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INTRODUCTION

The purpose of this module is to describe the roles of the many professionals who participate in the planning and implementation of intervention programs that support the development of children with disabilities and their families. The module will also provide you with an understanding of the team process in the context of medical, social, and educational settings. It is designed to inform you of the skills necessary to facilitate teams, emphasizing communication, consultation, problem solving, and conflict resolution. The physician is an important team member who actively contributes to program planning and service provision for their young patients with disabilities.

Successful intervention requires that all the professionals who interact with a family function under a common philosophy with shared goals and commitment. It is essential that members of the team recognize that all represented disciplines have particular expertise and are equally important in the development of services with a family and child.

ORGANIZATION OF MODULE

This module is divided into four components that will address the role of physicians and other professionals as they function in team-based models of service delivery. It seeks to provide you with a foundation of skills to function as an effective participant and facilitator on teams. The first component introduces you to the roles of other professionals. In component two, we will discuss the different types of teams and their various functions, the integrated service delivery model, and provide information about collaborative consultation and effective team process. The third component involves observing a discipline-specific assessment or intervention and interviewing the professionals who conducted it. The fourth component requires you to participate in a team meeting with a choice of:

1. A team meeting in an early intervention program or special education program in an elementary, middle, or high school.
2. A specialty clinic meeting, early intervention Individualized Family Service Plan (IFSP) meeting, or a school district Individualized Education Plan (IEP) meeting.

Ideally this participation will be for a patient from your own continuity clinic, but if necessary, the project coordinator can set up this opportunity for you with another family.

Summary of organization of module

- ❖ One half day/evening didactic
- ❖ One half day observation of assessment or intervention: physical therapy, occupational therapy, speech therapy, or audiology
- ❖ One half day participation in a team meeting of IFSP, IEP, or specialty clinic

OBJECTIVES

At the completion of the Team-Based Service Models module, you will be able to:

1. Describe the roles of professionals who provide services to children in early intervention, preschool, and special education.
2. Differentiate between multidisciplinary, interdisciplinary, and transdisciplinary models of service delivery.
3. Describe and explain the concept of role release, appropriate methods of providing direct and indirect consultation, and the components of the successful integrated therapy in service provision for children with disabilities and/or special health care needs.
4. Describe the role of the physician as a member of a transdisciplinary team in early intervention and special education with respect to assessment, program design, intervention, service delivery, and transition.

COMPONENT ONE: INTRODUCTION TO TEAM-BASED SERVICE MODELS

Location and Times:

These will be established by the project coordinator in conjunction with the chief residents. You will be notified by either the coordinator or a chief resident with as much advanced warning as possible.

Format:

Information will be presented through discussion, reading materials, and case studies. Videos are optional.

Resident's Responsibilities:

Please arrive on time and come prepared to participate in the conversation. It will be a more productive session if you have read the material beforehand. Be prepared to critique the session afterwards.

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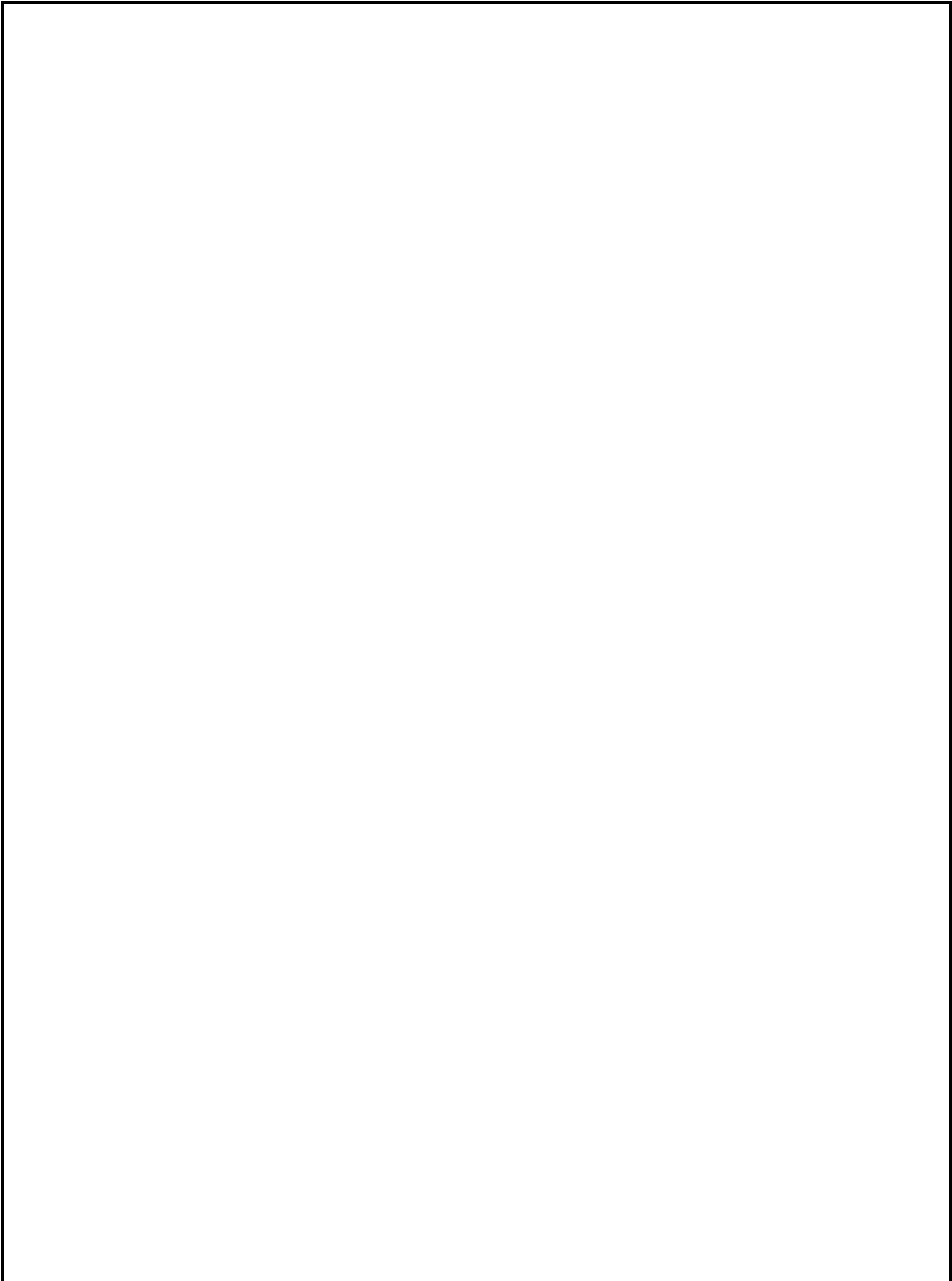


ROLES OF PROFESSIONALS

Professionals from medical, educational, and social service fields provide services to children with disabilities and/or special health care needs. The Individuals with Disabilities Education Act (IDEA) requires that both assessment and program development (IFSP or IEP processes) should be completed by a team consisting of the family and professionals representing at least two different disciplines. There are a number of specialists who provide services to children with disabilities and/or special health care needs and their families. The sections below outline differences in the training of professionals and the specific roles and responsibilities of each discipline.

DIFFERENCES IN PERSONNEL PREPARATION

Within early intervention and special education systems, a diverse number of professionals are entrusted with the provision of services to children with disabilities and/or special health care needs. Significant differences are apparent in educational experiences, licensure or certification, supervision, and job responsibilities both between different professions and within the same profession from state to state. Professionals bring to their practice a variety of differing beliefs, values, and skills related not only to their personal experiences but also to the personnel preparation standards of their specific discipline. These differences can be reflected in the manner in which each professional views the resources, priorities, concerns, strengths, needs, and preferences of the child and family. Differences may also impact the development and delivery of services with respect to the medical, educational, social, and financial systems in which these families are involved.

Differences in personnel preparation are most apparent in the field of early intervention, serving children from birth to age three. Because this area is relatively new (25 years), methods of personnel preparation are being modified and reformed to reflect the evolving knowledge base of the field. Most individuals currently in practice received traditional, discipline-specific training that may have touched only briefly upon infant, toddler, and preschool development. There are also major discrepancies in the nature and content of discipline-specific curricula and the hours devoted to aspects of infant and child development. Few training programs specialize in providing services to infants and toddlers, and hours of practical clinical experience vary widely from profession to profession. This has resulted in relatively little specific longitudinal training about infants and toddlers across disciplines.

The majority of traditional personnel preparation efforts focus on training professionals to practice their discipline-specific skills with individuals across the life span and in relative isolation of other professionals. The opportunity to be trained as part of a collaborative team is lacking in most programs. Professionals most often have received team training in a multidisciplinary model. In this model, each professional completes his or her own discipline-specific individual assessment, writes specific goals for the child and family, and develops discipline-specific intervention plans.

PERSONNEL PREPARATION AND TRAINING

Each of the professionals listed below has expertise in his or her discipline, and each plays an important role in the education and care of children with disabilities and/or special health care needs. Following is a description of

general personnel preparation and training requirements for each discipline involved in early intervention and special education.

Aide or paraprofessional

Several different types of aide or paraprofessional positions exist:

- **Family support providers** have obtained a high school diploma or general equivalency diploma (GED). They may be the parent or relative of a child with special needs. They provide information, networking resources, advocacy, and ongoing support to families.
- **Early intervention assistants** have either a high school diploma or GED. The early intervention assistant performs routine tasks under the direct supervision of professionals with advanced credentials and certification, and assists in the implementation of the IFSP.
- **Instructional assistants** are classroom aides assigned to work directly with a child in the classroom to help meet his or her educational needs as defined in the IEP. Entry-level preparation includes a high school diploma or GED and completion of training by the local education agency. A professional with state educational certification and the appropriate degree supervises instructional assistants.
- **Home health aides** are paraprofessionals who assist families with daily living tasks and routines. Entry-level employment requires completion of a six-week home health aide course. Some home health aides are certified by the Department of Health and are supervised by a registered nurse.

Educator or teacher

Personnel preparation for educators/teachers/developmental therapists includes philosophy of education, learning theory, program development, methods of instruction, child and adolescent development, and assessment. Educators select a particular group on which to focus. Choices include early childhood/preschool, elementary school, middle school, high school, or special education.

Educators or teachers at the elementary, middle, or high school level must have at least a bachelor's degree and state certification. Educators are supervised directly by the principal of their school or by agency administrators. Emphasis is placed upon continually improving knowledge and skills through graduate work and participation in inservice training opportunities. State certification is renewed according to specific guidelines on a predetermined schedule. Many states require pursuit of advanced degrees and continuing education units.

Special education teachers specialize in the provision of services to children with disabilities and/or special health care needs. Their course of study focuses on characteristics of different disabilities, assessment of these characteristics and their impact on learning, and the development of specific interventions to mediate or compensate for these learning differences.

For early childhood educators, professional skill development includes specific course work about early childhood development in the following areas: social skills, emotional development, cognitive skills (play and problem-solving skills), communication and language development, and early motor development (gross and fine motor).

Personnel preparation also emphasizes understanding family systems and relationships and providing support to families through knowledge of resources, preschool programs, and child care options.

In the field of early childhood, educational preparation, certification, and licensure vary dramatically among professionals. Daycare centers are staffed by teachers and their assistants. Head classroom teachers generally have a bachelor's degree. Classroom aides and assistants must have at least a high school diploma. The National Association for the Education of Young Children has strongly advocated that all professionals who work with young children should possess at a minimum a child development associate degree (CDA). The CDA is usually acquired through a two-year program of study.

Nurse

Personnel preparation for a nurse focuses on knowledge of disease processes, disease prevention, and health care across the life span. A nurse can practice general nursing or sub-specialize in a particular area of medicine such as pediatrics, adolescent, psychiatry, or emergency. Professional preparation includes concentrations in family dynamics, working with families, child and family assessment, and interagency collaboration. Levels of nursing expertise include the licensed practical nurse (LPN) and the registered nurse (RN). LPNs complete a one-year certificate program and their practice of nursing is performed under the supervision of an RN or a licensed physician. RNs may graduate with a diploma degree (two-year clinical training), associate degree, bachelor of science, master of science, or doctorate degree. It is helpful to remember that nurses placed in school settings often have not received additional training regarding children with disabilities and/or special health care needs.

Occupational therapist

The personnel preparation of occupational therapists emphasizes development across the life span. Curriculum components include human development and behavior, sensorimotor development, biology, normal and abnormal psychology, health science, neuroanatomy, and ethics and values. Because occupational therapists are prepared to work across the life span, specific concentrations in infant and toddler development are unusual, although their frequency is increasing. Occupational therapists can practice with a bachelor of science or a master of science degree. Occupational therapists are supervised by state medical/health boards and their national organization.

Increasingly, services once delivered exclusively by occupational therapists are being provided by certified occupational therapy assistants (COTA). COTAs complete a one- to two-year program of preparation followed by certification by the National Association of Occupational Therapists. They provide services with direct supervision and monitoring by a licensed, certified occupational therapist.

Physical therapist

Personnel preparation for the physical therapist emphasizes functional mobility across the life span of the individual. Course work includes gross motor and sensorimotor development, human development and behavior, normal and abnormal reflex patterns, biology, physiology, psychology, anatomy, neuroanatomy, and neurophysiology. Entry-level requirements include a bachelor of science degree and licensing by the state medical/health board.

Physical therapists are supervised by state medical boards and their national organization. As with occupational therapists, the life span training of physical therapists does not often provide specific focus on functional mobility needs of infants and toddlers.

Audiologist

Personnel preparation of audiologists includes specific training leading to competency in evaluating the hearing status of individuals. Audiologists are trained with a life span perspective. Their preparation includes the physiology of hearing, neurophysiology, neuropsychology, physiology, and structural mechanisms of hearing. Audiologists must obtain a master of science degree and be licensed and supervised by the Department of Public Health.

Psychologist

Recently, there has been an increasing interest in young children's mental health. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) has been revised to include a diagnostic manual for children ages birth to three (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, 1994). However, psychologists, as is true with other professionals, have had little training or specialization in working with very young children and their families. Typically, they have been prepared to observe and evaluate normal emotional development and those behaviors that appear atypical. Psychologists specializing in infant and toddler development often seek course work in exceptional behavior, normal and abnormal infant and child psychology, family dynamics, attachment theory, disorders of attachment, and infant

mental health. Entry-level for practitioners requires a doctorate degree and state licensure.

Social worker

Training for a social worker includes some educational components in common with nurses and psychologists. Foundation skills include human behavior and social environments, individual development across the life span, social welfare policies and services, social work practice and theories, and research methods. Interagency practices and case management skills are well-developed components in their educational process. Because of this training, social workers are often selected as service coordinators or case managers. A subspecialty can include work with infants, toddlers, and preschool children and their families. Within this subspecialty, specific instruction is provided regarding children with disabilities and/or special health care needs.

Speech and language pathologist

Personnel preparation for speech and language therapists requires a five-year program of advanced study. Course work includes speech and language development, development of articulation, pragmatics, discourse skills, oral motor processes necessary for speech development, physiology, neurophysiology, and biology. Entry-level requires a master of science degree and a one year clinical fellowship supervised by a licensed speech and language therapist. Licensure is accomplished through the Department of Health. Speech and language therapists are supervised through the Department of Health and their national organization.

Vision specialist

Most teachers of the visually impaired hold a master's (or higher level) degree in education or a related field, although there are some teacher preparation programs on the undergraduate level. Teachers of the visually impaired must be certified by the state in which they work. Connecticut currently requires two certifications: "Teacher of the Blind" and "Teacher of the Partially Sighted" in the appropriate age or grade levels. Most teachers of the visually impaired also hold certifications in general education or special education, and some have other degrees/certifications in related fields: infant/toddler development, rehabilitation teaching (of the blind/visually impaired), low vision specialist, orientation and mobility specialist, etc.

Nutritionist/Registered dietitian

Nutritionists provide nutritional counseling across the life span. Core competencies include nutritional assessment, in-born errors of metabolism, nutrition education, nutritional services, consultation, and technical assistance. Entry-level personnel preparation includes a bachelor of science in nutrition with 900 supervised clinical hours. Advanced degrees may be obtained in nutritional science and nutrition education. The state of Connecticut requires certification for all dietitians.

Physician

While pediatric training in clinical skills and knowledge is primarily concerned with normal child development, disease process, and primary care, residency programs are expanding their efforts to incorporate instruction and experiences in screening and assessment procedures, disabling conditions, behavioral and psychosocial aspects of atypical child development, family-centered practices,

and community service resources. The Ambulatory Pediatric Association (1996) developed a comprehensive set of educational guidelines, goals, and objectives that incorporate these and many other issues.

Please refer to Appendix A for recommendations from the American Academy of Pediatrics on "The Role of the Pediatrician in Prescribing Therapy Services for Children with Motor Disabilities." The American Academy of Pediatrics has also published an article entitled "Pediatrician's Role in the Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP)." Please refer to Appendix B for this article. In addition to the pediatrician, other medical specialists (e.g., neurologist, geneticist, cardiologist, pulmonologist, etc.) may also become important members of the IFSP or IEP team or be represented by the primary care physician at team meetings.

Responsibilities of Professionals

All of the professionals who provide services to children with disabilities and/or special health care needs and their families have the responsibility to:

- ❖ Refer to other specialists or service providers.
- ❖ Collaborate with other team members (including family members) to assess children and develop comprehensive and integrated intervention programs.
- ❖ Consult with team members to assist in determining appropriate strategies to promote development of specific skills.
- ❖ Provide case coordination or case management services if chosen to do so.

- Participate in the IFSP and IEP process.
- Evaluate effectiveness of service delivery and intervention techniques.
- Advocate for children and families.

ROLES OF PROFESSIONALS IN THE EARLY INTERVENTION AND SPECIAL EDUCATION SYSTEMS

The following summarizes the discipline specific roles and responsibilities of the professionals.

Aide or Paraprofessional

- Assists the child with disabilities and/or special health care needs in the home, school, and community.
- Works directly with the child in the classroom to help meet educational needs and implement goals.
- Provides physical assistance to the child when needed.

Audiologist

- Evaluates hearing, including assessments of pure tone air conduction thresholds and speech thresholds; predicts hearing loss from acoustic reflex, reflex-eliciting auditory tests, and communication handicap inventories.
- Conducts extended evaluations, including air conduction, speech thresholds, and word/sentence recognition tests.
- Conducts behavioral evaluations for sensorineural site that includes advanced acoustic reflex tests and tests of auditory adaptation, frequency discrimination, and intensity discrimination.

- Conducts auditory prosthetic evaluations, including such sound field tests as aided work/sentence recognition, warble tone thresholds, narrow-band noise thresholds, and comfortable and uncomfortable loudness levels while wearing an auditory prosthesis (e.g., hearing aid or assistive listening device).
- Coordinates auditory (aural) rehabilitation, including orientation to auditory prostheses, auditory training, and speech reading training.
- Assists team in understanding the nature of a child's hearing status and offers strategies for helping the child compensate when communicating with others.
- Recommends, monitors, instructs others in use of hearing aides and auditory trainers.

Developmental Therapist/Educator/Teacher

- Provides specialized instructional services.
- Designs learning environments and activities that promote the child's acquisition of skills in a variety of developmental and academic areas.
- Plans curricula that lead to achievement of the child's IFSP or IEP goals.
- Provides families with information, skills, and support related to enhancing the development of their child.
- Plans and provides educational interventions.
- Implements consultants' recommendations.
- Assesses family needs.

Nurse

- Conducts health status assessments for the purpose of providing primary nursing care.
- Provides nursing care to prevent secondary health problems.
- Recommends and develops health care practices and plans to restore or improve a child's functioning, promote optimal health and development, and ensure the child is able to benefit from other therapeutic and educational programs.
- Implements medical management plans to treat the underlying cause, or helps parents implement the treatment plan.
- Works with parents to meet the basic needs of the child (e.g., health needs, daily care, feeding).
- Administers medications and treatments and regimens prescribed by a licensed physician, including clean, intermittent catheterization; tracheostomy care; tube feeding; the changing of dressings or colostomy collection bags; and other health services in consultation with the physician.
- Enhances the child's and the family's ability to cope with the child's disabilities.

Nutritionist/Dietitian

- Conducts individual assessments and evaluates nutritional status and quality of food intake, feeding behavior, feeding skills, and growth.
- Works with caregivers to develop and monitor nutrition care plans.
- Provides caregivers with diet counseling and nutrition education.

- Assesses family needs.
- Supervises medical nutrition therapy, monitors nutrition intake, provides counseling about feeding behavior, etc.
- Refers families to relevant community services (e.g., food stamps, food pantry or community kitchen, WIC program).
- Identifies populations at risk of nutritional deficiency.

Occupational Therapist

- Assesses children's developmental and functional performance in play, self-care, and interaction with the physical and social environment.
- Develops and implements intervention plans to enhance sensorimotor, cognitive, communication, physical, and adaptive skills, as well as behavior and emotional well-being.
- Develops and implements therapeutic methods to aid in activities of daily living, such as eating, dressing, walking, and writing.
- Works with families to enhance caregiving and family well-being.
- Adapts home and school environments to enable a child to participate as independently as possible.
- Designs and develops adaptive equipment and seating to promote maximum functional ability and interaction with the environment.
- Provides services to prevent secondary physical or emotional problems.

Physical Therapist

- Focuses on muscle tone, positioning, and gross motor function (i.e. walking, using arms, sitting).

❖ Promotes sensorimotor function through the enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulomonary status, and effective environmental adaptation.

Physician

❖ Provides primary health care and specialized medical care, including diagnostic and treatment services, follow-up, and coordination of care.

❖ Assesses health, growth, development, and deviation.

❖ Diagnoses and treats chronic and acute health problems.

❖ Advocates for the health and well-being of the child and the family.

❖ Provides education and support to families.

Psychologist

❖ Administers psychological and developmental assessments to children and interprets findings.

❖ Assesses psychological and behavioral characteristics of children and their families.

❖ Obtains, integrates, and interprets information about child behavior, and child and family factors that impact learning, mental health, and development.

❖ Identifies psychological needs and resources.

- Plans and provides psychological and developmental interventions including behavior management plans for implementation in the home and the school.
- Provides clinical services and counseling to families and children.

Social Worker

- Assesses the family's capacity to manage basic needs (e.g., food, shelter, protection, medical care) evaluates living conditions, patterns of parent-child interaction, and social and emotional development of the child within the family context.
- Helps families access community resources, financing, recreation and community support (e.g., respite services, food stamps, home nursing services, parent support groups).
- Mobilizes and links families to available supports (e.g., extended family, community groups, friends, churches, public agencies, and programs); assesses and builds family strengths.
- Acts as service coordinator to identify, mobilize, and coordinate community resources and service provision across agency lines to enable the child and family to benefit from early intervention or special education services; serves as single point of contact.
- Assesses and provides direct counseling services related to problems in family functioning (e.g., marital relations, parent-child interactions, child support); implements parent support groups, family therapy, marital and individual counseling.
- Advocates for family rights and access to community services.

Speech/ Language Therapist

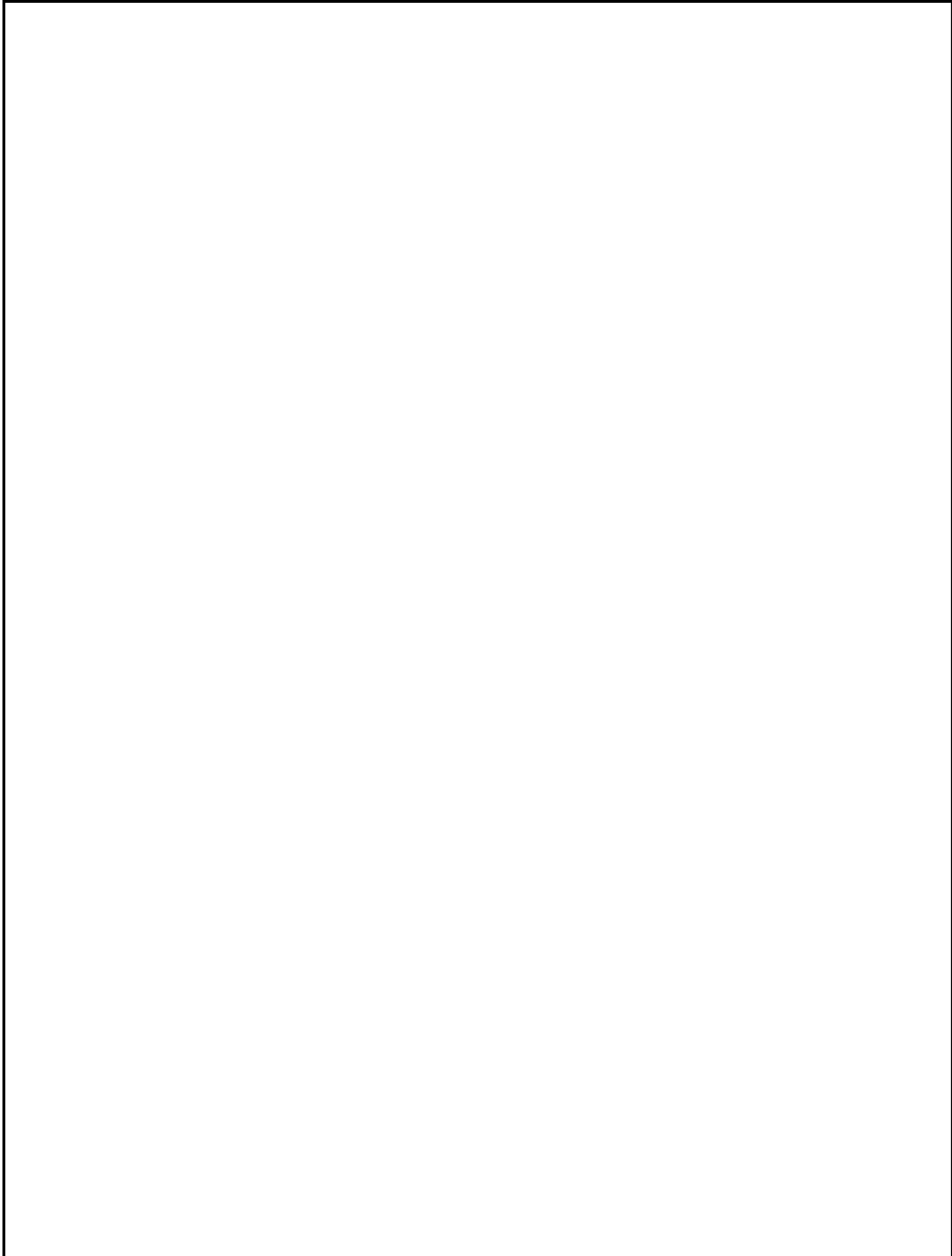
- Assesses children's communication skills, both specifically and in the context of overall development.
- Screens children for communication problems.
- Identifies disorders and delays in the development of communication skills, including oropharyngeal difficulties and issues concerning the production of speech sounds (e.g., structural components of the mouth, breathing, oral muscle control, articulation, and feeding skills).
- Develops alternative communication systems for children who are non-verbal (e.g., sign language, picture communication systems, voice activated computer programs).
- Assesses and provides services to children with atypical patterns of communication and pragmatic or social skills.
- Recommends, plans, and implements individual or group interventions for speech, receptive and expressive language development, and pragmatic or social skills.

Vision Specialist

- Conducts full developmental evaluations and functional vision assessments.
- Develops adaptive equipment or programs to improve vision or the use of vision as much as possible.
- Provides instruction in Braille, use of low vision aids, organization skills, adaptive equipment, and other skills needed for independence.

- Participates in the design of programs which encourage the use of residual vision and remediates the loss or lack of vision from birth.
- Work wherever the child is: home, daycare, nursery school, preschool, playgroup, etc.; often see children in a variety of settings, rather than just at one place.
- Work with families to provide support, information, advocacy, and assistance navigating through the "systems," etc.
- For children ages 0-3 who have a visual impairment as their primary or only disability, the vision specialists act as "service coordinators" within the state Birth to Three system and are responsible for assisting the family in identifying, finding, and coordinating all services for the IFSP. Typically, children in this "category" receive higher levels of direct service.
- For children ages 0-3 who have additional disabilities, vision specialists act as part of the existing 0-3 team, but are more likely to work on a consulting basis for this group of children, although direct service is also appropriate in many cases.
- For children ages 3-5 (or in preschool), vision specialists act as a part of the planning and placement team working in the school program, consulting with the educational team (teachers and therapists), and providing direct service (functional vision evaluation, pre-Braille/Braille instruction) as appropriate. They maintain contact with the family and sometimes provide home services.
- Provides curricular materials in Braille and large print as appropriate.

Adapted from Bruder, M.B. (1994). Working with members of other disciplines: Collaboration for success. Including children with special needs in early childhood programs. Wolery, M. & Wilbery, J. (Ed.s.). DC: NAEYC.



COMPONENT TWO: TEAM-BASED MODELS OF ASSESSMENT AND SERVICE PROVISION

Designing intervention programs to meet the educational needs of children with disabilities is a complex process; no single person has the variety of skills or breadth of knowledge necessary to do this alone. To avoid confusion and fragmentation of services, it is essential that service providers and family members work collaboratively to plan, coordinate, and implement the services needed by each child. The use of a team-based model directly impacts the educational process in three major areas, including:

- ❖ Assessment.
- ❖ Development of instructional goals.
- ❖ Direct or indirect teaching, therapy, and consultation services.

Essential skills necessary for team success include communicating effectively with one another, sharing expertise and skills, making joint decisions, and perhaps most importantly, coordinating service delivery efforts. When diverse professionals work as part of a team, effective communication and collaboration result in the development and delivery of optimal services to the child and family.

Types of Teams

There are three models of teams that typically serve young children with disabilities: multidisciplinary, interdisciplinary, and transdisciplinary.

Multidisciplinary teams

The multidisciplinary team consists of professionals who represent their own specific disciplines and provide individual assessments and interventions. Responsibilities include discipline-specific report writing, goal setting, and direct intervention for the child and his or her family. Parents are invited to share information with the team, while professionals report information from their assessments, intervention, and follow-up visits to family members through an "informing" conference. In the multidisciplinary model, information is presented in a rather fragmented manner and professionals do little crossing of discipline-specific lines. Parents typically play a more passive role on a multidisciplinary team, often receiving information without having much input of their own. This makes it difficult to develop and coordinate comprehensive programs with families of children with disabilities.

Interdisciplinary teams

On an interdisciplinary team, each professional also conducts discipline-specific assessments and interventions. However, professionals and the family have a formal commitment to communication and the sharing of information throughout the process of assessment, planning, and intervention. Parents are considered to be part of the interdisciplinary team, and their input about their child is welcomed. Usually, one team member is responsible for coordinating the child's services, but the interdisciplinary team also engages in some joint decision-making, program design, and implementation.

Transdisciplinary teams

By contrast, the members of a transdisciplinary team share roles and systematically cross discipline-specific boundaries. This approach was conceived as a framework within which professionals could share important information and skills with a child's primary caregivers. The transdisciplinary team develops a comprehensive intervention program to meet a child's developmental needs across the major domains of adaptive skills, social and emotional development, communication, motor skills, and cognition. The goals and actual intervention strategies are also integrated across these domains. A large benefit of the transdisciplinary model is the decreased number of professionals from different disciplines with whom a child must interact on a daily basis. Further, in the transdisciplinary model, all members of the team, especially the parents, participate in a continuous give-and-take on a regular, planned basis. Professionals from different disciplines teach, learn, and work together to accomplish a common set of service goals for a child and his or her family. The role differentiation among disciplines is defined by the needs of the situation, as opposed to the requirements of a specific discipline. Designated members of the team carry out assessments, interventions, and evaluations. The transdisciplinary model involves a greater degree of collaboration than other service delivery models, and for this reason it may be more difficult to implement. Transdisciplinary teaming requires a commitment of time and resources, both personal and economic.

A Comparison of the Three Team Models

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Assessment	Separate assessments by team members.	Separate assessments by team members.	Team members and family conduct a comprehensive developmental assessment.
Parent Participation	Parents meet with individual team members.	Parents meet with team or team representatives.	Parents are full, active, participating members of the team.
Program Plan Development	Team members develop the part of the plan related to their discipline.	Team members share their separate plans with one another.	Team members and parents develop a plan based upon family concerns, priorities, and resources.
Program Plan Implementation	Team members implement the part of the plan related to their discipline.	Team members implement their section of the plan and incorporate other sections when possible.	A primary service provider is assigned to implement the plan along with the family and consultation from other team members.
Lines of Communication	Informal lines.	Periodic child-specific team meetings; team members are responsible for sharing information with one another.	Regular team meetings, continuous transfer of information, knowledge, and skills.

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Guiding Philosophy	Team members recognize the importance of contributions from other disciplines.	Team members are willing and able to develop, share, and be responsible for providing services that are a part of the total program plan.	Team members make a commitment to teach, learn, and work together across discipline boundaries to implement a unified program.
Staff Development	Independent and within their own discipline.	Independent and outside of their own discipline.	An integral component of team meetings for learning across disciplines and for team building.

Adapted from: Woodruff, G., & Hanson, C. (1987). Project KAI, 77B Warren Street, Brighton, MA 02135. Funded by U. S. Department of Education, Special Education Programs, Handicapped Children's Early Education Program.

ROLE RELEASE

Transdisciplinary teaming requires *role release*, which refers to a sharing and exchange of certain roles and responsibilities among team members. Specifically, this process involves the release of some functions traditionally associated with one's primary discipline. The effective implementation of role release requires adequate sharing of information and training. Team members must receive appropriate training and supervision in the functions of other disciplines to assure that there is a common core of skills and that members will be able to competently assume the role of another professional.

The three levels of role release include an emphasis on:

- ❖ Communicating knowledge of basic information or practices related to either a specific discipline or the child's condition.
- ❖ Individual team members teaching others to recognize certain things and make decisions about their observations.
- ❖ Team members teaching others to perform specific functions, techniques, or tasks.

Each team member has specific skills and information he or she can share with others. Because of this, the sharing, or role release, should occur among all team members. However, each team member must continue to be recognized as the primary authority and resource for their own discipline with the added responsibility of direct training and consultation with colleagues. Role release is not role swapping. After techniques are appropriately taught to another professional, that professional must continue to be monitored and supervised by the authoritative discipline. For example, a physical therapist might reinforce speech and language skills while working with a child on motor skills. However, a speech and language therapist is primarily responsible for monitoring and implementing speech and language therapy. Thus, a bridge is created among team members across disciplines, and the needs of the child are met during many different activities and play routines by all individuals who interact with the child.

The concept of role release also recognizes that parents and other family members have valuable expertise and must be considered a vital part of the team. Their involvement in the team process as innovators, as well as implementers, must be actively sought, accepted, and encouraged by all team members.

CHALLENGES OF ROLE RELEASE IN THE TRANSDISCIPLINARY MODEL

Implementation of the transdisciplinary model can be challenging because of the differences between it and more familiar, traditional models of team process and service provision. Barriers to role release and the transdisciplinary team model may arise based upon philosophical, professional, and interpersonal differences or administrative difficulties. In particular, the time commitment required to effectively implement a transdisciplinary team model across all disciplines may be initially daunting. However, over the long term the transdisciplinary model is the basis for more effective planning and service provision, as well as more successful outcomes for children and families.

MISCONCEPTIONS AND CLARIFICATIONS ON TRANSDISCIPLINARY TEAMING

Misconception	Clarification
Traditional assessments are not used for transdisciplinary assessments.	Traditional discipline-specific assessments may be used in combination with functional or other assessments depending on the purpose of the assessment. This will assist the team in developing the best possible education plan for an inclusive program.

Misconception	Clarification
Transdisciplinary approaches advocate indirect and consultative services only, so that therapists do not interact directly with children.	Transdisciplinary approaches are highly flexible with service delivery reflective of program requirements stated in IDEA. Direct service providers intervene to teach students the skills necessary for functional situations. Intervention strategies are shared by team members so that those members having the most frequent contact with the student are able to effectively teach these skills in routine situations, allowing the therapist to provide consultation and indirect services. This frees the therapist to interact with the student in a more therapeutic role, while others assume responsibility for routine intervention.
Team members agree to select several sets of priority goals that represent each discipline. Separate IEP/ IFSP sections are written by the individual disciplines and combined to form a team document.	A single set of IEP or IFSP priority goals is selected by the team so that each student has a single IEP or IFSP with functional goals and objectives. Goal selections are based upon input from each discipline and the family. Team members build their intervention strategies around the set of IEP or IFSP goals that have been developed collaboratively.
Integrated therapy means providing therapy in the classroom.	Integrated therapy means that educational and therapeutic techniques are implemented cooperatively and that service providers assess, plan, implement, evaluate, and report progress on the child's individual needs and goals.
Transdisciplinary teams are less practical due to time required for meetings.	The transdisciplinary approach is most effective for including children with special needs in typical settings due to role release, shared responsibilities, more specifically focused direct therapy services, and for creating imaginative solutions to logistical barriers.

Misconception	Clarification
Therapists risk loss of professional identity or loss of employment.	Therapists may enhance their professional identity and typically do not risk loss of employment. Shared therapeutic input, which is incorporated meaningfully into educational programs, tends to increase other team members' knowledge of and respect for each other.

FUNCTIONS OF TEAMS

Typically teams are assembled with particular functional outcomes. Teams are often involved in problem-solving efforts, such as resolving immediate problems, developing innovative alternatives, and clarifying logistical issues. Early intervention and special education teams interact with children and families in several ways to:

- Diagnose and determine eligibility for services.
- Assess the child's and family's needs.
- Plan intervention strategies.
- Plan systems of service delivery.
- Resolve immediate problems in service delivery.
- Monitor service delivery, modifying it as needed and as appropriate.

Teams should remain flexible in their composition, dictated by the needs of the child and family and the overall goal or purpose for assembling.

Assessment teams require a variety of specialized professionals. The dominant feature of these teams is the need for highly trained individuals who can, along with the family, assess and identify the specific interests, strengths, learning style, and needs of the child.

The primary function of *problem-solving teams* is to plan a creative approach to a unique set of circumstances. The dominant feature of problem-solving teams is the need for team members to develop trusting relationships and communicate effectively. In special education and early intervention, teams are entrusted with the responsibility of planning interventions that recognize a child's strengths, and for providing inclusive environments that support the continued development of individual competence.

Tactical teams are assembled to smoothly implement service delivery. The primary feature of the tactical team is its role as a clarifying agent. Tactical teams are assembled to clarify team roles and to address highly specific tasks (e.g., transitioning a student with Down's Syndrome from the gymnasium to the computer class). Tactical teams have well established operating formats, are generally comprised of a small core of members who meet with greater frequency, and are highly focused and directed to monitor the implementation of a specific intervention strategy.

On a transdisciplinary team, all team members must be effective communicators with the ability to reduce complicated discipline-specific terms into respectful, understandable language for other team members. Early intervention or special education teams may assume any or all of the functions described above at various times during the year with different professionals moving in and out of the process.

ROLE OF THE PEDIATRICIAN ON TRANSDISCIPLINARY TEAMS

The importance of involving a pediatrician on a team providing services to children with disabilities and/or special health care needs cannot be underestimated. The physician plays an integral role in ensuring that a child's health care needs are met, thus maximizing the potential benefits of the specialized educational and related services interventions. Additionally, with advances in the ability to detect illness and developmental delay and improvements in the ability to intervene in significant ways, the pediatrician is key to monitoring a child's health and development. It is often in the pediatrician's office that differences in cognitive development, language skills, and social or play skills are first noticed. Frequently, questions arise from concerned parents who have observed differences between their own child and other children or siblings at similar ages.

Routine well child care is essential to the well-being of all children and their families. Coordinated care is particularly important for children who from birth are at greater risk than the general population for compromises in physical development, cognitive growth, and psychosocial outcomes. These include children with biological risk, very low birth weight, genetic conditions, congenital anomalies, metabolic disorders, and special health care needs. For children with disabilities and/or special health care needs, well child practices should be employed with the same purpose as provided for typically developing children; that is, to detect secondary diseases in an effort to maximize each child's opportunity for growth and development.

The pediatrician may often be the most logical choice as case manager for a child with disabilities and chronic health care needs. Pediatricians have access to information from schools, medical specialists, secondary and tertiary medical care centers, and community health care providers. In addition, pediatricians provide continuous medical care to children through adolescence, without the unnatural age-related breaks in services that are associated with educational transitions. Pediatricians, in their role as confidants, are also aware of the complexity of challenges faced by families and family systems. This enables them to contribute significantly to any team that is assessing a child and developing and implementing programs for that child.

Coordination and communication are essential when monitoring the complex treatment regimes of children with chronic health care needs and/or disabilities, particularly when medical conditions change unpredictably or frequently. Coordination among health care professionals, community health providers, educators, and social service agencies is critical to the well-being of the entire family. Because families with medically complex children spend disproportionate amounts of time overseeing their children's needs, there is often an increase in stress, fatigue, and social isolation. Coordinated care provides family support that reduces stress, promotes family involvement in typical daily routines and community activities, and allows parents to function in their primary caregiving roles. An additional benefit of community-based coordinated care for children with disabilities and/or special health care needs is the containment of health care costs through frequent, cost effective health supervision, health education, and early detection of secondary conditions which may further compromise a child's health and development.

Coordination of this nature can best be accomplished through the practices of family-centered care, the medical home model, and by being involved in transdisciplinary teams with family members and early intervention or special education service providers. As a member of the transdisciplinary team, the pediatrician's responsibility is to:

- Provide overall management of the child's medical needs and inform parents and siblings about these needs.
- Discuss how medical issues may impact the child's physical, psychological, educational, and social development with parents, as well as other team members.
- Discuss the impact of health care needs on the child's ability to participate fully in educational and related service programs.
- Discuss with parents and siblings how having a child with special health care needs may affect the family as a whole and its involvement in the community (e.g., schools, daycares, religious activities, recreational activities, extended family situations).

SERVICE DELIVERY

In a transdisciplinary model, the child's program is primarily implemented by a single person or a few people. The primary interventionist is determined by the team with input from the parents. In most early intervention and special educational programs, the teacher and program assistants take on the major direct service responsibilities. At times it is also appropriate for this role to be assumed by a special education teacher, who may provide services within the inclusive classroom on a regular basis. Related service providers, most

commonly therapists and health care workers, often serve as consultants. It is cautioned that this team model must not be used as a strategy to justify reducing support staff in inclusive educational settings.

INTEGRATED SERVICE MODEL

Best practice indicates that early intervention, special education, and related services for children with disabilities should be provided within the context of activity settings in natural environments (e.g., the home, daycare program, nursery school, kindergarten, community play group, mainstream third grade classroom).

The integrated service model is the most effective and efficient way to deliver comprehensive services to children with disabilities. It builds upon real life events and routines, making the connection more recognizable to both the child and parent, thus enhancing the generalization of learning.

In the integrated service model, the transdisciplinary team employs an integrated approach to assessment, program development, and program implementation. Team members share knowledge, program information, and clinical skills; they teach and supervise each other to integrate program goals and objectives into a meaningful and comprehensive intervention program. In addition to a transdisciplinary team approach and role release, the integrated service model supports the provision of both direct and indirect service delivery. Professionals may provide services directly, or they may train and consult with other service providers (e.g., parents, regular education teacher, nursery school teacher, classroom aide, occupational therapist) to provide the service indirectly.

Direct therapy is carried out when a specialist or related service provider works with the child individually. Direct therapy is usually provided by the therapist (occupational therapist, speech and language pathologist, etc.) with an emphasis on remediating a deficit or particular weakness or providing a service that only a licensed person can provide. It is usually delivered in isolation from typical activities and routines taking place within the child's environment. Direct therapy can be done within the classroom, however, "pull out" models are often used. A pull out model occurs when the child is removed from the classroom and therapy is delivered in another room without the involvement of his or her peers, or when the child is removed to a separate area of the classroom and "worked" with individually. Related service support staff, most commonly therapists, provide direct therapy with other professionals serving as observers. Direct services include assessment, intervention, program development, implementation, and evaluation.

Indirect therapy involves role release, in which related service personnel train other team members to perform specific interventions and then monitor their performance on an ongoing basis. Most often the teacher, paraprofessionals, and classroom aides take on the major direct service role. However, this role can also be assumed by certified and non-certified personnel, instructional assistants, or one-to-one aides in other natural environments. Parents also provide therapy services, particularly when they integrate activities into the child's daily routines at home.

Indirect therapy does not mean that therapists entirely stop providing direct services to children. In reality, for therapists to be effective trainers and

consultants, they must maintain direct contact with the child. For example, a physical therapist might provide indirect therapy by teaching the nursery school teacher how to facilitate rolling (to obtain a toy) for a young child unable to crawl, while also providing some direct therapy to the child and continually monitoring the skills of the teacher.

Successful indirect therapy requires that therapists and other professionals work closely together to ensure that goals and objectives for the child are integrated across the daily routines in the program, home, and community and that the child's progress is closely monitored in each environment. By integrating the child's goals into daily activities, his or her needs are met in a consistent, functional, and comprehensive manner. The integrated service model supports the following assumptions:

- Natural environments are the best places to assess children's abilities.
- Therapy should be implemented throughout the day and in all settings in which the child participates.
- Children should be taught clusters of skills needed for everyday living through games and functional activities.
- Skills should be taught and reinforced in the settings in which they naturally occur.

The success of a transdisciplinary integrated service model requires that all team members work together on an ongoing basis to plan, implement, evaluate, and monitor the delivery of services to children. Ingredients necessary for the successful collaboration of professionals from different disciplines include:

- Attitude - a willingness to share information and skills.
- Accessibility - availability for consultation and training.
- Communication - active listening and responsiveness with minimal use of specialist jargon and terminology.
- Transmission - an open and consistent flow of information among all team members.

Early intervention, special education, and related service professionals, including physicians, must work within and across disciplines to share information about a child's needs and to integrate the goals and objectives of each discipline involved in the care of the child.

TEAM PARTICIPATION

Service providers who have diverse philosophies, educational backgrounds, credentialing systems, values, and beliefs are expected to work together to develop integrated service models. Professionals are often required to work as part of a group of individuals with whom they have very little in common. As a team, they have the responsibility to identify and resolve problems, plan and implement changes, and initiate programs for children with disabilities and/or special health care needs and their families. Early intervention and special education teams are successful to the extent that they are able to develop integrated models of service delivery for children with disabilities and/or special health care needs within the context of the home, family, and community.

Consensus regarding the purpose, function, and goals of a team must be established early in the process of team formation. If the team is unable to reach early consensus, successful team functioning will be jeopardized. A major factor affecting the successful functioning of teams can be a real or perceived lack of administrative support. If consensus decisions are not sanctioned by and actively fostered within the administration, team functioning will be severely compromised. In very real terms, administrators must show support by providing release time from one's typical responsibilities to communicate, meet, plan, and work together as a team. This can be challenging since team members can have varied levels of administrative support within their different agencies or organizations.

CHARACTERISTICS OF SUCCESSFUL TEAMS

Successful teams adopt norms for functioning that act as guidelines to provide structure to the process, yet promote maximum flexibility to encourage creative solutions. Characteristics of successful teams include:

- Common goals and objectives.
- High levels of reciprocal communication and collegiality.
- Constant information exchange and give and take.
- Encouragement of divergent opinions and ideas.
- Acceptance and open discussion of feelings. Clearly delineated roles and responsibilities.
- Shared leadership and accountability.
- Balanced participation.
- Respect for individuals.
- Appreciation and understanding of team process, its benefits, and challenges.

GOAL SETTING

Effective teams establish clear goals, maintain the motivation to accomplish their mission and goals, and persevere to foster positive interactions among members. Teams must devote time to identifying their goals and objectives. Effective team process can only exist when members share the responsibility for accomplishing common goals. An effective team will:

- ❖ Set goals that are clearly understood and communicated to all team members: A collaboratively established philosophy or mission is the team's overall reason for existence.
- ❖ Have ownership of the goals and participate in setting them: Team members, particularly the family, need to feel that they have an opportunity to contribute to setting goals.
- ❖ Set goals that are clearly defined and measurable: Goals must be written in such a way that everyone has a clear understanding both of what is expected and how mastery of these goals is determined and measured successfully.
- ❖ Share individual or personal objectives with one another: Since teams are comprised of individuals, it is important to respect each member of the team. This is best done by open, honest, and respectful communication in which everyone feels valued. One significant result of successful team functioning is a diminished incidence of overlapping or duplicated services. In addition to the economic savings realized when duplication is reduced, there is also increased opportunity for team members to exchange information, acquire new skills, and improve interactive competence with families and other professionals.

CONSULTATION

Consultation is a voluntary process in which one professional assists another to address an issue, sometimes concerning a third person. Unlike other disciplines such as law or business, where consulting typically consists of two professionals involved in direct consultation, human service consultation is usually triadic: a consultant (a professional), a consultee (a professional seeking advice), and a client (a child receiving services and his or her family). In educational and medical environments, formal consultation should involve a process for guided discussion. This process allows individuals with different backgrounds, expertise, and experiences to cooperatively plan and develop strategies to achieve clearly defined outcomes for children and families.

Consultation can be used when providing either direct or indirect services for a child with a disability. A consultant may provide direct medical, educational, and related services, such as assessment or intervention, to address a child's needs, or they may provide indirect consultation, such as providing assistance to teachers, therapists, and parents. Physicians will typically provide both direct consultation (e.g., assessment of child's health status) and indirect consultation (e.g., discussing the effects of medication on a child's attention span) for service providers and families of children with disabilities.

LEADERSHIP STYLES

Each team member must assume a set of core roles with regard to team development, leadership, maintenance, and problem solving. These roles and responsibilities must be established within the team to ensure effective functioning. Every team member must demonstrate the same core of responsibilities, including:

- Preparing the family members for their role on the team and encouraging their active participation.
- Sharing information and expertise with other team members.
- Being clear and concise when reporting information and avoiding the use of jargon that other team members may not understand.
- Listening actively and communicating effectively.
- Recognizing the contributions of other team members and encouraging the sharing of information.
- Offering recommendations for addressing a child's needs from their professional perspective or area of expertise.

Medical, educational, and social services for children and their families must be provided in a manner that supports the family system. Within each team there are a number of tasks that must be identified and completed. Members are selected or volunteer for various task-related roles, based upon interest and professional expertise. For example, during a team meeting, the pediatrician may be the initiator, proposing a change or suggesting a procedure to be followed. The educator may then assume the role of clarifier, paraphrasing or restating the information provided by the pediatrician. The physical therapist may then summarize the information presented and initiate new information.

Standard setting is a leadership role in which team behaviors are established. It is important that all team members accept the rules and take part in enforcing them. Consensus testing is used for decision-making or conflict resolution and is usually done by the team leader. Task roles are fluid and constantly changing with the input of new information.

Members of transdisciplinary teams find that their roles change with respect to the needs of the child, family, and other team members. At times they will be asked to assume the role of leader, at other times that of participant. In the leadership role, an individual encounters a variety of situations that require different styles of management. Teams require different amounts of direction and support. A leader should be able to adapt his or her leadership style according to the needs of individual team members and the nature of the task.

FAMILY STUDY

Heather is a four-year-old girl with significant medical needs. She was born prematurely at 29 weeks and remained in the hospital until she was 16 weeks old. During her hospitalization, she had respiratory distress, feeding problems, and a brain hemorrhage. Her development was monitored by the follow-up clinic and at about 6 months she was diagnosed with cerebral palsy. The coordinator of the follow-up program immediately made a referral to the local Birth to Three agency with parental permission. An evaluation was completed and Heather began receiving early intervention services shortly thereafter.

Heather received early intervention services at a daycare center including physical therapy, occupational therapy, and speech and language therapy. On her third birthday responsibility for her services was transitioned to the local school district, yet Heather's parents decided to keep her at the daycare center where she had been since she was six months old. The school district had a specialized preschool program that they felt would be appropriate for Heather, but her parents wanted her to remain in a setting with children who did not have disabilities. The transfer of services from the Birth to Three system to the local school system had not gone well.

In addition to motor and language difficulties, Heather continues to have significant medical needs. These include:

- ❖ Hydrocephalus - V-P shunt inserted at one month.
- ❖ Asthma - aerosol treatments four times daily.
- ❖ Oral motor difficulties - requires G-tube supplements at night.
- ❖ Seizures - on phenobarbital, not well controlled.

The team working to develop an appropriate plan for Heather consists of:

- Her parents.
- Allied health professionals from the hospital where she has been receiving services.
- The coordinator of the follow-up program at the hospital.
- The primary health care provider.
- The director of the daycare center.
- The special education teacher from her school district.
- The occupational therapist.
- The physical therapist.
- The school nurse.

Presently, team members are experiencing communication difficulties and differences in opinion regarding Heather's programming. Her parents feel unsupported and confused. A team meeting will be necessary to address several issues and to design an appropriate program for Heather.

Ms. Lyons, the physical therapist and Mrs. Preston, the occupational therapist, have worked together for the past six years. Mrs. Preston received her training in occupational therapy 20 years ago. She was trained to work with patients on an individual basis, so working as a team member has been a new experience for her. At first, she was resistant to changing her method of providing therapy, but over the years, with training and support, she now appreciates the benefits of using a team approach for her patients.

Ms. Lyons received her graduate degree in physical therapy two years ago. Her training emphasized the philosophy of family-centered care and

experience with interdisciplinary teams. She has been one of the driving forces for changing the style of service provision in her agency.

The coordinator of the hospital follow-up program, Ms. Collins, has agreed to provide technical assistance to the daycare center on developing a program for Heather. Ms. Collins believes the hospital staff knows what is best for Heather. While she acknowledges Heather's social and emotional needs, Ms. Collins feels that her medical needs take precedence over all other domains of her life. Mrs. Grizone, director of the daycare center, has a master's degree in early childhood education and has been working in daycare programs for eight years. She has had children with special needs in her program before, but not children with Heather's complex needs. Mrs. Grizone believes that Heather will do well in her program if people would treat her like a typically developing child. She knows Heather will benefit from the special services provided by the hospital, therapists, and the school system, but thinks too much emphasis is placed on how Heather is different.

Mr. Gorman, the special education teacher assigned to Heather, is unhappy about having to provide services outside of his school building, especially at a site that is not in the district. He feels the daycare center is not set up for a child with Heather's needs and complains that he will have to carry all his special equipment to the center every time he goes. He feels the center is not going to be able to provide all of the special toys and equipment he will recommend, but he feels this is the center's problem.

Mrs. Greene, the school nurse, is not quite sure what her role is regarding Heather's medical needs. No one has really informed her about this case, she only knows she is assigned to provide nursing care to Heather at the daycare

center if she needs it. Mrs. Greene feels that driving out of the district to provide care for this child is not practical and she has made a note to ask her supervisor about it prior to the upcoming meeting. Heather's parents are confused and not sure what to do. They feel there is much apprehension on the part of the school staff and they are afraid this will be imposed on Heather. They also feel their needs as a family are not being recognized or listened to. They don't know where to turn.

FAMILY STUDY--REVISITED

DISCUSSION QUESTIONS

As Heather's primary pediatrician, evaluate the following:

What do you see as the primary concerns and issues at this time?

What specific issues are causing this team to have difficulty communicating?

How might the team members use role release or integrated service provision to enhance the efficacy of involvement in the team process and care for Heather?

As Heather's physician, what do you see as your role on this team?

As Heather's physician, what consultation strategies might you employ?

In what ways can you support Heather's parents?

Discussion Question Answers

- What do you see as the primary concerns and issues at this time?
  - Asthma
  - Conflicts between parents and school system
  - Team process and communication
  - Ongoing seizures
  - Heather's programming - where and how services will be provided
  - Parent's feeling lack of support and confusion

- What specific issues are causing this team to have difficulty communicating?
  - Differences in training, experience, and philosophy among service providers.
  - Lack of common goals and clear role delineations.
  - Negative attitudes on the part of several team members.
  - Lack of problem-solving and decision-making strategies.

- As Heather's physician, what do you see as your role on this team?
  - To identify Heather's medical needs.
  - To serve as a liason between early intervention providers, parents, school district personnel, and all medical professionals.
  - To collaborate with the school nurse regarding Heather's medical needs.
  - To support the parents.
  - To help the team sort out primary concerns in terms of Heather's medical needs on a day-to-day basis and the impact of these medical needs on her ability to learn and options for programming.

- As Heather's physician, what consultation strategies might you employ?
  - Offer consultation to the director of the daycare center and the school nurse.
  - Assist with problem identification, planning, and intervention.

- In what ways can you support Heather's parents?
  - Help parents identify their concerns, priorities, and resources within a team context.
  - Use effective communication skills, particularly active listening, questioning, and noting/reflecting feelings.

RESOLUTION

With the support of the pediatrician, Heather's parents requested a team meeting. In attendance were:

- ❖ Heather's parents
- ❖ Heather's paternal grandparents
- ❖ Mrs. Grizone, director of the daycare center
- ❖ Mr. Gorman, school district special education teacher
- ❖ Mrs. Greene, school nurse
- ❖ Ms. Collins, coordinator of the hospital follow-up program
- ❖ Mrs. Preston, the occupational therapist

Dr. Todd, the pediatrician, was unable to attend the meeting in person. However, 20 minutes of the team meeting was devoted to a conference call (via speaker phone) with Dr. Todd so that the medical concerns could be addressed.

Heather's parents had already expressed their concerns about the disagreements among team members and the lack of clarity about Heather's medical needs. Dr. Todd spent the first 20 minutes of the meeting discussing Heather's medical status. He noted the following:

- ❖ No complications with V-P shunt.
- ❖ Asthma is well controlled with current treatments.
- ❖ G-tube supplements are at night and do not impact school programming.
- ❖ Other medications are being explored to gain better control of the seizures.

The school nurse, Mrs. Greene, asked what her role might be regarding Heather's health care needs. Dr. Todd asked only that she keep track of Heather's seizures and support the daycare center staff in managing them. While Dr. Todd acknowledged Ms. Collins' concerns about Heather's medical needs, he also assured the parents and school nurse that he would be available should any difficulties arise. He urged the special education service providers and daycare personnel to go ahead with their programming.

Mrs. Grizone assumed a leadership role for the rest of the meeting. She started by asking the parents to express their concerns and to identify their priorities. Heather's parents restated their desire to keep her in a community daycare center, rather than in the school district's specialized preschool program. They were confident that Mrs. Grizone and her staff would provide an enriching and nurturing environment for Heather. They also expressed their concern about the reluctance of the school system personnel.

Mrs. Grizone then asked the school nurse if she had the clarifications she needed from Dr. Todd. Mrs. Greene acknowledged that she felt more comfortable about her role. Mr. Gorman was still concerned about the lack of equipment at the daycare center. Mrs. Grizone stated that she would look into the possibility of leasing or purchasing some of the equipment. The hospital nurse said she could help as well. While Mr. Gorman was still unhappy about having to travel out of district, he also began to see it as an opportunity to learn more about including children with disabilities and/or health care needs into natural environments.

Mrs. Grizone then asked Heather's parents if they had any additional concerns. They continued to have some reservation as to whether this plan could really

be successful for Heather. Mrs. Grizone acknowledged their reservations and asked if they would be willing to give the program a try with the intent to reconvene the team in six weeks. Heather's parents agreed, as did the other team members. They then proceeded to develop short term goals and objectives for Heather's IEP and participation in the daycare program.

COMPONENT THREE: OBSERVATION OF AN INDIVIDUAL ASSESSMENT OR INTERVENTION

Location and Times:

The observations may occur at inpatient, outpatient, or school-based settings. The visits will last between two and three hours and will be scheduled based on the block schedule.

Format:

Observe the assessment/intervention process for speech therapy, audiology, physical therapy, or occupational therapy to learn about components of assessment/ intervention including how families are involved in these processes. You will also interview the related service specialists to gain a more comprehensive understanding of the assessment/intervention process as it relates to roles of professionals. Please refer to *Guidelines for Observing an Individual Assessment or Intervention.*

Resident's Responsibilities:

You should plan to provide your own transportation to the assessment or intervention sites. Plan to arrive at the clinic or agency site at least fifteen minutes before the session begins. Introduce yourself to the therapist. Explain that the purpose of the visit is to observe an individual assessment/intervention session and to interview the therapist in an effort to better understand how the process relates to overall service delivery to this child and family.

Complete the *Resident Self-Evaluation*. The therapist should complete the *Performance Rating by Preceptor* form.

GUIDELINES FOR OBSERVING AN INDIVIDUAL ASSESSMENT OR INTERVENTION

Purpose:

- ❖ To understand the roles, functions, and responsibilities of various professionals providing assessment, intervention, and medical services to children with disabilities and/or special health care needs and their families.
- ❖ To understand how different philosophies, training, experience, and supervisory systems influence the delivery of services by professionals to families of children with disabilities and/or special health care needs.
- ❖ To understand the concepts underlying service delivery including direct therapy, indirect therapy, integrated service models, family involvement, and ecological and nondiscriminatory assessment.

Program Observation- -Suggested Outline:

Consider the following questions during this observation.

- ❖ Identify the following elements of the assessment/intervention process:
  - ♦ What is the purpose of the assessment/intervention?
  - ♦ Are the instruments, methods, and procedures identified and explained to the family?
  - ♦ Are the instruments, methods, and procedures used as designed? Why? Why not?
  - ♦ Is the assessment/intervention nondiscriminatory?

- ♦ Does the assessment/intervention incorporate principles of ecological assessment?
- ♦ How are the child's individual developmental and health care needs addressed during this assessment/intervention?

❖ Observe the following aspects of the professional's behavior.

- ♦ Does the therapist integrate direct and indirect therapy into functional skills, natural environments, and daily routines?
- ♦ How does the professional involve the family?
- ♦ How does the professional incorporate parenting practices, beliefs, values, and health care practices into the assessment/intervention process?
- ♦ How does the professional explain the role of the physician in assessment/intervention?
- ♦ Does the professional explain and demonstrate the link between direct, indirect, and integrated therapy; functional skills; natural environments; and daily routines?

❖ Does the professional include the family:

- ♦ In decision-making?
- ♦ In implementation of assessment/intervention procedures?
- ♦ In determining site, method, preferences, areas to be assessed?
- ♦ As information providers?
- ♦ As innovators of ideas?
- ♦ By obtaining information about beliefs, values, and cultural preferences?

- Identify how the family is incorporated into the assessment/intervention process.
  - Does the family appear comfortable with the professional? Why? Why not?
  - Does the professional avoid the use of jargon? If not, does he or she explain the meaning of terms to the family?
  - Does the family know the purpose of the assessment/intervention?
  - Does the family understand the choice of tools, site, and method of assessment/intervention?
  - Does the therapist offer suggestions for implementing ideas during routines within home, school, and community?

COMPONENT FOUR: PARTICIPATION IN A TEAM MEETING (SPECIALTY CLINIC, IFSP, OR IEP)

Location and Times:

You will participate in a team meeting. The meeting will last approximately one to two hours and will be scheduled based upon a mutually available time for the resident, family, and the team.

Format:

You will participate in a team meeting in one of several capacities: information provider, information seeker, collaborating professional, or family advocate. The goal of this experience is to provide you with a meaningful, practical situation where you can practice the skills learned in this module and provide information about the medical needs of the patient. Please refer to *Guidelines for Participating in a Team Meeting*. Ideally, this visit should be with a family from your continuity clinic. If that is not possible, the project coordinator will connect you with a family. In either situation, you will interview the family after the meeting in order to gain their perspective on working in a team setting with professionals from various disciplines. Please refer to *Guidelines for Family Interview on Experiences with Various Disciplines.*

Resident's Responsibilities:

If the child is from your continuity clinic, you should come fully prepared to participate in this meeting. Preparation should include speaking with the

family prior to the meeting and reviewing the guidelines for team participation and the didactic components of the module. This will enable you to be an effective participant in this meeting. You should also provide information about the child's medical needs.

Plan to arrive 15 minutes before the meeting start time. If this is an IEP meeting, report to the main office, introduce yourself, and state the name of the meeting that you will be attending. You should explain to the team members that you are participating in the meeting as the child's physician. You should feel free to ask questions and make suggestions or comments during the meeting. After the meeting is finished, talk with the family members to learn about their impressions of the meeting and their satisfaction with the team process.

You are responsible for completing the *Resident Self-Evaluation: Participation in a Team Meeting* and *Resident Self-Evaluation: Interview a Family About Experiences with Various Disciplines and Team Process*. A member of the team should complete the *Performance Rating by Preceptor,* and a member of the family should complete the *Performance Rating by Family.*

GUIDELINES FOR PARTICIPATING IN A TEAM MEETING (SPECIALTY CLINIC, IFSP, OR IEP)

Purpose:

- To have the opportunity to participate in a team meeting.
- To enhance your knowledge of team process and effective team participation.
- To integrate your professional role and responsibility with the roles and responsibilities of other professionals.
- To practice effective communication behaviors and skills when participating as a member of an interdisciplinary team.

Team Meeting Participation- -Suggested Outline:

Reflect upon the following points/questions prior to participating in the team meeting. These should serve as a guideline to effective participation in the meeting.

Family – Identify the following aspects of the family's involvement in team process:

- Was the family advised of the purpose of the meeting?
- Did the family know what to expect in terms of structure at this meeting?
- Did the family seem comfortable during the meeting?
- Were all of the team members introduced?
- Were the family's values, beliefs, cultural practices, parenting styles, and health beliefs respected?
- Was the family provided opportunities to participate?

Team – Identify the following aspects of team process:

- Were the team resources adequate for this meeting (e.g., time allotted, meeting location, etc.)?
- Were the goals of the meeting clearly understood and communicated to all team members?
- Did all team members, including family members, contribute in setting goals for the meeting?
- Were the goals clearly defined and measurable?
- Did the team employ systematic decision-making and problem-solving techniques?
- Was there a written agenda for this meeting?
- Was there a policy for role differentiation (e.g., facilitator, recorder, time keeper, etc.)?

Physician – Identify the following aspects of physician involvement:

- Did I prepare the family for their role on the team and encourage their active participation?
- Did I share information and expertise with other team members?
- Was I clear and concise when reporting information, and did I avoid the use of jargon?
- Did I listen actively and communicate well?
- Did I recognize the contributions of the other team members and encourage the sharing of information?
- Did I offer recommendations for addressing the child's needs from a medical perspective?
- Was I able to identify my role on this team?
- Can I explain the importance of my participation on this team to other professionals, the family, and colleagues?

- How will I participate in future teams?
- How will I use these skills in my practice with other children and families?
- What do I still need to learn in order to improve my practical skills?

Development of an IFSP – If this was an early intervention program meeting, identify the following factors in the development of the IFSP:

- Did the team identify the family's concerns, priorities, and resources?
- Were assessment results discussed in a manner that was understandable to the family (i.e., jargon was not used and terms were explained)?
- Did assessment results clarify the child's developmental strengths as well as needs?
- Were functional outcomes for the child and family developed that reflected the needs and priorities of the family and focused on useful skills?
- Were the functional outcomes written in a family-friendly manner?
- Did the team identify family routines and activities that take place in natural environments (settings in which infants and toddlers without disabilities normally participate)?
- Did the team develop appropriate adaptations and supports to promote the child's participation in natural environments?
- Did the team assign roles and responsibilities for service delivery?
- Was there a primary person identified to be responsible for implementing components of the intervention plan?
- Did the team specify which members would provide both direct and indirect services for the child?
- Did any of the team members engage in "role release" (sharing some of the roles traditionally associated with a particular discipline)?

- Were intervention strategies developed to promote the generalization of outcomes for the child?
- Were intervention strategies developed that were child-directed?
- Were intervention strategies developed to support the child's interests?
- Were intervention strategies developed to help the child become more independent?
- Were strategies developed for evaluating the effectiveness of the intervention?

Development of an IEP – If this was a special education program meeting, identify the following factors in the development of the IEP:

- Did the team collaboratively specify appropriate goals and objectives for all subject areas/developmental domains requiring intervention?
- Were parents and other guests encouraged to share their goals and objectives for current and future functioning in the home, school, or community environments?
- Were the goals and objectives for the child prioritized?
- If the student was 15 or older, were vocational options and preparation discussed?
- Were evaluation procedures and schedules identified for goals and objectives?
- After reviewing the full continuum of placement options, were placement decisions made based on the child's current level of performance?
- Were parents encouraged to participate in making placement decisions?
- Were appropriate measures taken to ensure that the child receives services in the least restrictive environment/natural environments?

- Were related services identified?
- Were scheduling constraints for related services discussed?
- Were strategies developed for facilitating ongoing communication between parents and service providers?

GUIDELINES FOR FAMILY INTERVIEW ON EXPERIENCES WITH VARIOUS DISCIPLINES

Purpose:

- ❖ To understand the family's perspective on the roles, functions, and responsibilities of various professionals providing educational, social, and medical services to the child and family.
- ❖ To understand how the family perceives team process and team interactions.
- ❖ To understand the importance of communication and collaboration in providing integrated, family-centered services to the child and family.
- ❖ To appreciate and respect the values, beliefs, cultural traditions, and parenting and health practices of the family.

***Family Interview--Suggested Outline*:**

(Review the following prior to interviewing the family.)

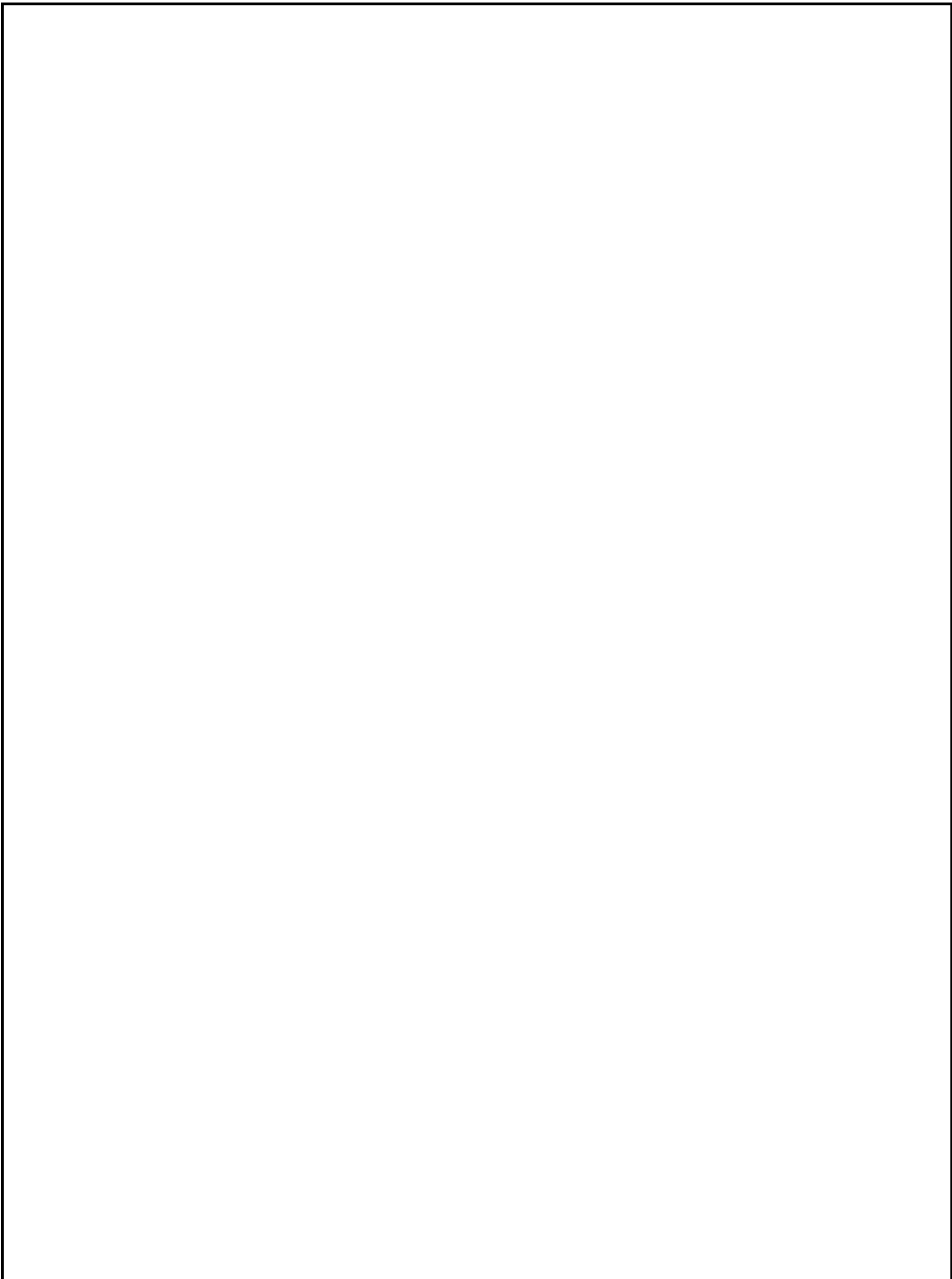
Identify the following aspects of the family's relationship with service providers:

- ❖ Who provides services to the family?
- ❖ Where are services provided?
- ❖ Who determines the amount, kind, and location of the services?
- ❖ How are services provided (separately, integrated, through role release)?
- ❖ Do professionals provide suggestions that can be made part of the child's daily life and routines?
- ❖ Do the professionals provide ideas that allow the child to develop functional skills?

- Have the professionals asked about and incorporated family beliefs, values, cultural traditions, parenting styles, and health beliefs and practices into the interventions?
- In what ways have professionals shown respect to the family?
- What roles do individual members of the team assume?
- Does this team engage in role release?
- How is the physician involved with other professionals?
- How often do the professionals communicate?
- How do the professionals maintain access to each other? How often?
- What evidence exists of the professionals' abilities to collaborate and consult?
- Are the services integrated into the child's and family's daily routines?
- Do the professionals avoid the use of jargon? If not, do they explain the meaning of terms to the family?

Discuss the following issues with family members:

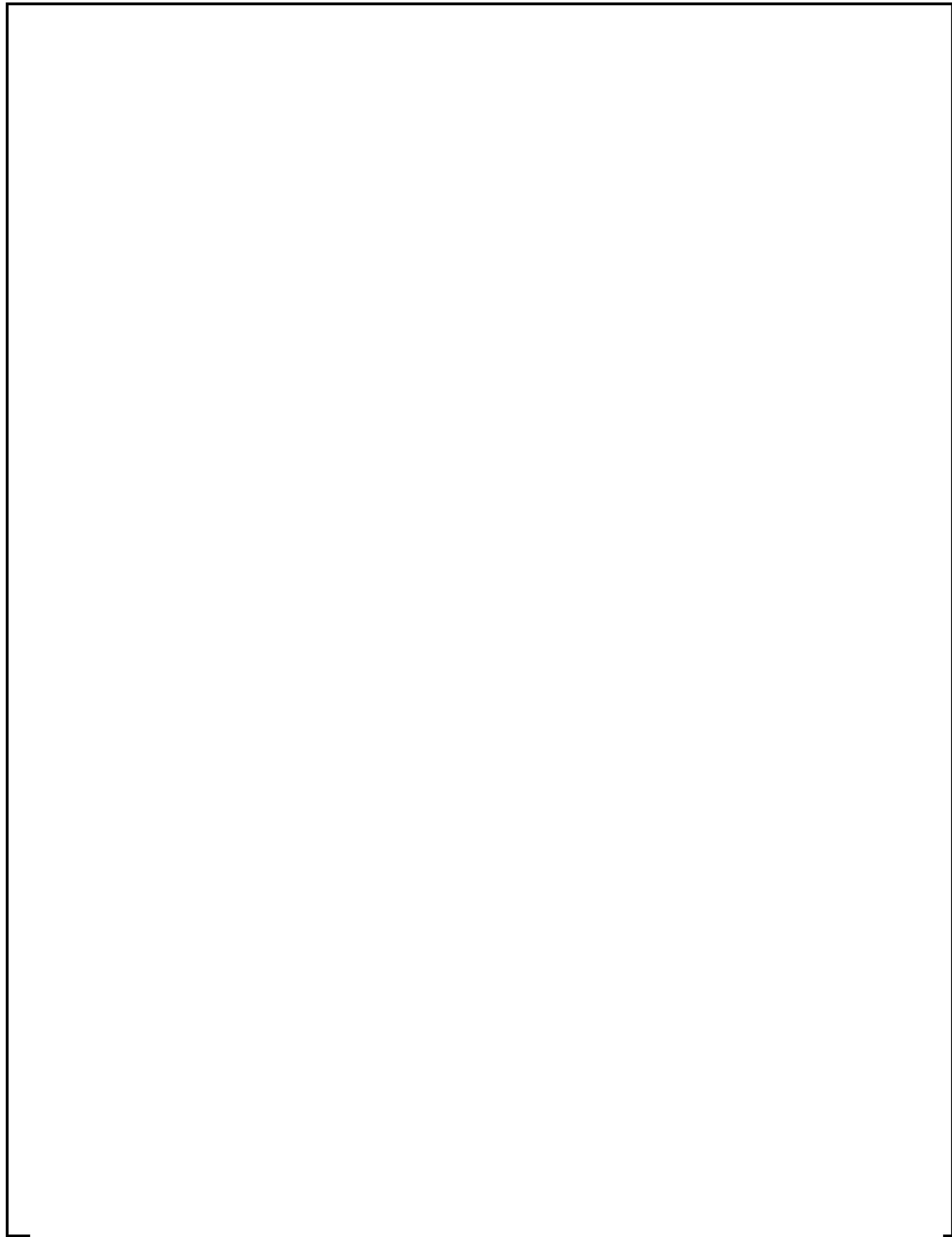
- How do the professionals include the family (as decision-makers, innovators, implementers, sources of information)?
- How do the professionals speak with the family?
- Do family members feel comfortable in their interactions with the professionals?
- Do family members feel they can disagree with recommendations and make choices for the family?
- Do family members feel that the professionals respect their time and daily routines?
- Do family members feel that the professionals address the needs of the entire family?



APPENDICES

A: **REPRINT OF:** American Academy of Pediatrics, Committee on Children with Disabilities (1993). The Role of the Pediatrician in Prescribing Therapy Services for Children with Motor Disabilities. Pediatrics, 98 (2), 78-80.

B: **REPRINT OF:** American Academy of Pediatrics, Committee on Children with Disabilities (1999). The Pediatrician's Role in the Development and Implementation of an Individual Education Plan and/or an Individual Family Service Plan. Pediatrics, 104 (1), 124-127.



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APPENDIX A

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