

More Answers to Your Questions About the Babies Can't Wait Coaching Approach

By: Kay Nelson, OTR/L, Tri-Alliance Representative and OT, BCW District 3-4 Core Team and
Pat Pratt, OTR/L, BCW Stakeholders Representative and OT, BCW District 2 Resource Team

During the past year, members of *GOTA* have asked questions regarding the new coaching model under development for the state Babies Can't Wait (IDEA Part C) early intervention system. These questions have been posed to *Leslie Jackson*, Federal Affairs Representative and Practice Associate of AOTA and staff from the state office for Babies Can't Wait.

Is AOTA familiar with Occupational Therapists in other states who are using the Primary Coaching Model as developed by the Family, Infant and Preschool Program in North Carolina?

Leslie Jackson: *Yes, AOTA is aware of several other states that have or are in the process of implementing a similar approach, which may go by different names. We wrote about this issue in the October, 2004 Scope of Practice Update (see <http://www.aota.org/members/area4/links/link02J.asp?PLACE=/members/area4/link/link02J.asp>). The reason most frequently cited by these states for choosing to adopt this model is to ensure their EI services, including the therapies, are being provided in natural environments rather than clinical settings.*

BCW: Some states may have chosen to adopt the primary coach model to ensure that Early Intervention services are being provided in natural environments. However, for several years, Georgia has led the nation in providing our Part C services in natural environments. Accordingly, Georgia was well-positioned to take the next step forward to comply with additional components of the Individuals with Disabilities Education Act (IDEA). The law also requires that resources used to achieve IFSP outcomes be family-centered and defines provider roles in natural environments as assessment, consultation and training. Georgia's resultant move to a primary coach approach is based on research evidence regarding the way young children learn and what families say they need from early intervention supports.

Pat Pratt and Kay Nelson: It should also be noted that "coaching" is an educational technology that has been used in business, health, and educational settings for many years. Basic professional education in Occupational Therapy, which addresses work with the whole person and focus on function, offers an excellent background for this model.

1. We are aware AOTA has been very active with IDEA reauthorization. Has AOTA taken a position on individual states use of primary coaching instead of direct Occupational Therapy treatment under IDEA?

Leslie Jackson: *See the October, 2004 Scope of Practice Update above. AOTA's position has always been that occupational therapy services must be provided in accordance with each state's OT Practice Act, regardless of the service delivery*

model; this is what is reflected in IDEA. IDEA is silent on “how” EI services are to be provided, and therefore does not preclude the use of transdisciplinary models nor direct/hands-on services. In other words, IDEA does not require the use of any particular model of service delivery. Keep in mind that the use of a primary coaching model is not inherently wrong or inappropriate. What is problematic, however, is how the model may be implemented.

BCW: The state of Georgia has always agreed with this and continues to ensure that no provider is operating outside of his/her practice act.

Pat Pratt and Kay Nelson: It is important that all OT's be knowledgeable of licensure laws, scope of practice and ethical issues; this applies to therapists who provide services under this model and in all practice arenas. Review of the law and history remind us that Part C services were always intended to provide early identification, evaluation, and service coordination, support family efforts to access formal and informal early intervention services, and to help develop or improve early intervention resources as necessary to meet family needs.

2. Under the Primary Coach Model, the role of the Occupational Therapist is to coach the caregiver, not provide direct treatment. Co-visits for coaching other team members are an important part of the model. How does the code of ethics and Occupational Therapy guidelines apply in this situation?

Leslie Jackson: *As stated above, the problem is usually with the implementation, not the model itself. If done “right”, it may be appropriate to provide direct/hands-on services in the Primary Coaching model if that is what is needed to help the child and their family to achieve the IFSP outcome(s). IDEA requires the IFSP Team to decide, on a case-by-case basis (you know, the “I” in IFSP), what services and supports each child needs and how each of those services should be provided (that pesky “I” again). Although IDEA does not preclude the use of a transdisciplinary model in delivering EI services, it also does not permit states/teams to use a ‘1 size-fits-all’ model.*

BCW: The primary coach model actually provides more opportunity to individualize services based on family/child priorities than does our more traditional model which often tends to be more of a “one size fits all” model.

Pat Pratt and Kay Nelson: From the beginning and throughout our training for this approach, we have been reassured by the national consultants and BCW state office staff that “hands-on” modeling and demonstration of practices, techniques, strategies, etc. are totally appropriate. One of the advantages of this model is the flexibility to provide services at a frequency determined appropriate by the team, primary coach and family.

3. If the Physical Therapist on a coaching team is the primary coach and the Occupational Therapist co-visits to coach the family and PT on promoting the

child's development in eating and self feeding skills, is it appropriate that the Physical Therapist, if she is comfortable, monitor and report back to the OT in team meetings the status of the families progress in feeding?

Leslie Jackson: *I would say “no” because feeding is not generally considered to be part of the PT’s scope of practice. If the primary issue for the child and family is feeding, then either the SLP or OT (or both) should be assigned to this case. The determination of the most appropriate provider should be based on what the IFSP outcomes are and which team member has the necessary expertise in that area, not whose turn it is in the rotation or who’s available. Furthermore, while each discipline is expected to release some of their traditional roles and learn new skills, the primary coaching model does not replace/supplant one provider for another or to train another provider how to do what you do. It is intended to facilitate other adults’ (most notably the parents) ability to care for a child. Think “home program” – how would you train a parent to work with their child at home? Same concept for the coaching model - in other words, how would you facilitate the child’s development via another person?*

BCW: The most appropriate provider should be determined based on what the IFSP outcomes are and which team member has the necessary expertise in that area. Some PT pre-service programs provide coursework on feeding and some physical therapists may take post-graduate continuing education related to feeding, just as occupational therapists and speech pathologists may also do. What is important here is that the primary coach is not assigned solely by discipline but instead by knowledge base. A critical part of the primary provider model is also to share information with other team members, as

Deleted:

well as families/caregivers. This does not mean "supplanting one provider for another" but it does ensure consistent communication, information, and accountability among team members who support the family/caregivers. This has not occurred on a regular basis previously under the more traditional model. It is not accurate to attempt to equate home programs with the primary coaching model. Home programs infer that the provider is deciding what needs to be worked on and is giving the family exercises to do with the child to achieve certain skills. This would not be congruent with the conceptual framework behind the primary coach model which is to be family-centered, strengths -based, resource- based, capacity -building and promotion-based- all important in ensuring that the family is supported in facilitating their child's development and participation in the things that are important to that family within the context of their natural routines and activities.

Deleted:

Pat Pratt and Kay Nelson: We have found use of digital video clips is extremely effective- both as resources for the family and also for evaluation and collaboration with the team. Another advantage of this model is the ability to co-visit as is needed by the family and primary coach.

4. If the Occupational Therapist is the primary coach for a child and one of the goals the family has identified on the IFSP is to develop language skills/speech for the child, can the speech therapist coach the Occupational Therapist in this area?

Leslie Jackson & BCW: See the response to #4 above.

Pat Pratt and Kay Nelson: We are finding that we have learned to do as the law intended - we are differentiating between language development, communication and speech. Parents teach their children communication and language everyday. As professionals in early intervention, occupational therapists can support families of children with special needs in their efforts. Coaching from the speech pathologist is often necessary and valuable in this process. However when the family's needs are best addressed by the speech pathologist, then that person would be the primary provider.

5. If the IFSP team feels the most appropriate primary provider for a child would be a speech therapist, but the speech therapist is unavailable, can the team then assign another provider, such as the OT, to provide primary coaching with co-visits from the speech therapist?

Leslie Jackson: *Depends on the outcome to be achieved and whether OT has the necessary knowledge and skills. However, lack of availability of an appropriate provider is not an acceptable reason. Each state is obligated under IDEA to ensure they have an adequate supply of personnel, so if they don't have enough SLPs (or OTs or PTs, for that matter) to provide the necessary services, they have to go out and hire them (or contract with one).*

Formatted

BCW: The first sentence above should be underscored. Each state is obligated under IDEA to provide the services that are listed on the IFSP. Adequate supply of personnel is something with which all states struggle.

Pat Pratt and Kay Nelson: Another advantage of this model is that team members determine the knowledge and skills that each other have and identify any gaps that may exist between all team members and then work to fill those gaps.

6. Can insurance companies be billed for Occupational Therapy Services provided through the primary coach model?

Leslie Jackson: *Only if you are providing occupational therapy services! Many insurance plans, including some state Medicaid programs, do not reimburse for "indirect"/consultative service delivery models. This is something the state EI lead agency has to deal with. Although what is described would be considered part of occupational therapy services (it's not just hands-on), most payers do not reimburse for these "indirect" services. However, this will vary from payer to payer so it's important to know what each one requires relative to billing.*

BCW: All BCW providers operating under the primary coach model need to determine when services are billable to third party payers and then bill as appropriate (either to third party sources or BCW), following the current BCW fiscal policies. BCW supports Ms. Jackson statement that "what is described would be considered part of OT services (it's not just hands-on)".

Pat Pratt and Kay Nelson: We have found that on most visits, it is simple to determine if we should bill third party payers or BCW. BCW has provided the option to bill for a generic coaching visit when it is clear that we should not be billing insurance or Medicaid.