be asking, "If there are feeding outcomes listed for a child, is it required that a feeding specialist go on joint visits for that child?" After careful review with Dathan and M'Lisa and the Birth to 3 Leadership team, here is the answer to your question:

1. When using the primary coach approach to teaming, there is no set criteria that establishes if or how often any specific team member has to make joint visits, other than the following: Joint visits are used when a primary coach's questions cannot be answered without the other team member

observing the situation, when the other team member's questions cannot be answered by the coach without direct observation of the situation, or when a parent requests access to another team member.

2. Each discipline has a scope of practice within which they are allowed to provide evaluation and treatment. According to ASHA, for example, it is not appropriate for SLPs to be asked to train others to perform professional level services unique to SLPs or for SLPs to perform services outside their scope of practice. This should always be taken into consideration when planning for joint visits.

When using a primary coach approach to teaming, then, the team's challenge is always to determine when the primary coach has enough knowledge and skill to coach the family on his/her own and when a joint visit is called for. In the case of feeding, this might depend on variables such as the types of feeding difficulty and the type of outcome written (e.g., is it a child who is tube fed who has an outcome to move safely to oral feeds or a child with autism who demonstrates challenging behaviors at the dinner table?). It would also depend on the specific discipline of the primary coach (e.g., is the primary coach a teacher whose scope of practice does not include assessing and treating feeding progressions or an OT or SLP whose scope of practice permits this?). These variables, along with the specific knowledge of the primary coach, would need to be weighed when deciding if joint visits are needed. Take, for example, the following three scenarios which highlight the different need for joint visits.

Child A presents with challenging behaviors at the dinner table and a limited diet. One of his outcomes involves sitting for mealtimes and trying new foods. His primary coach, a teacher, discusses his case at a team meeting where the feeding specialist, an OT, is present. The primary coach presents information on the current diet of Child A and also provides information about the strategies Child A's family has already attempted to use with Child A. Due to previous evaluations and discussion with the teacher, the team feels comfortable that there are no motor or sensory difficulties contributing to the difficulties at mealtime. During the team meeting, the teacher receives coaching from the feeding specialist to help determine what foods and strategies might be best to try with Child A in his home. In this case, a joint visit with the feeding specialist might not be needed.

Child B is a one month old child who is tube fed. His outcome involves moving safely to oral feedings. A PT was chosen as the primary coach because she has experience with medically fragile babies and the team expects there to be long term mobility issues for which the PT will be a great match. As M'Lisa pointed out at the second Intensive Institute, joint visits from a feeding specialist are most clearly indicated in scenarios like this when evaluation and on-going assessment is required for feeding progressions. She described a scenario much like this one and explained that joint visits from the feeding specialist would be required to assess the child's readiness for an oral diet. During joint visits, the feeding specialist would also work with the primary coach and the family to help them determine what is needed to be done between visits to ensure Child B was getting enough nutrition. When the feeding specialist had determined that Child B was ready for an oral diet, the feeding specialist would do as many joint visits as needed to determine that Child B was feeding safely. When the child was feeding safely, the feeding specialist would work with the primary coach and the family to help establish how the family will carry out feedings between visits, would work carefully with the primary coach to determine how coaching will take place when the specialist is not at visits, and might also provide information about red flags that would indicate that the child would need to be seen by the feeding specialist immediately. The primary coach would then continue working with the family without the feeding specialist present. Joint visits would be done only as frequently as the team felt necessary to reassess the child's safety or continue feeding progressions.

Child C is a one month old child who is tube fed. His outcomes involve moving safely to oral feedings. An OT is chosen as the primary coach because she has experience with medically

fragile babies and is beginning to develop competence in working with children with feeding challenges. There is a feeding specialist on the team who happens to be an SLP. The OT (primary coach) might do some initial visits without the SLP (the feeding specialist) that involve coaching the family to provide oral stimulation for Child C because the OT can do this independently. Then, as needed, the SLP/feeding specialist might do an initial joint visit to coach the OT in assessing the child's readiness to move to oral feedings. The OT might then work with the child and family independently for a while as they reassess the child's readiness together. When the child is ready for oral feedings, the SLP/feeding specialist might do another joint visit to coach the OT as needed as she works with the family to actually establish the oral feedings. Since the OT's training and scope of practice allows for the assessment and treatment of feeding disorders, fewer joint visits might be necessary as they work to establish oral feedings. Eventually, joint visits for feeding cases might not be needed at all.

The beauty of the primary coach approach to teaming is that a team is always building their capacity through joint visits and team meetings. The end result of that capacity building is different, of course, depending on the scope of practice and training of each practitioner. A teacher would not be expected to learn to assess and progress feedings; however, a teacher might learn broad strategies for successful mealtimes that she can use to independently coach families of picky eaters with challenging behaviors. An OT or an SLP, on the other hand, might eventually build enough capacity that she is less dependent on the feeding specialist's joint visits to complete more complex skills such as the progression of feedings.

EVIDENCE QUESTIONS:

Q: I'm trying to find experimental research studies that have been published in peer reviewed journals that back up the idea that having one provider in a home is more effective for both the child and the family than is having multiple providers in the home.

M³Lisa Shelden responds;

1) First of all, it might be helpful to understand that little to no experimental research studies exist in the field of early childhood. This question may just actually mean published studies...but the term experimental implies control and experimental groups...these studies are few and far between.

2) Also, there are no peer-reviewed published experimental research studies in journals that support having multiple providers go into families home to work the child. None exist.

3) The challenge here appears to be isolating the PSP teaming approach from the rest of the literature. So...because we have mountains of research about the importance of parent-child interaction (NOT therapist-child interaction) see Gerry Mahoney's website <http://www.responsiveteaching.org> and we have mountains of research on parent-mediated child learning opportunities...the use of primary provider is the most efficient and effective mode of intervention built upon a strong relationship with the caregivers.

4) Also look up the published studies from the Research and Training Center on Service Coordination at the University of Connecticut and read the report from the Pennsylvania study that is referenced in the Primary Coach Approach to Teaming on <http://fippcase.org/> (Dunst, C. J., Brookfield, J., & Epstein, J., 1998, December). Family-centered early intervention and child, parent and family benefits: Final report. Asheville, NC: Orelena Hawks Puckett Institute.

5) It is encouraged to go to the end of the CASE papers to the bibliographies and read those peer-reviewed published articles. Also, a project with NECTAC (National Early

Childhood Technical Assistance Center) is currently in the works that will identify research-based articles that support each one of the Guiding principles for early intervention...in the future this will help.

Here are some other helpful sites:

<http://www.coachinginearlychildhood.org>

<http://www.disabilityisnatural.com>

<http://www.poweroftheordinary.org>

<http://www.researchtopractice.info>

<http://everydaylearning.info/nlSources.php>

Q: I think the biggest challenge is getting the IFSP to actually reflect the services provided to families. It is difficult to capture a relationship and the depth of conversation and understanding that we have with families in regard to their daily routines and how they spend their time. Time and routines are dynamic and the responsiveness of the provider is essential. It still remains a challenge to reflect much of what takes place with families in the IFSP document and how to make the “document” as responsive as the service.

Keep going through the articles at <http://fippcase.org/>. The CASEmakers, CASEinpoints, BriefCASES and CASEtools articles may be of help.

You may also be interested in the article “Tips and Techniques for Developing Participation-Based IFSP Outcome Statements” at

http://www.http://fippcase.org/briefcase/briefcase_vol2_no1.pdf

Dathan Rush reminds us:” Coaching, use of natural learning environment practices, and a primary coach approach to teaming are not "service delivery models," but rather elements of evidence-based practices in early childhood intervention. We are required under Part C to use evidence-based practices. We have to be sure that "individual" as defined by some providers and families does not mean the use of preferred practices that may not be supported by research.”

The OSEP /NECTAC document *Seven Key Principles: Looks Like/Doesn't Look Like* also states in Principle Six: “The family’s priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support” and in Principle Seven: “Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations.” You can find this article at:

http://www.nectac.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf

Q: I understand that research showed parents were more SATISFIED with the coaching practice, but I wonder did the child show more PROGRESS?

The outcomes and benefits used to judge whether early childhood intervention and family support is effective include a number of measures of child, parent, and family functioning and capacity building. *Early childhood intervention and family support practices are considered effective only to the extent that children, parents, and families become more capable and competent.* These types of outcomes include, but are not limited to, improved child development and interactive competence, parent well-being, parent empowerment, parenting competence and confidence, and family quality of life. Major emphasis is placed on assessing both child and parent self-efficacy as indices of improved mastery and sense of one’s own capabilities. This is the case because persons with strong self-efficacy and personal control beliefs are more likely to use their capabilities to

produce desired effects and life circumstances (Coleman et al., 2002; Skinner, 1995; Zimmerman, 1990).

Early childhood intervention and family support are defined as the provision and mobilization of children's learning opportunities, parenting supports, and family and community resources in a family-centered manner. The intersecting and overlapping elements of the model include the contexts for children's learning opportunities (activity settings), the methods and procedures for promoting child competence (development-enhancing parenting styles and practices), and the experiences afforded parents strengthening existing and promoting new parenting competence (participatory opportunities). Additional information about the integrated framework can be found in our [CASEinPoint \(Volume 1, Number 1\)](#) and [CASEmakers \(Volume 1, Number 1\)](#) publications.

In addition, from M'Lisa Shelden: "The comment about IFSP outcomes being met faster when using an evidence-based approach in early intervention comes from several sources: 1) The pilot study manuscript clearly depicts this outcome for the children involved in the study (a study Shelden and Rush are intending to publish); 2) When we were working with Georgia with three pilot teams, the teams requested the shift to writing outcomes for periods of three months rather than six months because they were having to schedule the reviews earlier because the outcomes were being achieved sooner than they had been in using a different approach. ALL other states we have worked with are also reporting this and the majority use a three month IFSP period as the rule rather than the exception.

The notion behind this does go back to a study by Bruder & Dunst, 1999 (Zero-to-Three) from the Child Learning Opportunities series of studies...the children who experienced focused work on skill development consistently had FEWER learning opportunities than those children who were afforded enhanced opportunities to participate in everyday life. Young children develop skills based upon participating in life...not because of drilled practice and instruction on discrete skills. The concept of generalization (research as far back as the 1950's) also supports the use of natural learning environment practices to promote achievement of child outcomes. Additionally, the Dunst, Trivette, Bruder work DOES talk about child outcomes...3500 children were involved in the studies. Also...Gerald Mahoney's work (go to responsiveteaching.org) or read Relationship-focused Intervention (2009) - can download full-text from the internet (International Journal of Early Childhood Special Education, Vol. 1(1), 2009...the MOST important predictor of child development is parent-child interaction (NOT therapist-child interaction).

So much is available to support the practices that it can be a bit overwhelming...in contrast, little-to-nothing is available to read that supports decontextualized, therapist-child interventions focused on skill acquisition. Therapists can absolutely be assured that working on acquisition of skills through participation in everyday routines is the BEST and most efficacious approach to supporting enhanced child development".

Here are some additional resources on outcomes for children using these approaches:

Bruder, M. B., & Dunst, C. J. (1999-2000). Expanding learning opportunities for infants and toddlers in natural environments: A chance to reconceptualize early intervention. *Zero to Three*, 20(3), 34-36.

Dunst, C. J., Hamby, D., Trivette, C. M., Raab, M., & Bruder, M. B. (2000). Everyday family and community life and children's naturally occurring learning opportunities. *Journal of Early Intervention*, 23, 151-164

Q: As I work with several people around instituting evidence-based practices and I go to trainings that mention—there is research on this technique—I am wondering how to know if the research being mentioned is “good research”.

This is a great question. Many of us look beyond the underlying meaning and the foundation of “Evidence Based Practice” and delve directly into the implementation process. It’s absolutely necessary for us to define EBP and to have a uniform understanding of its meaning before we can ever begin implementation.

Many professional organizations have developed definitions of EBP including The American Psychological Association, The Institute of Medicine, Council on Social Work Education, Center for Mental Health Services and The Council for Exceptional Children. Although some professional organizations including APTA, AOTA and ASHA do not define EBP they go to great lengths in defining characteristics of EBP in early intervention and how it relates to their specific discipline. Even more relevant to Birth to 3 is the Individual’s with Disabilities Education Act (IDEA) which requires special education (including early intervention / Part C) to base their practices on evidence gathered via research and for the research to be peer reviewed and to verify that the practices are based on evidence not chosen for convenience or by personal preference.

The EBP movement began with the work of British physician Archie Cochrane who sought to identify “treatments that work” using the results of research evidence. Another important aspect of Cochrane’s interest was to identify and end treatments that do harm or are not effective. In practice, the idea was to supplement professional decision making with the latest research knowledge. The goal was to enhance the scientific base of professional practice in several disciplines – medicine, nursing, psychology, social work, etc. In turn, educational efforts in these disciplines could be oriented to provide beginning professionals with effective tools and a model for the continuing improvement. The one common thread across all definitions of EBP refers to applying the best available research evidence in the provision of services to enhance outcomes. And, specific to Birth to 3, families must have a key role in the research, selection, design, and implementation of EBP. Families often present first-hand evidence of what and does not work for their child and family.

Finally, how to determine if techniques are evidence-based? In reviewing the research there is a 5 step process for evidence-based decision making

1. Pose the question.
2. Find the best available research evidence.
3. Appraise the evidence quality and relevance.
4. Integrate research with values and wisdom.
5. Evaluate.

Also, access further information at <http://www.nectac.org/topics/evbased/evbased.asp>

Keep in mind that different organizations and programs establish different criteria for an evidence-base. Some require randomized or quasi-experimental design while others include single subject or a combination of experimental and single subject designs. Some criteria require multiple studies on the same practice. Some, such as the one proposed by Buisse and Wesley identify the role for professional wisdom and values to help ascertain the efficacy of an intervention.

Here is a decision-making process that integrates the best available research evidence with family and professional wisdom and values.

<http://www.recognitionandresponse.org/content/view/101/113/>

One important variable across all criteria is the quality of the studies that deem the practice to be evidence-based. It is also important to carefully consider the research question being asked. Examine the outcome the research supports and the measurements used to study the question. For Birth to 3 it would be important to understand the context for establishing the efficacy of an intervention. For example, a critical examination of whether or not the results

of a study conducted in a clinical setting discuss implications for generalization to other settings and circumstances.

This is another excellent resource:

Evidence-based Practice in the Early Childhood Field [Paperback]
Virginia, Ph.D. Buysse (Editor), Patricia W. Wesley (Editor)

BILLING QUESTIONS

Q: A provider was scheduled for a 60 minute visit, and was engaged in an important conversation with the family, so the visit ended up lasting for 75 minutes. Because they blocked 8 visits in 12 weeks, they wondered if the next visit should be reduced to 45 minutes to balance that extra 15 min. from the previous visit?

M^lLisa Shelden responds:” It seems the answer to this question would need regional/local interpretation. My understanding, however, is that when frequency and intensity are specified...the IFSP is "covering" or "promising" for example six, 1 hour visits. If repeatedly, these visits last for longer or shorter amounts of time, then the IFSP should be changed to reflect the accurate amount. I am not sure about billing...but it appears that most of the time a provider is approved for a number of units over a particular time frame. As long as the provider does not exceed the amount approved for the time frame, then it seems the provider would be paid. So...yes, monitoring and adjusting your cumulative time across the approved billing time frame would ensure that a practitioner does not exceed approved billable units.”

Q: How billed to MA? How billed to a 3rd party payer?

Billing practices and documentation do not change. Providers still utilize their specific billing codes and documentation. Observation, action/practice and informative feedback are expected components of each coaching session and are your billable services that link with the IFSP outcomes as billable practices. What is changing is the focus on making certain that IFSP outcomes and provider practices and feedback are fitting within the context of the family’s routines and activities, and that reflective questioning and joint planning leads towards family’s increased confidence in implementing meaningful strategies during daily routines between visits.

Q: How does billing work when you go to a home and the child is sleeping but you still stay and coach the adult? It’s our understanding that the child needs to be present to bill.

You are correct. If the child is not able to be a part of the visit, the visit could not be billed.

Q: How do services get documented on Program Participation System (PPS)?

Currently services are documented linked to the discipline of the provider who is delivering those services, so you will continue to document in this way.

Q: Say our team decided to implement primary provider and I, as an SLP, was chosen to be the primary provider for a child with a wide range of needs. Then pretend I spend an entire session with a family talking about gross and fine motor concerns. How could I bill for this as an SLP, since I would have no objective data that would relate to the plan of care I had written (which can only include speech/language goals, as that is all that is within my scope of practice to treat)?

M^lLisa Shelden responds:

1) If indeed a SLP spent an entire session talking about gross and fine motor activities it would not be billable to a third party payor.

2) It is difficult to conceptualize a situation in which this would occur if the SLP were using evidence-based practices that support natural learning opportunities. It would be unusual to identify any real-life activity setting that only involves gross and fine motor skills.

3) Practitioners need to be using natural learning environment practices in order to think about the use of a primary provider approach to teaming.

4) Let's say in this example that the SLP has used the ABC-Matrix or Interest-Based Checklist or the Routines Based Interview (RBI) and has identified with the family that they are challenged by mealtime...particularly because the child has language, cognitive, and motor delays. Because of these delays and because the child is so messy during mealtimes parents feed the child for her. As a part of supporting the family around mealtime the discussion would include information about self-feeding and how allowing the child to have this new opportunity will help the child learn new skills and refine existing skills. As a part of this discussion, the SLP would also discuss and reflect upon with the parent opportunities to support interactive communication, independence, and problem solving. This would be a billable event by the SLP.

5) It seems that this SLP also imagines herself working with the child on stacking rings or playing with puzzles or putting objects in and out of containers. If these are indeed activities that the child likes and the parents currently implement with the child during play together, the SLP could indeed offer the PARENTS support around these activities BUT would also be discussing the other developmental aspects of the playtime including communication, problem solving, gross motor, and the social-emotional aspects of parent-child interaction. This would also be a billable event by a SLP.

6) Say for example, you happen to be a the primary provider, a speech therapist, talking with the family about the child playing in the sandbox with siblings. You are discussing with parents ways for the child to communicate with siblings about sharing the shovel, and asking for help getting out of the sandbox. The parent begins to ask a lot of specific questions about how to best position her child in the sandbox. This is when you should use your professional judgment to determine if it would be best to talk with your teammates and possibly plan a co-visit with a person with more specific knowledge around positioning (perhaps a PT or an OT). Before the end of every home visit, it is important to plan jointly with the parent for the next visit, including the time, date, and location. If that plan centers around an activity, such as sandbox time where movement is also a family concern in addition to communication, an arrangement or plan for the OT/PT to join the primary provider might be made. This ensures appropriate ways of addressing a parent's concerns through the use of a team so as to avoid asking one professional to go outside of their scope of practice and billing capabilities.”

Q: In follow-up to above question, my follow up billing questions are:

1. In the scenario explained under number 6, where the PT and the SLP do a joint visit, would both the SLP and the PT bill for the session? Is this allowed under MA? (I was thinking that joint visits had to be prior authorized).

2. From the scenarios above, I think I am understanding correctly that the intent is for a therapist (or a teacher) to address all developmental aspects of any given activity. The example under number 4, with eating, might involve positioning for eating, using hands for eating, and communication during eating. So say a particular session revolved around all those things and an SLP was the primary coach. Two questions about this one:

2a. Would the daily documentation for the visit contain objective data for the positioning, the fine motor/hand use, and the communication? If so, wouldn't this create a problem in linking it back to our plan of care, which only contains SLP goals?

2b. Would the entire session be billable under 92507 (speech/language therapy) even though only part of the session revolved around coaching for communication and the rest of it revolved around coaching for positioning/fine motor hand/utensil use?

Response from M’Lisa Shelden:

- 1.) If prior authorization for billing of therapy services is required, then you are correct...the therapists could not bill unless approval had been received...that's why when planning the IFSP it is a good practice to try to anticipate what supports the primary coach will need if at all possible...this would then cut down on delays in supports because of payment issues. Unless a consultation code exists, in most places therapists cannot bill for services provided at the same time. So, they might need to choose who would bill or split the time. The previous answer also still holds...as in any model, the practitioner must decide what percentage of his/her visit is billable based upon the content discussed as it relates to the plan of care that has been submitted to the third party payer.
- 2) YES...your understanding is correct.
 - 2a) The data documented for that specific visit can contain whatever the practitioner feels pertinent. The third party payer cares ONLY about what they are paying for that is related to the plan of care and that requires the specific expertise of that particular discipline.
 - 2b) In most places...for SLP the billing is tied to the visit (the procedure)...not a specific amount of time or unit of time like it is for PT and OT. If, however, this is not true and SLP billing is for a specific unit(s) of time, then regardless of the model used, the SLP would need to determine what portion of the discussion was related to her approved plan of care and required her SLP knowledge and expertise.

Q: How might there be increased funding to look at this model?

There are several Wisconsin initiatives moving forward that could help support this work, including some potential “un-reimbursed therapy” reimbursement and special education billing. If the team meeting and joint visit costs are not reimbursed, the Birth to 3 Part C dollars received by your county from the State of Wisconsin could help pay for those costs. Though Part C is the “payer of last resort”, if these costs are not reimbursed through your current billing practices, you could utilize the Birth to 3 dollars the county receives.

Q: Are therapy services billed to insurance and Medical Assistance? In the Primary Provider Model, how is non-direct time billed?

M’Lisa reminded that this is not a “model”, but an approach, that includes three components: natural learning environments, primary coach approach to teaming, and the way we interact/coach the adults in the child’s life. Refer to the Seven Key Principles from NECTAC document, key principle # 6. The billing for the discipline is based on a deficit needing the particular expertise of that discipline, and the demonstration of progress over time. It is expected you provide information to the “caregiver” of a very young child as a part of the therapy intervention (example of a Grandpa with Alzheimer’s after a hip replacement and informing the nephew/caretaker of safety and precautions). There is no need to divide the session by direct/non-direct.

Q: When we are doing joint visits, what documentation needs to be in the file for billing purposes? We are doing home visit notes and leaving a copy with the family. If they both sign this, will this be enough for an audit etc.? We want our home visit notes to reflect the joint plan.

First, examine the need or specific purpose of having the secondary coach present in the home. If the time is split among the two therapists it would be necessary to track the amount of time each

therapist spent with the family/child. It would not be possible to bill for the entire session for BOTH therapists.

Third party payers reimburse for medically necessary services that require expertise to remediate deficits and promote skill acquisition, which is the ultimate result of early intervention.

The manner in which the practitioner(s) delivers the service should not be dictated by the payer. Part C of IDEA does, however, state that supports and services should be provided in the child's natural environment and be designed to promote the competence and confidence of care providers to enhance the child's growth and development through participation in everyday activities.

Coaching is the evidence-based strategy the practitioner uses to interact with parents and care providers to maximize child progress both when the practitioner is and is not present. Mediating parents' knowledge and skills is an added benefit of the use of coaching practices. The practitioner is not, however, billing the third party payer for how he/she interacts with the parent or care provider (i.e., coaching), but rather for the time and expertise necessary to achieve the developmental progress of the child.

Q: If a child would have a PT as the primary coach and SLP as consult, how is it written into the IFSP? As consult, does that mean discuss at a team meeting or face to face visit at some pre-determined amount or a combination of both? How is that time billed and written up on a 90 day note? Also, can Service Coordinators bill for ongoing discussions for those children in a team meeting? If they meet 10 minutes with a PT and SLP, do they bill 10 minutes or capture 30 minutes for everyone?

First, it's important that we address the use of "consult" vs. "secondary coach". Much confusion can arise when using the terms "consult" and "secondary coach" interchangeably. To eliminate confusion "secondary coach" is the preferred term when discussing a "joint visit" in which a fellow colleague of a different discipline accompanies the primary coach on a visit.

For further clarification around the differences, see

Misperception 10: Coaching is the Same as Consultation.
February 2008 Volume 4, Number 1 CASE inPoint

Second, DHS Birth to 3 is developing guidance around the specific question about how to document "primary" and "secondary" coaches within the IFSP. This guidance is to be available in the very near future.

Third, "as consult does that mean discuss at a team meeting or Face to Face visit at some pre determined amount or a combination of both?", the simple answer is "yes", it would be appropriate (and expected) for ALL team members (all disciplines) to be available during weekly team meetings and when appropriate and necessary become a secondary coach as part of a joint visit. As far as billing, nothing has changed in regards to the guidelines for Birth to 3 and MA billing.

Fourth, "Can Service Coordinators bill for ongoing discussions for those children in a team meeting?" Again, the MA requirements for service coordination billing have not changed. Here is the MA document specifically addressing SC and billing.

<https://www.forwardhealth.wi.gov/kw/pdf/casemanagement.pdf>

Coming soon, additional resources to support Wisconsin Birth to 3 Teams in implementing the primary coach approach to teaming within natural environments.
September 2011