Preface

In 1985, M'Lisa L. Shelden was working as a physical therapist at a residential facility in Oklahoma, where many of the residents were deemed (by school personnel) unable to attend the segregated school on the campus. Because of this, physical therapy sessions became the big event of their day. With the work of Lou Brown, Michael Giangreco, and others in her head, M'Lisa began to visualize a different approach for physical therapy. With support from the administration (Jerry Poyner, Superintendent), the notion of what the life of residents could be began to shift, and the therapies became the strategy for supporting participation in real-life activities; a means to an end . . . not the end. For some of the residents, this meant leaving the facility for jobs or new lives in their home communities. For others, this opened the door to attending school, increasing independence in self-care, and planning for life beyond the residential facility. Instead of physical therapy sessions focusing on attainment of developmental skills, the strategies employed often involved the use of assistive technology to support access, participation, and independence. The intrusion of the therapy supports into the lives of the residents became one of the major challenges in implementing this approach. The number of times each day or week that classes, mealtimes, or leisure time was interrupted by the different therapies actually became problematic. The shift to supporting the residents in their daily activities was the impetus for M'Lisa to return to graduate school to learn more about educational support for young children, especially those with severe challenges. She was on a mission to learn more about teaming approaches, more specifically transdisciplinary teaming. During her master's degree program and continuing into her doctoral studies, M'Lisa focused on learning about inclusion and teaming approaches that supported families, teachers, and children with severe disabilities.

In 1990, M'Lisa joined the faculty at the University of Oklahoma Health Sciences Center. One of her primary roles was to support the newly formed statewide SoonerStart early intervention program in hiring therapists and implementing recommended practices. The SoonerStart program had made the decision to implement a transdisciplinary teaming approach. M'Lisa and Dathan D. Rush first met this same year. Dathan was newly recruited to serve on an early intervention team as a speech-language pathologist, and M'Lisa joined the same team to serve as a physical therapist and learn more about teaming in early intervention. As many of you know, the Dathan and M'Lisa journey began here. We were very fortunate to have true visionary leadership at the time in early intervention in Oklahoma. Specifically, Marileigh Dougherty, Department of Health; Cathy Perri, Department of Education; Cyd Roberts, Department of Health and Human Services; and Ann Taylor, State Interagency Coordinating Council Chair, who provided the space, trust, and fortitude to support the program and the two of us as we developed in our roles as technical assistance providers and Dathan when he joined the leadership team at the Department of Health as the assistant director and training coordinator for the statewide early intervention program. We often share with early intervention providers that we have been doing this a long time. This most often refers to using a primary service provider (PSP) approach to teaming. After more than 25 years of practicing, we like to believe we have made every mistake possible related to using this approach, and we cannot be convinced that we have not heard every reason (excuse) why the approach should not be implemented.

One year at a Division for Early Childhood conference, M'Lisa attended a presentation by Robin McWilliam and Don Bailey that included a discussion on the difficulties of studying transdisciplinary

teaming. They remarked on the challenges of quantifying teaming and capturing all of the ways that effective team members support one another. This presentation and additional work by Robin and others (Geneva Woodruff, Mary McGonigel, Michael Giangreco, and Corrine Garland) helped us in our desire to continue to explore what teaming using a PSP approach should look like when well implemented. In the early years, we had the opportunity in Oklahoma, Nebraska, and Georgia to help teams with members that were 1) very interested in learning about teaming using a PSP, 2) scared to death about implementing a PSP approach to teaming, and 3) repulsed by every aspect of the approach. We both agree that although we might have a favorite group, we learned immensely from all team members whom we had the opportunity to support.

Of course, over the years, the constraints and challenges in early intervention have increased in number and complexity. Two issues surface as the most frustrating for us. The first issue is the complication of billing for services that further drives the notion of a service-based approach to intervention that is outdated and not considered best practice in early intervention. The second issue is the role expectation of practitioners working in early intervention. We discuss this at length in this text, but the idea is that early intervention is redefining what it takes to be an effective practitioner. To be skilled solely in one's discipline or technical craft is not enough. All early intervention practitioners must understand typical child development (beyond their own discipline), parent and parenting support, and maintain up-to-date knowledge in evidence-based practices in order to be helpful to parents and child care providers. For example, to serve as a helpful PSP in early intervention, M'Lisa cannot be defined as simply the motor expert, and expectations of Dathan must extend beyond that of understanding communication development. When a PSP approach to teaming is implemented with fidelity to the evidence-based characteristics, safety nets and accountability strategies are in place to help ensure that all children and families receive equitable, high-quality supports and services that are responsive to family-identified priorities that make a meaningful difference in the lives of children enrolled in the program.

In 2002, we joined the team at the Family, Infant and Preschool Program in Morganton, North Carolina. With the support of Carl Dunst, Melinda Raab, and other team members, we worked diligently to identify evidence-based characteristics, implementation conditions, and logistical recommendations to clearly define a PSP approach to teaming. Our journey has been challenging and rewarding. We have learned so much from the teams we have worked with and applaud their courage and tenacity needed to move practices forward in a world where often the right thing to do is never the easy thing to do.

Our intent with the second edition of this book is to provide a resource to help states, programs, teams, and individual practitioners work through the process of implementing a PSP approach to teaming. We have included practical tools to support implementation and hope that *The Early Intervention Teaming Handbook* will serve as a companion to *The Early Childhood Coaching Handbook* to assist you in your work with children and their families. We have added new tools to support team meeting facilitators in their very important (and difficult) role. Also new to this revision are resources to support program administrators, team meeting facilitators, and professional development providers. The new PSP Teaming Scenario Matrix includes the topic, characteristics of the child, team members involved, chapter, and page number. The purpose of this matrix is to help the reader easily find scenarios of interest. Because the topic of PSP approach to teaming continues to generate many questions, we have developed a table of Commonly Asked Questions listing the topic, chapter, and page numbers where the answers can be found.

We continue to imagine a day in the (not-so-distant) future when we are remembering back to the old days of IFSPs that contained service delivery statements identifying multiple providers responsible for outcomes that are based on child deficits. We muse about the day when early intervention providers everywhere say to one another, "Remember when we all made separate visits to see the child and family?' "Can you believe we used to do that?" "How did that ever make sense to us?" The exciting fact that keeps us hopeful is that one does not need to travel far or look very hard to find teams of providers that will share this type of information now. Early intervention teams across the country are forming, changing, and perfecting their practices based on current evidence. If you

are skeptical of using a PSP approach to teaming, then we challenge you to read on with your mind open to the possibilities. If you want to learn more, then we have worked hard to provide you with new ideas, information, and tools that you can use immediately to support you in your work. Finally, if you are a change leader—a PSP who can never go back to working without a team—then we congratulate you on your hard work and challenge you to keep an open mind as we continue learning about our practices to ensure the best possible experience for every child and family enrolled in early intervention.

To the early intervention teams and their leaders from across the country with whom we have worked who demonstrated courage, tenacity, and perseverance in helping to shift the paradigm of how families and practitioners can work together on behalf of infants and young children

CHAPTER 1

Introduction to a Primary Service Provider Approach to Teaming

The audience was already a bit unsettled: 200 early intervention providers in tiered stadium-type seating ready to fight for their professional identities and ethics. It was 1990, and the group was gathered to learn more about primary service provider (PSP) teaming, a transdisciplinary model of service delivery in early intervention set to be implemented statewide. Participants were members of existing teams that included psychologists, social workers, child development specialists, speech-language pathologists (SLPs), and newly added members from occupational therapy and physical therapy. Many resented that the state was trying to cram another program with more regulations and requirements down their throats. Moreover, the state was attempting to dictate how they were to provide their services. This was crossing a line, and providers were not willing to sit by passively and be told how to practice their chosen professions.

Sandwiched in the crowd was a speech-language pathology supervisor tapped to work in the new Part H early intervention program. He seated himself with a group of SLP supervisors and other members of his team. They had been anticipating this event for weeks and were not supportive of this misguided new model. The implications of transdisciplinary teaming were unsettling: "If I'd wanted to be a physical therapist, I would have gone to physical therapy school." "How am I expected to teach someone everything I learned about communication intervention in graduate school?" "I don't want to be held liable if someone does something wrong and a child is injured." "Well, I'm an SLP, I'm not about to do stretching exercises with a child." "I'm just not going to do it!"

Like a gladiator thrown to the lions in ancient Rome, the program director entered the room. She approached the microphone and made a few brief remarks about the federal regulations in IDEA Part H, requirements for teaming, and best practice in transdisciplinary service delivery. This, she told the crowd, would be the first of several meetings to help providers learn how to use the PSP model.

Silence.

The director then introduced the speaker—a physical therapy faculty member from a large state-funded university. Wearing her signature mismatched earrings and red Converse high-tops, she approached the podium seemingly unaware of the intense feelings surrounding her. She went through her presentation, trying to make her case for a transdisciplinary model of service delivery in early intervention. As she reviewed the other models of service delivery, some providers recognized that they had been using a variation of multidisciplinary service delivery already—they met weekly to report about children on their caseload but typically did not receive feedback,

information, or support from other team members. Outside of the team meeting, each service provider worked independently on separate treatment plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"I don't know either."

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

They looked at each other simultaneously and said, "Not!"

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

"I'd say so."

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

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

The purpose of this text is to provide a common definition, characteristics of the practice, and implementation strategies for using a PSP approach to teaming within the context of evidence-based practices in early childhood intervention. This information is based on research in how people learn, early childhood intervention, family-centered helpgiving, and team-based supports as operationalized through the authors' more than 30 years of experience in the fields of physical therapy, speech-language pathology, early childhood special education (ECSE), and early intervention as well as the experiences of early intervention teams using these practices across the United States and beyond.

A BRIEF OVERVIEW OF COMMON TEAMING MODELS

Using teams comprised of individuals with a variety of expertise and knowledge in the field of early childhood intervention has been a consistent component of education legislation (Individuals with Disabilities Education Act Amendments [IDEA] of 1997 [PL 105-17]), recommended practice documents (Division for Early Childhood, 2014), and theoretical and research literature over the last 40 years (Antoniadis & Videlock, 1991; Briggs, 1997; Dunst et al., 2007; King et al., 2009; Nash, 1990; Nash, 2008; Sloper et al., 2006; Woodruff & McGonigel, 1988). Bell (2007) stated that a survey of U.S. organizations indicated that more than 48% use teams of some sort. Acknowledging the large amount of work contributed by teams in the workplace is commonplace in business and industry (West, 2012) as well as in education (Malone & Gallagher, 2010; Silverman et al., 2010) and health care contexts (Nandiwada & Dang-Vu, 2010; Weller et al., 2014).

Historically, several different teaming models for providing early childhood services have been suggested in the literature. The multidisciplinary, interdisciplinary, and transdisciplinary team approaches are three models of team interaction that have been readily discussed. The approaches differ based on the level of team interaction, parental involvement, the assessment process, and intervention methods (Fewell, 1983; Haynes, 1976; Kingsley & Mailloux, 2013; Peterson, 1987; Woodruff & McGonigel, 1988).

A *multidisciplinary approach* to teaming was initially defined as a group of professionals who work independently and interact minimally with each other (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Each member of the team performed a separate evaluation and wrote an

individual report, including discipline-specific goals. Each practitioner then performed intervention at separate times and focused on the remediation of the weaknesses noted during the evaluation (McGonigel et al., 1994; Rush & Shelden, 1996). When a multidisciplinary team functioned in this manner, team members viewed the child based on identified deficits from their own discipline's perspective and children received discipline-specific interventions that may have resulted in overlaps and gaps in services (Giangreco, 1986; Orelove & Sobsey, 1996).

Interdisciplinary teams traditionally had more interaction among the team members on an ongoing basis. Each team member continued to perform a discipline-specific evaluation and write discipline-specific goals. The team met to discuss the results of each evaluation and develop an intervention plan (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Team members provided intervention services at different times and discussion among team members occurred primarily at team meetings (Fewell, 1983; Peterson, 1987; Rush & Shelden, 1996). The primary purpose of team meetings in an interdisciplinary approach was for each discipline to report on child status.

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

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

The stages of transdisciplinary team development involve six steps (Haynes, 1976; Woodruff & McGonigel, 1988). Role extension is the first step and refers to professional development activities including, but not limited to, self-study, workshops, conferences, and university coursework intended to deepen one's knowledge in his or her own discipline (e.g., a PT attending a course on lower extremity splinting for infants and toddlers with low muscle tone). Role enrichment is the second step and involves individual team members developing an understanding of the terminology and core practices of the other disciplines on the team. This can happen through conversations at team meetings, journal club review and discussion, and sharing information via a resource library. Role expansion is the third step and occurs based on individual team members' acquisition of enough information to make informed observations and program decisions outside of their own disciplines. Role exchange is the fourth step of transdisciplinary team development and occurs when team members have adequate knowledge of the theories, methods, and procedures from other disciplines to incorporate them into their own intervention process while working alongside or with the other team member. For example, role exchange occurs when an SLP is implementing newly acquired positioning techniques during a joint visit with the team's PT. Role release is the fifth step and occurs when a team member is fully functioning in the role of PSP and implements intervention methods typically associated with another discipline with accountability to the team member from the associated discipline. Role support is the sixth step and occurs when the PSP needs support of a specific discipline because intervention strategies are complex, new, or require the direct involvement of a particular discipline. For example, a child needs to learn how to use a walker and is currently being supported by an occupational therapist (OT) as the PSP. The PT would provide support to the child, OT, and family by teaching the child how to safely and successfully use the walker.

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

AGREED-ON TEAMING APPROACH IN EARLY INTERVENTION

Using a PSP is most commonly associated with a transdisciplinary model of team development in which one member of the team is chosen to work directly with the child. Role release, or teaching the skills traditionally associated with one discipline to another team member who functions in direct service capacities with the child, is a distinguishing feature of transdisciplinary teamwork (Woodruff & McGonigel, 1988). The need for a teaming approach using a PSP is based on the fact that focusing on services and multiple disciplines implementing decontextualized, child-focused, and deficit-based interventions has not proven optimally effective (Boyer & Thompson, 2014; Campbell & Halbert, 2002; Dunst, Bruder, et al., 2001; Dunst et al., 2007; Dunst, Trivette, et al., 2001; Garcia-Grau et al., 2019; Hughes-Scholes et al., 2015; McWilliam, 2000). A PSP can be used effectively with young children and their families (American Occupational Therapy Association [AOTA], 2019; American Physical Therapy Association Academy of Pediatric Physical Therapy, 2013; American Physical Therapy Association Section on Pediatrics, 2010; American Speech-Language-Hearing Association [ASHA], 2008a, b; Division for Early Childhood, 2014; Pilkington, 2006; Vanderhoff, 2004; Workgroup on Principles and Practices in Natural Environments, 2007b).

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

The Academy of Pediatric Physical Therapy of the American Physical Therapy Association web site (http://www.pediatricapta.org) contains two resources: 1) a question and answer document containing facts specifically about a PSP teaming approach and 2) a fact sheet on team-based approaches used by PTs. Transdisciplinary teaming and use of a PSP is specifically cited as a "recommended practice in early intervention settings" (Section on Pediatrics of the American Physical Therapy Association, 2013, p. 2). The fact sheet stated the following:

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

In 2008, ASHA put forth three documents regarding the roles and responsibilities of SLPs in early intervention. The documents include a position statement, guidelines, and a technical report. Each of the documents indicates that the SLP may practice within a transdisciplinary model and serve as the primary provider "based on the needs of the child, relationships already developed with the family, and special expertise" (ASHA, 2008b, p. 16) of the practitioner. Due to the emphasis on team interaction, members of transdisciplinary "teams benefit from joint professional development

and can enhance each other's knowledge and skills as well as through role extension and role release for specific children and families" (ASHA, 2008b, p. 4). More recently, ASHA added an early intervention practice portal to their web site (https://www.asha.org/practice-portal/professional-issues/early-intervention/) that includes a description of the use of a PSP.

The Division for Early Childhood of the Council for Exceptional Children recommended practices document states that practitioners and families collaborate with each other to identify one practitioner from the team to serve as the PSP between the family and other team members based on child and family priorities and needs (Division for Early Childhood, 2014). The document further states that using multiple providers is not recommended. Rotating multiple practitioners in and out of a family's life on a regular basis has been found to negatively affect family functioning (Dunst et al., 2007; Greco & Sloper, 2004; Law et al., 1998; Sloper, 2004). Furthermore, using a PSP minimizes any negative consequences of having multiple and/or changing practitioners (Bell et al., 2009; Dunst et al., 2007; Law et al., 1998; Shelden & Rush, 2010; Sloper, 2004; Sloper et al., 2006).

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

1. *Agreed Upon Mission and Key Principles for Providing Early Intervention Services in Natural Environments* (http://www.nectac.org/~pdfs/topics/families/Finalmissionandprinciples3_11_08.pdf)
2. *Seven Key Principles: Looks Like/Doesn't Look Like* (https://ectacenter.org/~pdfs/topics/families/Principles_LooksLike_DoesntLookLike3_11_08.pdf)
3. *Agreed Upon Practices for Providing Early Intervention Services in Natural Environments* (https://ectacenter.org/~pdfs/topics/families/AgreedUponPractices_FinalDraft2_01_08.pdf)

Table 1.1 summarizes the mission and seven key principles developed by the workgroup. Principle 6 states, "The family's priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support" (Workgroup on Principles and Practices in Natural Environments, 2007b, p. 7). Principle 6 also delineates concepts that support using a primary provider, such as formalized communication mechanisms, opportunities for joint visits, and shared responsibility for achievement of individualized family service plan (IFSP) outcomes.

Haynes (1976) first introduced a transdisciplinary model of teaming into the literature. The original intent of this teaming model was to provide efficient patient-focused services to remediate deficits in a variety of locations. This approach was originally adopted by many early intervention teams in the late 1980s as a recommended practice in early intervention. In this text, we put forth a refinement of the transdisciplinary approach to teaming and the use of a PSP as it applies to Part C early intervention. In our experience, if teams are not using a multidisciplinary or interdisciplinary approach, then they refer to their teaming model as a PSP approach. In fact, we attempted to change the nomenclature and identify a new name for a teaming approach that used a PSP coaching interaction style and focused on supporting family members and teachers to promote child learning through everyday, interest-based opportunities. We began using the term *primary*

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

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

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

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

coach approach to teaming (Shelden & Rush, 2007, 2010) because commonly used definitions of the transdisciplinary model of team interaction lacked the essential elements of a focus on the adults in the child's life instead of a sole focus on practitioner–child interventions, as well as how to interact with and support the adults in a way to promote confidence and competence in using everyday life activities as the venue for learning, growth, and development. In yielding to the terminology most commonly used in early intervention, this text intends to provide a common definition for the field, practice characteristics, and detailed information on how to operationalize this teaming approach. Regardless of the terminology used, the field of early childhood intervention has moved beyond the use of a pure transdisciplinary model of team interaction.

Woodruff and McGonigel (1988) provided a table that compared the elements of practice of multidisciplinary, interdisciplinary, and transdisciplinary models of team interaction. They compared how teams conduct assessment, develop and implement the service plan, communicate with one another, involve parents, participate in staff development, and guide philosophy. We offer an additional comparison of a PSP approach to teaming in Table 1.2. More specifically, a PSP approach to teaming differs from a transdisciplinary service delivery model in that the PSP is not asked to engage in role release and take on the role of practitioners from other disciplines involving specific techniques targeted at skill development. Rather, the PSP becomes an expert on a family's and child's activity settings, routines, and interests in order to promote parent mediation of child participation in everyday activities. For example, for a child who is having difficulty walking on their own and has an IFSP outcome targeting playing with their twin brother and/or sister in the backyard, many team members across all disciplines would be equipped to support the parents in promoting the child's interest and success of playing with their brother and/or sister. If, however, the child needed foot splints to support their success in this interest-based activity setting, then the PT (PSP or not) would be responsible for either constructing or assisting the family in acquiring the needed assistive technology.

In a PSP approach to teaming in early intervention, the PSP acts as the principle program resource and point of contact among other program staff, the family, and other care providers (i.e., the team). The PSP mediates the family's and other care providers' skills and knowledge in relation to a range of needed or desired resources (i.e., child learning, child development, parenting supports). A PSP approach to teaming is characterized by the team members' use of coaching practices to build the capacity of parents, other primary care providers, and professional colleagues to improve existing abilities, develop new skills, and gain a deeper understanding of how to promote

Table 1.2. Models of team interaction

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

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

child learning and development within the context of interest-based, everyday learning opportunities (Dunst, Bruder, et al., 2001; Rush & Shelden, 2005; Shelden & Rush, 2007, 2010). Using a PSP approach to teaming does not equate to only one practitioner supporting a child and family nor does it imply any prescription for frequency and intensity of service provision. In this approach, the child and family have access to any and all team members as needed via joint visits with the PSP and team meetings. Determining frequency and intensity is an IFSP team decision based on

many factors rather than the perception that frequency and intensity equals the amount of service provision delivered by one member of a multidisciplinary or interdisciplinary team (e.g., 1 hour per week).

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

1. Role expectation
2. Role gap
3. Role overlap
4. Role assistance

Remember

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

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

Role expectation refers to three minimal areas of competency when practicing in Part C and using a PSP approach to teaming. The first expectation is that each team member will be an evidence-based practitioner, which includes knowing the evidence to support practice in his or her own discipline, early intervention (Part C federal regulations and the mission and key principles for providing early intervention in natural environments), and early childhood development (beyond the areas of development typically associated with a particular discipline). The second expectation is that every team member is competent in providing parent and parenting support. *Parent support* is defined as assisting families related to identification, use, and evaluation of needed resources such as transportation, housing, crisis intervention, and medical services. *Parenting support* involves evidence-based information, techniques, strategies, and approaches that assist parents in meeting identified needs related to topics such as toileting, supporting positive behavior, helping a child sleep through the night in his or her own bed, and/or expanding a child's repertoire of foods. Finally, the third expectation is that all team members know how to mediate parents' and care providers' abilities to support child learning and development by using evidence-based adult learning and interaction methods (e.g., coaching) (Rush & Shelden, 2020). The Role Expectation Checklists (see Appendix 1A) may be used by practitioners to conduct self-assessments of current knowledge and skills related to preparedness for working on teams providing Part C services using a PSP approach to teaming. The Role Expectation Checklists—Administrator's Guide (see Appendix 1B) can be used by team leaders and supervisors to help structure an interview for a new staff member or contract provider, conduct orientation, and identify professional development needs of team members.

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

Remember

Role expectation includes three minimal areas of competency. Each team member will be

1. An evidence-based practitioner
2. Competent in providing parenting and parent support
3. Able to mediate parents' and care providers' abilities to support child learning and development

Remember

Role gap occurs when the primary service provider does not have all of the needed knowledge and skills to adequately support a child's learning or implement necessary parent/parenting supports.

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

Role overlap is when multiple team members feel confident and competent to fill the role of the PSP for a particular child and family. Role overlap maximizes flexibility and efficiency for teams in selecting the PSP. For example, when identifying the most likely primary provider for an infant with Down syndrome whose mother is challenged by feeding him, many team members would have the knowledge, skills, and expertise necessary to support this child and family with role assistance from other team members as needed. When role overlap occurs, role assistance would most likely take the form of colleague-to-colleague coaching opportunities, conversations during team meetings, and joint visits with the family. Role overlap occurs more frequently as team members work together for longer periods of time. This occurs not necessarily because team members are releasing or exchanging intervention techniques or strategies, but due to collective experience implementing evidence-based practices in early intervention and shared conversations at team meetings, observations during joint visits, and supporting one another over time.

Remember

Role overlap occurs when multiple team members feel confident and competent to fill the role of the primary service provider for a particular child and family.

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

Remember

Role assistance is

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

A PSP approach to teaming differs from a transdisciplinary or other approach in which one practitioner serves as the liaison

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

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

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

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

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

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

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

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

Remember

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

The operational definition of a PSP approach to teaming is the requirement of a geographically based team consisting of individuals representing multiple disciplines, in which one member is selected as the PSP, receives support from other team members and provides support to the parents and other care providers using coaching and natural learning environment practices to strengthen parenting competence and confidence. A geographically based team is a group of early intervention practitioners consisting minimally of an early childhood educator or special educator, OT, PT, SLP, and service coordinator(s) responsible for all referrals to an early intervention program within a predetermined area defined by zip code or other geographical boundary. A specific child's IFSP team is composed of members from the geographically based team.

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

Although a PSP approach to teaming may be used in isolation as part of early intervention under Part C, the law requires that services be provided in natural learning environments and the intervention focuses on supporting parents and other care providers in confidently and competently promoting child learning and development. This text focuses on using a PSP approach as one of three key components of an evidence-based approach to early intervention. The other two components are implementing natural learning environment practices or, more specifically, using child interests and everyday activity settings as the contexts for learning, and coaching as the strategy for building the capacity of the important adults in the child's life (see Figure 1.2). Enhanced capacity of parents and other care providers in early intervention includes both global child and family outcomes. Desired child outcomes include supporting child learning, promoting positive social relationships, and providing opportunities for children to learn and use appropriate behaviors to meet their needs. Family outcomes in early intervention involve assisting parents in understanding their children's strengths and needs, knowing their rights and how to advocate effectively, helping their children learn and develop, ensuring availability of family support systems, and gaining access to desired resources in their community.

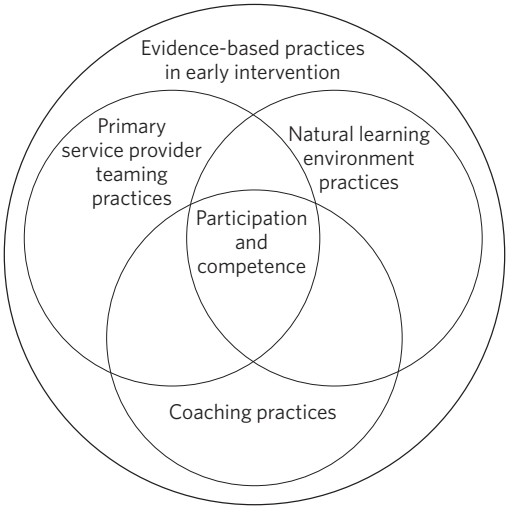

Figure 1.2. Evidence-based practices in early intervention.

Natural Learning Environment Practices

Under Part C, the content of the intervention must be evidence based and provided in the natural learning environments of eligible infants and toddlers (Workgroup on Principles and Practices in Natural Environments, 2007b). Natural learning environments are the locations where children would be if they did not have disabilities. Natural learning environment practices support parents of children with disabilities and other care providers in understanding the critical role of everyday activity settings and child interests as the foundation for children's learning opportunities (Campbell & Sawyer, 2007; Chiarello, 2017; Dunn et al., 2012; Dunst, Hamby, et al., 2000; Dunst, Trivette, et al., 2001; Graham et al., 2009; Hughes-Scholes et al., 2015; Humphrey & Wakeford, 2008; Hwang et al., 2013; Keilty & Galvin, 2006; Kellegrew, 2000; Kramer et al., 2018; Lim et al., 2016; McWilliam, 2000; Spagnola & Fiese, 2007). Activity settings include, but are certainly not limited to, taking a walk, eating a snack, going down a slide at the park, feeding the cat, making dinner, riding in a car, watering the garden, and fishing with Grandpa. Using these practices also supports parents and other care providers in recognizing and using child interests to capitalize on the number and variety of learning opportunities that naturally occur in the lives of all young children. *Interest-based learning* is defined as children's engagement in activities and with people and objects they find interesting, fun, exciting, and enjoyable (Dunst, Herter, et al., 2000; Raab, 2005). For example, when children are involved with objects (a favorite spoon) or people (brother or sister) that they find interesting, research shows that they will be more motivated to pay attention longer, resulting in positive benefits related to child learning (Dunst, Herter, et al., 2000; Raab, 2005).

Most practitioners are trained to determine a child's delays in skill development and either directly attempt to remediate the deficits through practitioner–child interventions and/or teach parents strategies to work on delayed or absent skills within a daily routine or activity setting. For example, if a child lacks head control, then a practitioner might recommend more opportunities for tummy time throughout the day and teach the parent ways to help the child tolerate being on the stomach for longer periods of time or encourage the child to push up on extended arms. Conversely, a practitioner who understands that child participation in activity settings is part of early childhood intervention will spend time with the parent observing and identifying the child's interests and existing opportunities for expression during which the child has an inherent opportunity to learn and practice new skills. For example, a practitioner learns that a child loves to lie on Daddy's stomach while he watches his favorite sports teams on television (i.e., activity setting/child interest). The practitioner encourages the father to continue this activity, discussing all the valuable learning

opportunities the child experiences by participating in this interest-based activity setting on a regular basis (i.e., every evening and multiple opportunities on the weekends). If the father is interested and willing, then the practitioner also discusses ways to involve the child further in the activity. The father realizes that another one of his daughter's favorite activities is when they blow raspberries or she tries to imitate exaggerated mouth movements that he makes. While she is on his stomach when he is watching the game, he blows raspberries and makes silly faces to engage her more or extend the amount of time she is happy in this position. This is an example of a simple, interest-based, responsive strategy the father could easily use to maintain the child's engagement in a fun and interesting activity that would not only lead to improved head control but also promote the child's social, cognitive, and communication skill development while spending quality time with her daddy in a naturally and frequently occurring context. Evidence-based strategies and techniques are taught by early intervention team members as parent-mediated tools for supporting child participation in interest-based everyday activity settings.

Coaching Families

Early intervention practitioners should use a capacity-building approach with families of infants and toddlers with disabilities in order to support parent competence and confidence for promoting child learning within the context of natural learning opportunities (Trivette & Dunst, 2007). Capacity building is a process that assists parents in recognizing and taking advantage of everyday activities and situations that have development-enhancing qualities to increase children's learning (Dunst et al., 2010, 2014; Mangin, 2014; Rush & Shelden, 2020, Stormont & Reinke, 2012). Practitioners must adopt a method of parent engagement that is consistent with how people learn in order for parents to benefit from early intervention practitioners' use of a capacity-building approach to increase parenting skills and abilities (Donovan et al., 1999).

As previously mentioned, coaching is one style of interaction identified as a practice for building the capacity of parents, care providers, and colleagues in early intervention (AOTA, 2010; ASHA, 2008a; Hanft et al., 2004; Rush & Shelden, 2020; Trivette et al., 2009; Workgroup on Principles and Practices in Natural Environments, 2007b). Coaching does not mean just telling another person what to do; it is a process that starts with what the other person already knows and does and supports that person according to his or her needs and priorities. Coaching is an interactive process of reflection, sharing information, and action on the part of the coach and coachee used to provide support and encouragement, refine existing practices, develop new skills, and promote continuous self-assessment and learning. Coaching involves asking questions; jointly thinking about what works, does not work, and why; trying new ideas with the child; modeling with the child for the parent; sharing information; and jointly planning next steps (Hanft et al., 2004; Rush & Shelden, 2020). A coaching interaction style is as hands on by the PSP as necessary, but it also ensures that what the practitioner is doing and discussing with the parent is meaningful and functional within the context of everyday life and promotes the parents' ability to support child learning and development during the times when the practitioner is not present.

Operational Definition of Coaching Practices

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

> An adult learning strategy in which the coach promotes the learner's ability to reflect on his or her actions as a means to determine the effectiveness of an action or practice and develop a plan for refinement and use of the action in immediate and future situations. (Rush & Shelden, 2005, p. 3; Rush & Shelden, 2020)

Following is a brief example of how a practitioner would engage a grandparent in a coaching interaction. Consider a situation in which a grandmother tells a practitioner that she would like for her

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

Coaching Characteristics

The characteristics of a particular practice inform a practitioner of what to do to achieve the desired effect. A review of coaching research by the authors suggests that coaching has five practice characteristics that lead to intended outcomes: 1) joint planning, 2) observation, 3) action/practice, 4) reflection, and 5) feedback (Rush & Shelden, 2020).

Joint Planning

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

Observation

Observation typically occurs with the practitioner directly viewing an action on the part of the parent, which then provides an opportunity for later reflection and discussion (e.g., a practitioner observes a parent moving the child from playing with a favorite toy to the bedroom for a nap). Observation may also involve modeling by the practitioner for the parent. When the practitioner models for the parent, the practitioner discusses what the parent is going to do with the child and asks the parent to make specific observations while the modeling occurs. The practitioner builds on what the parent is already doing and demonstrates additional strategies. Following the model, the practitioner prompts reflection by the parent regarding how the parent's actions match intent, are similar to or different from what the parent typically does, and are consistent with what

research informs about child learning and what the parent wants or is willing to try based on the practitioner's modeling (e.g., following further discussion, the practitioner demonstrates preparing the child for the transition from play to naptime by talking about what will happen and offering the child a choice of what favorite snuggly the child would like to take to bed).

Action/Practice

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

Reflection

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

Feedback

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

PURPOSE OF A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

The fundamental purpose of using a PSP approach to teaming is to enable families to establish and maintain an ongoing working relationship with a lead team member with needed expertise, who then becomes an expert on the whole child and family rather than promoting an isolated focus on developmental domains and deficits by each practitioner. The intent of this approach is to promote positive child and family outcomes and minimize any negative consequences of having multiple and/or changing practitioners involved in the family's life. Families are faced with varying degrees of consistency of approaches, information, and interaction styles when multiple practitioners are involved (Bell et al., 2009; Dunst et al., 2007; Law et al., 1998; Shelden & Rush, 2010; Sloper, 2004; Sloper et al., 2006). These circumstances can potentially lead to confusion or conflict, leaving the parent to decide what to do and whom to trust and believe.

BENEFITS OF A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

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

Efficiently using family and program resources is another important benefit of a PSP approach to teaming. Using a primary provider allows for increased coordination of supports and services instead of a more fragmented approach to addressing child and family priorities. For example, in a more fragmented approach, a family could potentially be introduced to three or four practitioners with separate meeting times and reasons for visiting. The parent must then remember who does what (e.g., SLP to work on talking, PT to work on rolling), on what day and time (e.g., Tuesday at 4:00 p.m. for OT, Wednesday at 9:00 a.m. for SLP), the expectations for involvement during the visit (e.g., observer, active participant), the homework to be completed between visits (e.g., practice giving choices, pull-to-stand exercises), what needs to be available for the practitioner or whether to bring toys and materials, practitioner preference for sibling involvement, and how the environment should be set up and maintained while the practitioner is present (e.g., television on or off).

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

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

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

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

ORGANIZATION OF THIS BOOK

This text is intended to be a working guide for how to operationalize a PSP approach to teaming in early intervention and, therefore, features learning tools to assist the reader in applying the content to everyday practice. The content is applicable to practitioners working in early intervention, parents, program administers, policy makers, technical assistance providers, and higher education faculty and students interested in learning more about teaming. Case studies and scenarios are provided to illustrate and provide examples for how PSP teaming practices are implemented in early

intervention. The PSP Teaming Scenario Matrix (located directly after the References) provides a comprehensive list of all scenarios in the text (see p. 223). This matrix details the location of the scenario within the book, the topic of the scenario, and the specific disciplines involved. Readers are provided with opportunities to reflect, remember, and take action throughout the text. Reflection opportunities include thinking about current or future practices and applying or using the information learned to build on one's current knowledge and skills. Remember notations contain brief summations of critical points to assist readers in retaining key concepts. Take action opportunities challenge readers and include ideas for how to put information into action by applying what is being learned to a real-life context. A list of commonly asked questions about the PSP approach to teaming and the location of the answers in the text is provided at the end of this text (directly following the PSP Teaming Scenario Matrix on p. 225).

TERMINOLOGY USED IN THIS BOOK

This book contains terminology that may be familiar to the reader or may be defined by different readers in different ways. The authors have provided definitions of some of the terms used throughout the text to ensure a common understanding.

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

Caregivers or care providers: Individuals other than parents who care for and are important in the child's life, including grandparents, aunts, uncles, family friends, baby sitters, and nannies.

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

Dedicated service coordination: A separate individual operates as the service coordinator and solely provides this service to the family.

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

IDEA Part C: The federal legislation that provides regulations for how states provide early intervention services to eligible children from birth to age 3.

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

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

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

Multidisciplinary team: Professionals working independently of each other and interacting minimally with other team members (McGonigel et al., 1994; Woodruff & McGonigel, 1988). Each member of the team performs a separate evaluation and writes an individual report, including discipline-specific goals. Intervention is then performed by each service provider at separate times and focuses on the remediation of the weaknesses noted during the evaluation (McGonigel et al., 1994; Rush & Shelden, 1996).

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

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

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

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

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

Teachers: Individuals who teach in infant/toddler classrooms.

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

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

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

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

CONCLUSION

The purpose of this text is to define a PSP approach to teaming as one component of a three-part approach for providing evidence-based early intervention practices. This three-part approach also includes using natural learning environment practices as the context for intervention and coaching as the style of interaction with the important adults in the child's life. Using a PSP is a key principle identified by the Workgroup on Principles and Practices in Natural Environments of the NECTAC and is recognized by ASHA, AOTA, the Section on Pediatrics of the American Physical Therapy Association, and the Division for Early Childhood of the Council for Exceptional Children as an appropriate teaming approach in early intervention. The federal regulations for Part C clearly delineate the involvement of teams comprised of individuals from multiple disciplines in the design and delivery of early intervention supports and services. Furthermore, evidence, practical experience, and common sense inform us that having one primary liaison from the team to the family is an effective means of providing supports. This text is designed to assist the reader in operationalizing the research-based characteristics of the practices in early intervention contexts.

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