Early Intervention Teaming and the Primary Service Provider Approach: Who Does What, When, Why, and How?

Emily Marturana
School of Communication Science and Disorders, Florida State University
Tallahassee, FL

Cara McComish
Division of Speech and Hearing Sciences, University of North Carolina at Chapel Hill
Chapel Hill, NC

Juliann Woods
School of Communication Science and Disorders, Florida State University
Tallahassee, FL

Elizabeth Crais
Division of Speech and Hearing Sciences, University of North Carolina at Chapel Hill
Chapel Hill, NC

Abstract

The speech-language pathologist’s (SLP’s) roles and responsibilities as a team member using a Primary Service Provider (PSP) approach is discussed using the American Speech-Language-Hearing Association (ASHA) Roles and Responsibilities of Speech-Language Pathologists in Early Intervention: Guidelines (ASHA, 2008b) document as a foundation. We provide definitions, address “myths” that are frequently identified as barriers to implementation, and offer strategies for SLPs serving as either consultative or primary providers on the early intervention team.

Primary Service Provider Approach

Working as a member of a team is both an IDEA-legislated requirement (Individuals with Disabilities Education Improvement Act, 2004) and a recommended practice to address the diverse needs of young children eligible for early intervention (EI) and their families (Sandall, Hemmeter, Smith, & McLean, 2005). Despite the long history of teaming in related fields, such as education, health, and social service, challenges to effective teamwork persist and affect child and family outcomes and satisfaction in EI. Fragmentation or duplication of services, lack of coordination in types and frequency of service provision, and limited communication and collaboration among team members are only a few of the many challenges identified in the research literature related to teaming practices (Fialka, 2005; Horn & Jones, 2005). The National Early Intervention Longitudinal Study (Hebbeler et al., 2007) collected information on over 3,000 children receiving EI services and found that the majority of families received 2 (19%), 3 (19%), or 4 (17%) services, while 26% received 6 or more services within the first 6 months of enrollment. “Services” included physical therapy, developmental monitoring, occupational therapy, special instruction, speech-language therapy, and service coordination.
More than half of the children received speech-language pathology services (52%), highlighting the critical need for speech-language pathologists (SLPs) in EI and the importance of effective teaming practices for SLPs.

While many children receiving EI services continue to have multiple service providers, statewide efforts to change service delivery approaches to address many of the identified challenges regarding teaming are occurring. In a 2009 survey of state Part C coordinators, more than half of the respondents identified the use of a Primary Service Provider (PSP) approach as a preferred service delivery practice (“Models or Approaches,” n.d.). In a PSP approach, one team member provides the direct services and supports for the child and family and serves as the liaison between the family and the team. The PSP approach emphasizes continuity and coordination of information and resources for the child and family while decreasing fragmentation and duplication of services. The family has the opportunity to establish a relationship with a single provider who supports their participation and decision-making in the intervention process.

PSPs are identified by the team, including the family, based upon the child’s needs and family priorities. It is not a discipline-specific role, but rather should be a thoughtful consideration of the “best fit” for the child and family. The PSP is similar to the team leader of a transdisciplinary team. While the PSP meets regularly with the family, the consulting team members interact with the PSP and directly consult with the family only as needed. The PSP’s roles include seeking input and ideas from all team members, extending skills to embed intervention strategies from team members, coordinating intervention services and supports to ensure that the child’s and family’s priorities are addressed, and serving as a liaison between team members. In highlighting the PSP approach to EI service delivery, we address several myths that may be identified as barriers to implementation.

**Myths About the PSP Approach**

**Myth # 1: The PSP approach is not within ASHA’s scope of practice for SLPs or I can’t be a PSP because I am not trained to do physical or occupational therapy.**

Working as a PSP is a service delivery approach, not a specific practice area, so it is neither inside nor outside the SLP’s scope of practice. As the American Speech-Language-Hearing Association (ASHA) Code of Ethics specifies, individuals may practice only in areas in which they are competent (i.e., individuals’ scope of competency), based on their education, training, and experience, and so they would definitely not be conducting interventions appropriate only to physical or occupational therapy or special education. ASHA’s EI documents discuss the PSP approach and emphasize the importance of services that are comprehensive, coordinated, and team-based for the child and family (ASHA, 2008a; 2008b; 2008c). They further emphasize collaboration with families, caregivers, and other professionals as an integral component of providing family-centered supports and services to young children and their families. For some children and families, an integrated approach that facilitates a strong relationship with one provider with access to consulting team members as needed is the most appropriate service delivery approach. An SLP’s unique contribution can be used as either the PSP or as a consultant, depending on the family’s priorities and child’s outcomes. This approach necessitates the SLP to be knowledgeable and competent in building relationships with caregivers, supporting caregivers’ attachment and interaction with their children, and collaborating with team members in service implementation. SLPs who have limited experience or training related to transdisciplinary teaming may be uncertain about how the PSP approach fits within the ethical guidelines or scope of practice for SLPs. ASHA’s Code of Ethics describes professional competence and performance in terms of an individual’s “level of education, training, and experience” (ASHA, 2010). Serving as either the PSP or consultant on a PSP team is an appropriate, ethical role for SLPs with the appropriate training and support. The PSP approach does not advocate for SLPs to violate scope of practice in working outside of qualifications, but rather enhances and streamlines EI services by offering families...
strong, individualized support from one provider with a focus on their child’s holistic development. Early relationships are the building blocks of all domains of development (Shonkoff & Phillips, 2000), and the PSP approach facilitates the family’s strong relationship with one EI provider to support the caregiver-child relationship.

Another way to facilitate and enhance relationships is through collaboration and coaching. Coaching is an adult learning strategy used to support caregivers and other professionals to implement intervention, but is sometimes misunderstood as a service delivery model (Rush & Shelden, 2008). An SLP serving as the PSP on an EI team might provide coaching to help caregivers implement communication strategies to support language development during daily routines. The PSP may also receive coaching from other professionals on the team to problem-solve, gain, or refine skills related to other developmental domains. The SLP can then integrate communication therapy targets with other developmental areas in order to best support the child and family’s needs in everyday activities. As the PSP, an SLP’s primary responsibility is the same as in other models of EI service delivery—to support the child’s communication in the context of his or her natural environment using a comprehensive, team-based approach. On a team where another professional serves as the PSP, the SLP will coach the PSP to implement communication strategies during home visits with caregivers. When the PSP coaches caregivers and other professionals (and vice versa), joint planning and active participation from all team members is facilitated.

Myth #2: PSP is only for home visits. I spend more time at early care and education settings, so I can’t use this approach.

PSP refers to the role of the SLP, not the setting or site, and describes the role the SLP plays. The PSP approach applies to all settings and communication partners, including family members, teachers, and/or childcare providers. While the percentage of children served outside of the family home is less than those served at home (Hebbeler et al., 2007), the number is increasing and represents an important component of the SLP’s program assignment, albeit, at times, a challenging one for coordination and communication.

When an early care and education center is the preferred location and the teacher or childcare provider is identified on the Individualized Family Service Plan (IFSP) as a team member participating in services and supports, the PSP goes to the setting and develops a consultation and coaching plan with the identified caregiver(s). The PSP initiates a relationship with the caregiver, learns about the child’s participation in various routines and activities throughout the day, collaboratively identifies opportunities to embed intervention, coaches the caregiver in “how to” integrate the interventions throughout the day, monitors progress, and consults with the team. These procedures parallel the home-based PSP approach with two important caveats. First, the team, including the family and the teacher, may need to discuss how to implement the IFSP outcomes within the setting in a manner that complements the family’s approach at home. Expectations, schedules, and philosophies are likely to vary between the home and center settings. This information should be addressed by the team to ensure that both the family’s voice is heard and that the programs are coordinated to support the child’s progress. Rather than planning new or different outcomes for each setting, addressing family priorities across settings maintains their role as the decision-maker on the team and provides additional opportunities for the child to practice and generalize new skills.

The second caveat for the PSP at a center is maintaining communication between all team members, including the family and early care and education providers. Sharing information, coaching, and monitoring progress should occur for the family as well as for the teachers. Meeting at drop-off or pick-up times and using communication notebooks, e-mail, texts, video, or other communication strategies can maintain everyone’s active involvement. When serving as a team member in a consultative role, the SLP would be ready to coach the PSP on materials, strategies, and specific techniques to support the child’s communication outcomes and complete joint visits as a consultant, as needed.
Myth #3. All the PSP does is service coordination. Our EI program has a service coordinator, so I don't need to provide support with resources and transition planning.

ASHA's position statement on SLPs' roles in EI indicates that the SLP may provide service coordination and should be involved in the transition process from EI (Part C: birth to 3 years) to preschool services (Part B: 3 to 5 years). Regardless of whether the SLP is also the PSP and/or providing service coordination, the SLP should be prepared to participate in resource support and the transition process from eligibility determination to placement in a preschool or other early care and education program, if appropriate.

At the transition to school-based preschool services, the documentation of needed services and goals shifts from a focus on child development and the family system in an IFSP to an academically focused Individualized Education Plan (IEP). Families report that this process can be daunting as they anticipate meetings with unfamiliar professionals who will be making decisions about whether or not their child is eligible for a preschool placement and/or therapies (Hanson et al., 2000). In a PSP approach, the primary provider has a strong relationship with the family and can be instrumental in facilitating communication with and between the transition team members. Preparing family members for what to expect during the upcoming IEP meeting can decrease anxiety about the unknown; additionally, the SLP's presence at the meeting can provide a familiar face and information about the child's developmental progress and current status. The PSP's role is just as essential if the child is not eligible for school-based services. Providing resources, referrals, and supporting the family in identification and access of other appropriate options can empower caregivers and provide opportunities for the child's continued development and learning.

Attending transition meetings can be difficult for SLPs in private practice or hospital settings, where time spent in transition-related activities may not be seen as “billable.” Depending on the state and agency policies under which the SLP works, this time may actually be considered “billable” as consultation time (although often at a reduced rate when compared to direct therapy activities). Strategies for the SLP to participate in these meetings include finding out about the potential for reimbursement at his/her particular practice and/or state, scheduling sessions directly before or after transition meetings to fit into both the SLP and family’s busy schedule, or using technology such as Skype (http://www.skype.com) to participate in meetings “virtually.”

Myth #4: I am an SLP in a unidisciplinary setting, so teaming isn't possible. I'm not only the primary provider, I'm the only provider!

Not all SLPs in EI are part of what some may view as “traditional” teams, where providers from different disciplines work for one organization. Further, not all children receiving EI have service coordinators who can help bring team members together. Because of the diversity of SLP work settings serving infants and toddlers (e.g., private practice, outpatient, university clinic), some professionals may find it more difficult to form or maintain a “team.” For example, although hospitals have multiple disciplines represented, it may be difficult for professionals to “co-treat” or provide cross-consultation due to billing restrictions. While some private practices include multiple disciplines, there are many SLPs who operate as independent contractors. Similarly, many university clinics provide speech-language and hearing services; however, cross-disciplinary efforts are likely the exception. Therefore, SLPs in these types of settings may face additional challenges in teaming and communicating as members of a team. Despite these limitations, it is important for SLPs to assume this responsibility and to communicate effectively with others who are or could be “potential” team members.

In any setting or service delivery approach, it is first important to identify potential team members. As mentioned previously, most infants and toddlers with disabilities receive services and supports from multiple professionals (Hebbeler et al., 2007); therefore, finding out what services are provided to the child and family is a first step. If the child has a service coordinator, the SLP can make contact with that professional and urge her/him to set up a
meeting or a communication strategy for everyone working with the child and family. If the child does not have a service coordinator, the SLP could provide the family with information about requesting coordination services from the local EI program.

The next step is to arrange for some type of information sharing among the professionals and the family. When professionals are not under one umbrella organization, coordination across providers becomes more difficult but not impossible, especially given today’s technology. If face-to-face meetings are not practical due to travel time or reimbursement issues, potential alternatives may include teleconferencing, Skype, Google Groups (http://groups.google.com), and/or using e-mail or fax (with the family’s approval) to share (or better still, generate) goals, updates on progress, and needed modifications. In this instance, the SLP could assume the role of PSP or coordinator with a focus on the benefits that may result for the child and family, as well as the professionals involved.

In addition to professionals, it is important to consider other individuals who are important in the child’s everyday activities and experiences. Does the child have multiple caregivers throughout the day (childcare providers, grandparents, family friends, neighbors, etc.)? Are there other children in the family? Brainstorm with the family who could be part of the day-to-day implementation of intervention strategies and who could help with planning and monitoring the IFSP objectives. With the increased focus on natural environments, communicating with all of the key people in the child’s daily life is a vital component in implementing effective intervention services.

We recognize, however, that building these types of teams may be slow or sporadic and especially difficult when organizing face-to-face meetings. In this case, perhaps teams could be viewed as committees. Effective committees may only meet occasionally in full and may use a subcommittee format to accomplish the rest of their work. Similarly, EI teams could follow the same practice with occasional full meetings and more frequent smaller subgroup meetings. The biggest factor is communication among team members and keeping everyone on the “same page” throughout the process while supporting the child and family.

**Conclusion**

In conclusion, answering the question, “Who does what, when, why, and how?” is neither easy nor exact. That is a good thing. The answers to those questions should be individualized to meet the child and family’s identified outcomes, rather than applied to all children and families in EI. Whether or not to use a PSP approach should be up to the team, including the family, based on the child and family’s priorities and concerns and on state and local guidelines for service delivery. While PSP is not the answer to all service delivery challenges, it can be a good match to address the needs of many families and can strengthen the knowledge and skills of SLPs through teamwork with other professionals.

The evidence base for the PSP approach is emerging. However, it is not as much a new or unknown approach as it is updated from the transdisciplinary model of teaming. SLPs should acquaint themselves with how the PSP approach is being implemented in their local programs prior to making any judgments about its utility or recommendations for specific families. Implementation varies widely in that each state, and some local programs have variations that address the unique service delivery challenges of their area. On their Part C Web sites, some states provide information about their use of the PSP models. These include Colorado (http://www.eicolorado.org), Florida (http://www.doh.state.fl.us/alternatesites/cms-kids/families/early_steps/early_steps.html), and Georgia (http://health.state.ga.us/programs/bcw/faq.asp).

While a PSP approach certainly can be within the SLP’s scope of practice, it may require significant professional development to facilitate the SLP’s shift to a collaborative consultation and coaching approach with both caregivers and team members. Self-reflection and frequent communication are also valuable tools for EI teams. Gaining competence as a PSP will require
time spent with team members learning new strategies for teaching children and families, sharing results, revising plans, and coordinating joint visits or consultations. Although the more traditional team meeting may be replaced by virtual- or technology-supported options, communication remains essential to the success of the PSP approach. Finally, teaming also is essential, not only in PSP but in all types of service delivery in early intervention. SLPs must advocate for the necessary training and team time to ensure the delivery of high-quality EI services and supports for children and families.

References


