APTA Section on Pediatrics

Early Intervention SIG Update

December 2011

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A Message from the EI SIG Chair

Welcome to the Early Intervention Special Interest Group (EI SIG)! The EI SIG of the Section on Pediatrics (SoP), APTA, exists to provide opportunities for its members to meet, confer, and promote quality of practice for infants and toddlers with developmental disabilities and their families.

The EI SIG has been busy this year maintaining mechanisms of communication and sharing resources through our webpage on the Section's website, articles in the Section's spring and fall newsletters, postings on the SoP APTA communities of practice, responding to inquiries, providing educational programming at SoPAC 2011 in Anaheim, planning for CSM and SoPAC 2012, and developing our first annual newsletter. To meet members' needs and interests we are also investigating an EI SIG Facebook Page and Twitter account. In the meantime, we encourage you to reach out to others when you have questions, share practice tips, fun ideas, and good things that you are doing on the Section on Pediatrics APTA community of practice.

This year our subcommittee and tasks forces have been working on the following new resources:

- Professional development guide to promote achievement and application of EI competencies in practice
- Collaboration tool to promote successful transition from EI to preschool (in collaboration with the School-based SIG)
- Power point on the role of physical therapy in EI
- Resource on primary service provider approach to service delivery
- Resource on relationship-based approach to service delivery

We welcome your participation on these projects as well as new ideas for future endeavors. Your role in the EI SIG is essential to how we function and what we accomplish. Please email us to become involved in the EI SIG. My service to the SoP has provided me immeasurable benefits and friendships that will last a

lifetime. I hope as a group we can celebrate the good news about early intervention and discover solutions to improve service delivery.

I want to take the opportunity to thank the following members who have contributed their time and expertise to these projects: Tricia Catalino, Kendra Gagnon, Elisa Kennedy, Sue Rabinowitz, Barb Pizzutilo, Deb Seal, Yvette Blanchard, Mary Jane Rapport, Sheree York, Lynn Jeffries, Trina Puddefoots, Rita Guthrie, Krista Kellogg, Tiffani Bacon, M'Lisa Sheldon, Rebecca Downey, and Terrie Millard.

I wanted to end by sharing some good news. A recent report from the National Early Childhood Technical Assistance Center (NECTAC, July 2011) outlines the positive outcomes of early intervention including fostering child development, enhancing parenting skills, and reducing the need for special education services. Thank you for your service to young children and their families.

- Lisa Chiarello, PT, PhD, PCS

Tip for EI Practice: Improving Caregiver-Therapist Communication

Family-centered care has a tradition in the delivery of services for children and families enrolled in early intervention (EI) with the premise of a collaborative process between providers and caregivers. Physical therapists in the EI setting partner with the family and child to foster the child's growth and development, however family-centered care can be challenging if there are barriers to communication or a lack of common ground between the therapist and caregiver. The following tips according to DeGrace and Castles (2009, p. 31) describe several strategies for frequent and open dialogue to improve caregiver-therapist communication and family-centered care at the home, daycare, or in the community. As with any recommendations in family-centered care, these tips will be most successful if agreed upon by the caregivers and can change as priorities change.

- With permission from the family, consider using email or other forms of electronic communication to share information between team members. A group email will deliver the same information to everyone at the same time and can be a time saver.
- For some situations a communication notebook may promote daily communication between child-care personnel and parents. For example, a spiral notebook can be carried back and forth by the child, between home and child-care setting; however this strategy should be agreed upon by all involved as it could be a burden for a

busy teacher or parent.

- Provide caregivers with a personal contact card with your name, title, work/mobile number, and email address on it. On the back of the card, make a statement encouraging the parents to contact you any time they have concerns, questions, or need more support.
- Attend and participate in events that are planned for parents and hosted by their clients' child-care centers. Let parents know you will be available during these occasions for short meetings by sending a note home.
- Ask parents to supply a portfolio of their child. A child portfolio can be a handwritten one-page document or a scrapbook, consisting of information about the child's likes and dislikes, personal hobbies, family photos, family tree, or any other facts the family would want you to know.

And finally, it is important to always show a positive attitude toward parents, be sensitive and responsive to parental concerns (eg, providers should consider the effect of therapy on the family and integrate home exercise programs into the family's daily routine), and provide information about resources and options available to parents (Hanna & Rodger, 2002).

References:

DeGrace, E., & Castles, T. (2009). Understanding and strengthening parental involvement. In I. McEwen (Ed.), Providing physical therapy services under Parts B & C of the Individuals with Disabilities Education Act (IDEA) (pp. 29-35). Alexandria, VA: Section on Pediatrics, American Physical Therapy Association.

Hanna, K., & Rodger, S. (2002). Towards family-centered practice in paediatric occupational therapy: A review of the literature on parent-therapist collaboration. Australian Occupational Therapy Journal, 49, 14-24.

- Tiffani Bacon, PT, MPT, and Tricia Catalino, PT, DSc, PCS

From Research to Practice

The purpose of this column is to highlight a recently published article relevant to pediatric physical therapy practice in early intervention. In this issue, we will highlight the following article:

Hickman R, Westcott McCoy S, Long TM, & Rauh MJ (2011). Applying contemporary developmental and movement science theories and evidence to early intervention practice. Infants and Young Children, 24(1), 29-41.

Purpose of the paper: To discuss the evolution of knowledge and models of practice specifically relevant to children with motor disorders in early intervention (EI).

Content of the paper: The evolution of EI practice for children with motor concerns is summarized in two main categories: 1) first-generation EI models which were based on perspectives that were developmental and child-centered, and 2), second-generation models which are family-centered and support-based (contextual). For each category, the authors describe the model, discuss the theories and applicable intervention strategies and summarize their research outcomes. Through a discussion of the evidence and knowledge acquired through research for each generation of intervention models, the authors propose the need for a "phase shift" in EI practice with children with motor concerns toward the second-generation models. These models are grounded on ecological and dynamic systems theories of development and focused on outcome at the activity and participation levels of the WHO-ICF model. Barriers to implementation of family-centered services from the therapists' perspectives are also discussed briefly.

The next section of the paper offers a rich and clear discussion designed to assist the therapist better understand how to translate knowledge about human motor development into interventions. Highlighted concepts, accompanied by descriptions of intervention strategies, include: the importance and characteristics of practice, the effects of activity on brain development, and, the importance of meaningful goals and environmental context. Lastly, the authors emphasize the importance of partnering with parents and caregivers and proper training of personnel in order to best meet the challenge of the "phase shift" needed in EI practice with children with motor concerns.

Concluding remarks: This article offers a clearly written synopsis of past and current knowledge pertinent to clinical physical therapy practice in EI. By reading this paper, practitioners of all ages should be able to recognize their own model of practice and areas of future growth. This article can be used as a tool for reflection and discussion between peers. The richness in clinical examples provided in this article should help pediatric physical therapists better understand how the theoretical knowledge gathered from the theories can be translated into practice. A must read.

If you have questions, please contact Yvette Blanchard, ScD, PT, at yvetteblanchardpt@gmail.com or the lead author of this paper, Robbin Hickman, at robbin.hickman@unlv.edu.

- Yvette Blanchard, ScD, PT

An Overview of the New Part C Regulations

On September 28, 2011, final regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities were published in the Federal Register. These long-awaited regulations implement changes in

Part C of the Individuals with Disabilities Education Act necessitated by the reauthorization of the IDEA in 2004. In these regulations, the U.S. Department of Education amended and finalized the regulations proposed in May 2007. These recently published final regulations became effective on October 28, 2011.

There is one component that is not yet finalized. Due to the economic changes that many States have experienced since the publication of the proposed regulations in May 2007, the Department received many informal inquiries requesting guidance on the maintenance of effort (MOE) provisions (from proposed § 303.225) (which implement part C's supplement not supplant requirements). States also have expressed concern about their ability to meet the MOE requirements and their continued participation in the part C program. In response to these concerns, the Department intends to obtain additional public input and conduct further rulemaking in this area. Thus, this MOE component remains in a proposed state while the other sections of the regulations were finalized.

There are no new or revised sections that would significantly alter physical therapy as an early intervention service under Part C. However, there are a few changes that may be of interest to physical therapists who work with infants and toddlers who are eligible for early intervention services under Part C.

Issues of funding for services have received significant attention given the burden of cost and the state of our economy. Part C services must be provided free of charge unless the State has established a system of payments. States may not access a parent's private insurance to pay for Part C services unless the parent provides consent to do so. States wishing to use private insurance funds belonging to a parent or their child to pay for Part C services should have already included this option in a system of payments, especially in cases where the use of private insurance involves co-payments and deductibles. The requirement to obtain parental consent to use private insurance has not changed in these final regulations. While a State may be facing a potential loss of revenue from not being able to access private insurance because parents will not provide consent, this would be offset by the benefits of protecting the autonomy of the family and the benefits of ensuring that the family is not unknowingly incurring costs - both of which are important legal requirements under IDEA.

When States access private insurance as a funding source, they must ensure that the use of private health insurance to pay for Part C services will not: (1) count towards or result in a loss of benefits due to the annual or lifetime health insurance coverage caps for the infant or toddler with a disability or their family, (2) negatively affect the availability of health insurance for the child and

their family, (3) result in the discontinuation of health insurance coverage, or (4) be the basis for increasing the private insurance premiums for the child or their family.

Some States have enacted laws that require provision of FAPE (free, appropriate public education) for all children, including infants and toddlers with disabilities as a subset of children with disabilities. In those States which use funds under Part B of IDEA to ensure FAPE, the State also must ensure that those services that constitute FAPE are provided at no cost. For example, if a State has established a system of payments under part C of the Act, but under State law mandates FAPE for a particular subgroup of children under the age of three (either by age and/or disability group, such as individuals who are blind), the State cannot charge for any services that are part of FAPE for that child or family. Because the section of regulations (303.521(c)) clarifies current requirements and practice, and does not add or significantly alter existing rules, this is not expected to result in any change in costs for State agencies, early intervention service providers, or families.
A few of the other additions and changes that may be of interest to physical therapists who provide early intervention services to infants and toddlers include the following:

- 'Multidisciplinary' means the involvement of two or more separate disciplines or professions and may include one individual who is qualified in more than one discipline or profession.
- Evaluation and assessments of the child and family must be multidisciplinary and performed by qualified personnel. Therefore, if one individual completes an evaluation while representing two or more separate disciplines or professions, that individual would have to meet the definition of qualified personnel in each area in which the individual is conducting the evaluation or assessment.
- The IFSP team must include the involvement of the parent and two or more individuals from separate disciplines or professions, and one of these individuals must be the service coordinator.
- When conducting evaluations and assessments of the child, qualified personnel determine whether it is developmentally appropriate to use the language normally used by the child.
- Informed clinical opinion must be used by qualified personnel when conducting an evaluation and assessment of the child. In addition, informed clinical opinion may be used on an independent basis to establish a child's eligibility even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the

results of evaluation instruments used to establish eligibility.

- A family-directed assessment must be conducted to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet their child's developmental needs. The family-directed assessment must be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment.
- The definition of 'Natural Environment' was modified by:
- adding in the phrase "or community settings" after "home"
- adding the phrase "same-aged" before the phrase "infant or toddler without a disability"
- replacing the reference to "normal" with "typical"

Therefore, the term 'Natural environments' has been modified. Natural environment means settings that are natural or typical for a same-aged infant or toddler without a disability and may include the home or community settings.

Some additional changes in the regulations deal with the timelines for post-referral processes, but these changes do not alter the 45 day timeline. The existing 45 day timeline continues to be the requirement for completing the initial evaluation, assessments and IFSP meeting. Exceptions are allowed when parental consent has not been obtained. New regulations in the area of procedural safeguards require that printed copies of evaluations, assessments, and IFSP to be provided to parents after each IFSP meeting. Requirements for States to follow around issues of 'payor of last resort' help to clarify the need to obtain parental consent prior to the parent enrolling in a public benefit program or allowing use of private insurance. The definition of personally identifiable information (PII) was modified to align with the FERPA definition, and a revision was made requiring (state) lead agencies to hold public hearings and provide a public comment period of a minimum of 30 days before adopting any new or revised Part C policies or procedures. The definition of physical therapy and the need for physical therapy to be provided by a qualified physical therapist, remain unchanged.

The Part C regulations offer additional guidance and clarification to States on many issues, including those which have an impact on funding, financial resources and acquisition to private insurance. In light of the economic vulnerability of many States, and the desire to continue their participation in Part C, these regulations address many procedural areas that do not directly impact the delivery of physical therapy. As pediatric physical therapists providing early intervention services, we should explore the new federal regulations and know

where to find content pertinent to our responsibilities as part of the early intervention service delivery process and our desire to assist children and their families to reach their goals. The Part C regulations can be easily accessed at www.idea.ed.gov. In addition, the Division of Early Childhood (DEC) of the Council for Exceptional Children, has provided an excellent resource comparing the new 2011 final regulations with those from 1999 in a side-by-side comparison. This document can be found online.

The Section on Pediatrics will continue to work closely with the APTA staff in Governmental Affairs to insure that members' questions and concerns are addressed and recommendations for future regulatory changes are considered. Please contact Mary Jane Rapport, Section on Pediatrics Federal Affairs Liaison, (maryjane.rapport@ucdenver.edu) or Deborah Crandall (deborahcrandall@apta.org) with any questions.

- Mary Jane Rapport, PT, DPT, PhD

Teaming in Early Intervention: The "State" of the Nation

According to a document prepared by the National Early Childhood Technical Assistance Center (NECTAC) entitled Models or Approaches to Early Intervention Service Delivery Endorsed of Used as Reported by States (Pletcher, 2011), 49 states report implementation of teaming approaches that involve the use of a primary service provider (http://www.nectac.org/topics/natenv/updatemodels.asp). The Mission and Key Principles for Providing Services in Natural Environments (Workgroup on Providing Services in Natural Environments, 2007) identified that the family's priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support (Key Principle) 6).Based on the interest in teaming approaches in early intervention, each newsletter will highlight a statewide early intervention program from 2 perspectives; (1) the statewide Part C Early Intervention Coordination, and (2) a physical therapist currently working in early intervention.

For this newsletter, representatives from the state of Georgia have graciously agreed to share information about the current approach being implemented in their state. Chase Bolds, the Part C Coordinator and Sarah Davidson, PT agreed to answer a few questions. Sarah has been a physical therapist for 7 years and has worked in pediatrics her entire career. She has worked for Babies Can't Wait for the last 5 ½ years in southern Georgia.

Q) What approach to teaming in early intervention are you using in your state?
Chase: Each district Part C program in Georgia uses the Primary Service Provider Model, which incorporates

teaming in the model. Teams are usually determined by geographical area and meet once weekly or bi-weekly to support one another and share information. Teams are made up of service coordinators and providers from various disciplines including but not limited to, occupational therapists, physical therapists, speech-language pathologists, nurses, nutritionists, special instructors, and family members. The team supports the child and family toward attainment of child IFSP outcomes.
Sarah: The primary service provider model.

Q) Why did your state decide to use this approach?
Chase: The state lead agency redesigned the program with the goal of program improvement. There was a need for the Georgia Part C program to serve children and families more efficiently, effectively and to improve child outcomes.
Sarah: The implementation of this teaming approached happened before I began working in early intervention, but I am assuming that it was shown to be the best practice within research available for promoting success for the children and families as well as costs for the state.

Q) What are some of the biggest challenges facing early intervention in your state?
Chase: The number of children and families served in Georgia Part C program.
Sarah: I do not feel I can entirely speak about challenges for my state, but I can speak for challenges within my district. Some of the biggest challenges for my district are the large size of the coverage area, lack of specific disciplines, and provider availability to meet the needs of the children enrolled in our program. The challenge of the coverage area, is that my district is a large rural area and therefore providers may travel significant distances to see 1 family. The distances make it hard for it to be profitable for individual providers working in early intervention because of the cost of travel, the time it takes to travel, and then the reality of seeing fewer children and families in 1 day, as compared to other, specifically, therapy clinic-based settings. My district is continually seeking new providers in all disciplines. Many of the providers we do recruit only serve a few children, or can only see children a few hours a week. This creates a challenge for scheduling team meetings, joint visits, and IFSP meetings.

In my District, we initially needed to work and develop as a smaller, core team, and then branch out across the district. Every team within our district has unique characteristics with strengths and weakness and each has to be developed independently. We have had to work through the typical team process of getting to know one another, learning each other's strengths and professional boundaries, learning how to manage conflict with each other, acceptance of our roles within the team, and then ongoing functioning as a team. The

continual challenge is that there are many different subsets of teams within my district. We have the core team, then a core team within each individual team, and within each individual team there are other undefined "teams" that form between providers. All of this challenges the roles, and overall functioning of the team.

The ongoing challenge of coverage is due to providers having to travel extended distances to "physically" be a part of the team meeting. Our district uses technology to allow providers to be present by video or audio, but not in person, which brings a different set of challenges and adjustments.

With this approach we also have the ongoing challenge of training. When you're working on a team it is really apparent when all providers are not on the same level. An additional challenge is continuing to ensure that new providers understand what the primary service provider model is, what it is not, what coaching is, and the purpose of the team meeting. These challenges are variable, as they change within every team. With every progression brings new and different changes and challenges.

Q) What are some of the challenges in early intervention related to physical therapists in your state?
Chase: Recruitment and retention of physical therapists to serve children and families in rural areas of the state.
Sarah: Challenges related to physical therapists in Georgia, most vocally, surrounds funding, billing, and reimbursement. This is due to a large portion of our client list utilizing Medicaid and other government subsidies, and funding continues to be cut from those programs, therefore, reimbursement for physical therapy services continues to be in jeopardy. When it is taken into account that a therapist travels an extended distance to one child's home, and is paid a lower rate, as compared to insurance rates, or a therapy clinic that has seen 2-3 clients in the same time period, it makes it difficult to obtain and retain therapists. Our district, as stated earlier has had an exceptionally difficult time attaining providers/therapists of any sort, especially when competing with other facilities that can offer greater incentives.
We also have ongoing challenges of availability, as I am the only Babies Can't Wait physical therapist provider for 16 counties. This situation does not allow me the flexibility to fully serve children in the true capacity of the primary service provider model. Support of other physical therapists can be a "challenge" because there are so few physical therapists within the state that also serve BCW. This can be a challenge when it comes to continuing education, because trainings are not often specific to the primary service provider model, or the instructors' present techniques that are not appropriate for the home environment, and the instructor is not adept or experienced in providing services natural environments.

Q) What makes EI successful in your state? Or what are you most proud of related to the early intervention program in your state?
Chase: The quality of early intervention services provided to children and families in our state. The Babies Can't Wait providers are very dedicated to the families they serve. They routinely demonstrate a high standard of professionalism and desire to provide high quality services to children and families in the state.
Sarah: What I am most proud of within early intervention in Georgia is that we have continued to serve families at a level of very high quality. Families continue to be supported and are learning to help their children even with all the cuts, changes, and challenges that early intervention has faced over the past few years. The providers who continue to serve families enrolled in Part C have grown into a stronger team, and as a group we are supportive of each other. The providers who have survived through all the challenges have proven to be truly committed to early intervention for the betterment of families and children.

The information shared by representatives from Georgia in this brief newsletter article is very helpful in gaining further understanding of what teaming looks like in early intervention including some of the issues, challenges, and benefits related to this approach. Special thanks to Chase Bolds, Part C Coordinator and Sarah Davidson, PT for their time and willingness to share their insights into use of a primary service provider approach to teaming from a statewide and district perspective. For more information related to the recommended practices in early intervention see the Mission and Key Principles for Providing Services in Natural Environments (Workgroup on Providing Services in Natural Environments, 2007) and Seven Key Principles: Looks Like/Doesnâ€™t Look Like.

- M'Lisa Shelden, PT, PhD

Programming Update

The Section on Pediatrics Annual Conference (SoPAC) will take place at Walt Disney World in Orlando, FL September 28-30, 2012. The SoPAC planning committee is considering several submitted proposals in the area of early intervention (EI) and the EI SIG is active on this committee. Ideas for presentations in the provision of EI services are always welcome. Please consider submitting a proposal for future conferences or contact Tricia Catalino, PT, DSc, PCS, at Tricia.Catalino@tun.touro.edu if you have ideas for this coming SoPAC.

EI Resource

The new video, Child Outcome Step by Step, describes the three child outcomes adopted by OSEP and is a valuable resource for early intervention providers. You

may access this video online. Edelman, L. (Producer). (2011). Child Outcomes Step By Step (Video). Published collaboratively by Results Matter, Colorado Department of Education; Desired Results access Project, Napa County Office of Education; and Early Childhood Outcomes Center.

Early Intervention SIG Leadership

- Chair, Lisa Chiarello, PT, PhD, PCS, lc38@drexel.edu; Pennsylvania
- Vice Chair, Tricia Catalino, PT, DSc, PCS, tricia.catalino@tun.touro.edu; Nevada
- Secretary, Kendra Gagnon, PT, PhD, kgagnon@kumc.edu; Kansas
- Executive Committee liaison to the EI SIG: Sally Westcott McCoy, PT, PhD
- Practice Committee liaison to the EI SIG: Lynn Jeffries, PT, PhD, PCS

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Get Involved in the EI SIG!

We are currently seeking volunteers for the following task forces, work groups, and subcommittees:

- EI to preschool transitions
- Development of recommendations for translating EI competencies into practice
- Yearly newsletter
- SoPAC programming
- Fact Sheets in development: Relationship-based approach to intervention AND Primary service provider approach to teaming

Upcoming Events

CSM 2012, Chicago, IL, February 8-11
Thursday, 2/9/2012 at 11:15, Early Intervention Special Interest Group Meeting and Presentation: Opportunity to learn about the on-going activities of the EI SIG, share your ideas, and meet other EI therapists from around the country. A short presentation will be provided on current trends in early intervention practice.

PT 2012, Tampa, FL, June 6-9

SoPAC 2012, Orlando, FL, September 28-30
There will be programming related to the primary service provider approach, as well as other topics relevant to EI. Be sure to check out the SoPAC 2012 schedule, once it has been finalized, for more information.