Frequently Asked Questions for Physicians/Providers: Babies Can't Wait & the Primary Service Provider Model of Service Delivery

What does the Law say?

The Babies Can't Wait (BCW) Program is Georgia's Part C Early Intervention Program under the federal Individuals with Disabilities Education Improvement Act (IDEA), the same law that governs special education services for children in public school systems. Part C establishes a comprehensive, coordinated, multidisciplinary, interagency system of early intervention supports for infants and toddlers with disabilities from birth to age 3 and their families. In Georgia, the Department of Human Resources (DHR) Division of Public Health administers Babies Can't Wait. Since its inception, the IDEA has mandated that all Part C programs nationwide must provide services to families of eligible infants and toddlers from birth to three years of age in natural environments. The law defines natural environments as "settings that are natural or normal for the child's age peers who have no disabilities" (34 CFR 303.18), such as home, childcare or community settings.

Why are natural environments important?

Providing services in natural environments is not just the law. It reflects the core mission of early intervention, which is to provide support to families to help their children develop to their fullest potential and allows children and families to more fully participate in their communities. When services are provided as part of a family's routines and activities, the family has more opportunities throughout the day to encourage their child to learn and practice new skills and the child is more likely to achieve desired outcomes.

What is happening in Babies Can't Wait related to their model of service delivery? Why is Babies Can't Wait changing? What model is being adopted?

Current IDEA language encourages state Part C programs to examine not only where services are provided but how services are provided, the research and evidence that supports the services, and the effectiveness of the services. Part C programs are being encouraged to provide supports that focus on helping families and care providers promote children's development and participation within their families and communities, through the numerous learning opportunities that occur within natural daily activities and routines.

The IDEA defines the roles of service providers in early intervention as "assessment, consultation and training" (CFR 303.12) in order to support families and caregivers. The role of the service provider is that of a coach, consultant, or facilitator; an equal partner in supporting learning and sharing strategies with the family/care provider and other professionals, rather than solely as a provider of one-on-one services to the child. Babies Can't Wait is implementing a model of service delivery in which a primary service provider will support the family/caregiver's and other professionals' learning through the primary service delivery model. The primary service provider/coach will function as part of an active team, which also includes the parents/caregivers and other professional team members, and will have access to input and support from the other members on the team on a regular basis and whenever needed. Each child's team is comprised of professionals from the following disciplines, which may include but are not limited to, occupational therapy, physical therapy, speech-language pathology, nursing, nutrition, and/or early childhood education/special education, which are determined to be necessary to support the child and family toward attainment of IFSP outcomes or goals. The primary service provider could be any one of these team members.

Will a primary service provider model of service delivery mean a reduction in or less individualized services to children and families?

Services in a primary service provider model will be better individualized to meet the needs of each child and family since the focus will be on team-identified routines, strengths, and needed supports unique to each child and family. In a primary service provider model, multiple professionals may be present for fewer sessions, but the knowledge shared between professionals and caregivers for use across various settings and activities is greatly increased and ultimately provides the child many more opportunities for practice of skills. For example, when services are provided in a clinic setting, a child may receive one hour of direct therapy a week. If, however, that same hour is used by the therapist to coach the family or childcare professional in how to support the child's development across all developmental domains through natural activities such as feeding, dressing, bathing, or play, learning opportunities for that child/caregiver are expanded to many more hours per day or week.

How will this approach be different from services that might be provided at a clinic/rehabilitation facility or through professionally-driven intervention in natural environments?

Services provided in a clinic/rehab facility or through professionally-driven interventions in natural environments are typically based on the clinician's assessment of a child's skill deficits. There is little opportunity for the clinician to identify and build on each family's strengths and the resources that families have to use in supporting their child's learning. Intervention in such an approach is primarily focused on the mastery of isolated skills rather than the interrelated nature of all areas of a child's development. This approach results in limited generalization of skills to other settings. Since they have no opportunity to observe the child during daily activities with his family, clinicians are left without crucial information to use in supporting the child toward full participation in daily life.

With a change in service delivery methodology, the primary service provider or coach will focus on promoting competence and positive family functioning and will support families to encourage each child's development while building on existing strengths and interests. Support is provided during daily routines, in familiar settings and with familiar toys and objects in those settings. This model recognizes that family members and care providers are the primary influences for nurturing growth, development and learning in young children. It also provides caregivers with the formal and informal supports necessary to enable them to promote their child's participation in family and community life. "The essential features of a family-centered approach to early childhood services include… providing support in a manner that is empowering and that enhances parental competence." (Shonkoff, J.P. & Phillips, D.A. From Neurons to Neighborhoods, 2000)

"Infants and toddlers with disabilities need to learn skills through high frequency, naturally occurring activities in their environment" (Lee, Swanson, & Hall, 1991; Shumway-Cook & Woollacott, 1995). "Interventions within natural environments with key care providers and familiar toys and materials allow for: 1) generalization of skills; 2) learning opportunities with natural consequences; 3) task specificity; and 4) functional outcomes" (Cripe, 1997; Shelden, 1998; Shumway-Cook & Woollacott, 1995; Stokes & Baer, 1977; Warren & Horn, 1996).

As this model is implemented, should physicians also be referring families and children for additional services in clinic settings?

Families can always choose to seek services from providers who do not provide services in natural environments and who do not practice in a primary provider model. However, those services are not considered BCW early intervention services and families are financially responsible for those services. And, physicians may always choose to refer families and children for appropriate services outside of the BCW system. However, it may be helpful for families and physicians to know that BCW provides much more than therapy. BCW is an educational system that provides families of eligible infants and toddlers with service coordination (case management), access and linkages to formal and informal supports and resources, assistance in accessing funding sources and support as children transition from BCW at age three, all of which

are not easily accessible without participation in the BCW system.

What evidence exists to indicate that this model works for children and families?

Research in the field of early intervention and early childhood education/special education indicates this approach leads to real gains in child development, improvement in the family's feeling of competence in meeting their child's developmental needs, and attainment of meaningful, functional outcomes for children in the context of their family and community. Articles of relevant research are available upon request from any Babies Can't Wait office. In addition, a brief list of recommended articles is provided for your reference below.

- Campbell, S. (1997). Therapy programs for children that last a lifetime. Physical and Occupational Therapy in Pediatrics, 7(1), 1-15.

- Cripe, J.W., & Venn, M.L. (1997, November). Family-guided routines for early intervention services. Young Exceptional Children, 18-26.

- Dunst, C. (2000). Revisiting "rethinking early intervention." Topics in Early Childhood Special Education, 20, 95-104.

- Dunst, C.J., Bruder, M.B., Trivette, C.M., Raab, M., & McLean, M. (2001). Natural Learning Opportunities for Infants, Toddlers, and Preschoolers. Young Exceptional Children, 4(3), 18-25.

- Dunst, C.J., Harter, S., & Shields, H. (2000). Interest-Based Natural Learning Opportunities. Young Exceptional Children Monograph Series No. 2 (pp. 37-48). Denver, CO: Division for Early Childhood of the Council for Exceptional Children.

- Hanft, B.E., & Pilkington, K.O. (2000). Therapy in natural environments: The means or end goal for early intervention? Infants and Young Children, 12(4), 1-13.

- Jung, L.A. (2003). More is better: Maximizing natural learning opportunities. Young Exceptional Children, 6(3), 21-26.

- McWilliam, R.A. (2000). It's only natural…to have early intervention in the environments where it's needed. In S. Sandall & M. Ostrosky (Eds.), Young Exceptional Children Monograph Series No. 2 (pp. 17-26). Denver, CO: Division for Early Childhood of the Council for Exceptional Children.

- Mullis, L. (2002). Natural environments: A letter from a mother to friends, families, and professionals. Young Exceptional Children, 5(3) 21-24.

- Rainforth, B. (1997). Analysis of physical therapy practice acts: Implication for role release in educational environments. Pediatric Physical Therapy, 9(2), 54-61.

- Rosenkoetter, S.E. & Squires, S. (2000). Writing outcomes that make a difference for children and

families. Young Exceptional Children, 4(1), 2-8.

• Shelden, M.L., & Rush, D.D. (2001). The ten myths about providing early intervention services in natural environments. Infants and Young Children, 14(1), 1-13.

What information exists in Georgia to support this model?
In Georgia, information from multiple pilot sites throughout the state indicates an increased rate of family satisfaction and family confidence in their abilities to support their young children with disabilities. Professionals working in the primary provider model report improved positive outcomes for children and families, greater support among colleagues, and improved efficacy as practitioners. Throughout the country, at least 7-8 states are currently involved in training and planning to change to a similar model of service delivery and 6-8 others have already successfully implemented a similar model, while more than 25 states are currently discussing ways to accomplish such a change within their early intervention systems.

What are the positions of the national associations for physical therapy, occupational therapy, and speech-language pathology related to this model?
As early as 1988, it was recognized that family-centered services and the provision of supports during daily activities and routines were most effective for young children and their families. The provision of supports through coaching is the most recent adaptation of this approach to early intervention.

In position statements issued in 1989, the American Speech-Language-Hearing Association (ASHA) (www.asha.org) stated that the speech-language pathologist should deliver family-centered services focused on the communication-related interaction between the child and his/her family members. The roles practiced by speech-language pathologists should be implemented in a comprehensive, community-based program that is family-centered and is also coordinated with other services that the families and their children may need or receive. ASHA concluded that speech-language pathologists “assume important consultative functions with agencies and professionals who provide early intervention services.

The Section on Pediatrics of the American Physical Therapy Association (APTA) (www.apta.org) issued a document in 2001 that encourages professionals to “observe children engaging in real-life activities with families and care providers across natural settings” and to “coach families and care providers in everyday places during real life activities and routines”. APTA also notes that early intervention services in natural learning environments “support families in promoting their children’s development, learning and participation in family and community life (the purpose of Early Intervention) and “recognize family members and care providers as the primary influence for nurturing growth, development and learning.” APTA Competencies (1991) include the following: (7.9) “develop an individualized family-focused intervention program to enhance the growth and development of the child through a partnership with the family” (8.4) “function as a consultant by providing technical assistance to other early intervention team members, community agencies, and medical facilities” and (8.6) “demonstrate skill in formal and informal teaching of students, families, paraprofessionals, and professionals concerning physical therapy in early intervention”.

In 1988, an American Occupational Therapy Association (AOTA) (www.aota.org) position statement noted “the AOTA supports a family-focused approach to early intervention and preschool services. When families’ needs are successfully addressed, children make more progress” and “Occupational therapy supports the concepts of family-centered approaches, best practice, and professional collaboration in the provision of early intervention and preschool services.” A fact sheet from the American Occupational Therapy Association (AOTA) in 2005 noted that “occupational therapy practitioners, as part of the multidisciplinary team, provide services to young children and their families” and “design interventions that promote healthy development, establish needed skills, and/or modify environments, all in support of participation in daily activities.”

When will these changes be implemented?

Final deadlines for full implementation have not been established. By June 2006, core teams of early intervention professionals will be trained in each Public Health District throughout the State in order to continue toward full implementation statewide. In addition, Babies Can't Wait continues to gather and disseminate information from national and state resources, professional associations, institutes of higher education, families and practicing early intervention service providers to inform careful implementation of positive systems change.

Will providers be required to teach other providers skills that are outside of their discipline's scope of practice, with the expectation that any type of therapy is to be delivered by the primary serviced provider only?

No. Under the Primary Service Provider Model, providers are expected to deliver discipline specific services to children enrolled in Babies Can't Wait Program. Therapy services provided by a primary service provider will not fall outside their specific therapy scope of practice. These services will be delivered by the Primary Service Provider/therapist of record. During a family based therapeutic invention, if a child exhibits or presents with a concern out side of the provider's scope of practice, the current primary service provider will take the concern back to the team for discussion and support from other appropriate professional disciplines on the team. Support from other team disciplines can be in the form of suggestions, additional strategies, and assessment by other disciplines if necessary to address a specific concern and can include adding another discipline(s) to the IFSP for additional support. The primary service provider can be changed if the team including the family decides that a different discipline has the expertise needed to provide on going support for the family and child to achieve IFSP outcomes.

Will providers be required to "teach" parents how to provide therapies for their children?

Primary Service Providers will provide medically necessary therapy services provided directly to an individual child as well as engage parents/caregivers in discussion, education, and reflection about strategies to promote a child's participation in daily life. During a session with the Primary Service Provider parents are expected to be in attendance, to be participants and to observe demonstrations by the provider in order that the parent understand how to incorporate strategies into the child's and family's naturally occurring routines and daily activities. Educational components of the visit including discussion and reflection with the parent/caregiver are not a Medicaid billable service. Billing for these activities will be directed to the local Babies Can't Wait program.

Under the Primary Service Provider Model, can the provider bill Medicaid for the therapy services?

Providers are permitted to bill Medicaid for skilled medically necessary therapy services provided directly to the individual child according to the definitions of the procedure codes and time limits established by Medicaid in the CIS billing manual.

Ex: Mary has a feeding issue. The Speech Language Pathologist spends one hour working with Mary on swallowing issues. This is an activity billable to Medicaid.

Is there any part of the Primary Service Provider Model that we cannot bill Medicaid for?

You cannot bill Medicaid for conversations with parents for return demonstration by the parent/caregiver. You cannot bill Medicaid for procedure codes not authorized for your specific discipline as detailed in the Children's Intervention Services (CIS) Medicaid manual.

Ex: The Physical Therapist just concluded a 30 minute session with Michael. The Physical Therapist spent the next 15 minutes discussing positioning with Michael's mother who also showed her understanding by return demonstration of the strategies discussed. The Physical Therapist could only bill Medicaid for the 30 minute session. The 15 minute conversation with Michael's Mother as well as the demonstration is not a Medicaid billable activity. However, it can be charged to the BCW program.

What if I have more questions?

Contact your local Babies Can't Wait Early Intervention Coordinator, BCW Parent Educator, or the State Babies Can't Wait office at 404-657-2726 or toll free at 888-651-8224. Or visit the Babies Can't Wait website periodically for updated information: http://health.state.ga.us/programs/bcw/

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