

## FAQ's about Mecklenburg CDSA Primary Service Provider (PSP) Pilot

### **1. Will teams serve the same number of children?**

The CDSA is responsible for serving all children referred to and enrolled in the Infant-Toddler Program, and this model will not change that. The pilot team is expected to support 100-125 families, which is in the range of our current service coordinator caseloads.

### **2. How does the CDSA plan to pay providers for team meeting and other non-billable time?**

The CDSA will reimburse network team members for team meeting time and will have a mechanism to pay network providers for services they provide that are not billable to a pay source. We will also be collecting data on the cost and process for this teaming model.

### **3. How do less experienced providers learn to provide services in this way?**

All PSPs will have a solid knowledge base of child development across all domains and will know how to support a child within the family system, in addition to the knowledge of their licensed field. PSPs will have team support, training on coaching and natural learning environment practices, and ongoing support during team meetings to improve their skills and build fidelity to the practices.

### **4. How does the team communicate?**

All team members are required to attend weekly team meetings to ensure consistent communication. IFSP teams can still staff and have informal meetings as needed between team meetings.

### **5. If a speech language pathologist (SLP) is the PSP, how is he/she going to provide PT?**

If the SLP is the primary provider, the SLP supports the family around the activities and routines they identified on the IFSP. The SLP will have knowledge of child development across domains and of NLEPs and coaching practices and be able to support outcomes on the IFSP. The SLP should be able to support basic motor development for young children, but if specialized knowledge is needed to support the child and family, the PT will be asked to accompany the PSP on a joint visit or possibly become a secondary support ongoing. Therapists will never be asked to work outside their practice act or to provide the therapy of another discipline.

### **6. How often can families receive support from the Sensory Support Program (Hearing/Vision)? What if a child has multiple needs, how often can they get hearing and/or vision services?**

Children with diagnosed hearing and vision needs will receive support from vision and hearing teachers on the team. These teachers may be the primary provider for the family depending on the needs of the child. If they are not the primary provider, they will serve as secondary supports and will determine with the IFSP team how often and what kinds of support the family may need related to vision or hearing.

**7. Who decides who the PSP will be and how often they see the family?**

The early intervention team goes through a rigorous process to choose a “most likely” PSP and presents that person to the family. The IFSP team ultimately decides if the PSP is the right fit and then determines the type, frequency, and intensity of services based on family priorities, child and family needs, and outcomes.

**8. How do PSPs deal with scheduling challenges?**

PSPs will use FAB scheduling (Flexible/Activity-based/Burst of Service) for all families. The PSP, SC, and family will determine when, where, and how often the early intervention visits occur based on the family’s changing needs. Since all families will have this option, provider schedules will be more fluid week to week.

**9. If we are a referral source, how do we explain which model the family will get? In other words, how will the conversation with families need to change regarding how the CDSA supports families and meets their children’s needs?**

The most helpful information a family can receive is to be told that once they are referred to the Infant-Toddler Program, they will be linked with a Service Coordinator who will explain the program to them in detail and answer their questions. They will go through an initial assessment to help identify their needs, priorities, and resources and will be linked with professionals who can support their family. This is true for both the current model and the PSP model. It would be best to let the SC explain the details of the program once they visit the family.

**10. What happens when children need multiple providers to treat a specific diagnosis? How do you provide specialized EI services to families if they are only seeing one provider?**

Each family has access to a whole team of professionals from multiple disciplines. Research shows that the more providers who are providing direct, ongoing services to a family, the higher the stress for families. Best practices state that if services are contextualized within a family’s daily routines and activities, children learn better and families are more confident. Using these approaches, families still have access to any discipline they need to address their concerns, they just may not all be visiting the family separately each week. The PSP is the main contact for the family, and other disciplines drop in and out as needed. Those other disciplines are on the team, attend team meetings weekly, and understand the details about each family’s needs and concerns. Every team member’s expertise is needed for the team to function well.

**11. If a child has other needs outside of the treating therapist’s expertise, how are these addressed?**

If a child has needs that the PSP cannot meet, the PSP goes back to the team and asks for support. The request is addressed quickly so the family does not have to wait for assistance. If someone on the team has the expertise needed, they may consider a

joint visit with the PSP or provide secondary supports. If no one on the team has the expertise or knowledge needed to address the issues, the team finds someone outside the team to help the team build their capacity to support the family.

**12. Could the PSP change?**

The PSP for an individual family can change if needed, but it is not recommended unless there is a significant change in the family's needs or if there is a poor fit (e.g., in communication or personality). The team takes the long view in choosing the PSP at the beginning of the referral to make sure the person working with the family can best meet the family's needs while they are enrolled in the program.

**13. How do we ensure the correct specialists are seeing the child so that diagnoses are not missed? What are the safety nets for children?**

We use the process for choosing a PSP as outlined by Sheldon and Rush (2013) to ensure that the best provider is chosen for the family right from the beginning. All other providers on the team who are not the primary are still responsible for supporting the PSP to ensure that all the family's needs are met while they are enrolled. Any of those specialists can see the family with the PSP if new questions or concerns arise. The safety net for families is the fact that all families are staffed with the entire team as part of the team meeting process and all families have access to all team members as needed. Families in our current model do not have that safety net. Link to PSP choice process:

[http://fipp.org/static/media/uploads/casetools/casetool\\_vol6\\_no3.pdf](http://fipp.org/static/media/uploads/casetools/casetool_vol6_no3.pdf).

**14. What happens if the PSP is not the right fit for the family and they are not meshing well?**

As with all Infant-Toddler services, families have a choice of provider and SC. If the family feels the person working with them is not a good fit, the SC will facilitate a conversation and problem solve around the concern. Families can change PSPs if their issues/concerns cannot be resolved.

**15. What does a joint visit or secondary support look like?**

When the PSP or the family has a question or concern that requires other experts to address it, another team member can provide that support. This provider may give ideas to the PSP during a team meeting or through one-on-one conversations, or he/she may accompany the PSP on a joint visit. The visit occurs with the PSP so everyone knows what is suggested and discussed. If the visiting provider, family, or PSP feels the family needs more support, the visiting provider may agree to come out for a series of sessions with the PSP to provide more specialized support. If so, they become a "secondary support" to the family and provide treatment at the frequency and duration the IFSP team determines to be necessary.

**16. Will *all* the members of a team ever go to a family's home and do a child assessment, e.g., complete a full, play-based assessment similar to what is being done in the school system?**

All children entering the Infant-Toddler Program receive a developmental evaluation needed for eligibility determination. All families receive an initial child assessment to assess how the child is functioning in the home and community, and these assessments are multidisciplinary. Once the IFSP is written and the PSP is chosen, children may receive assessments from any discipline/member of the team that the family deems necessary as questions or needs arise. This will be an individualized process for each family.

**17. What role does the parent play in selecting the PSP?**

The IFSP team makes the ultimate decision about who the PSP will be and the parent is a key member of the IFSP team. The team recommends the person they believe will be the best fit, but the parent has the option to choose another person from the team. Services are required to be provided in the family/child's natural environment, which can include many locations such as places in the community the family frequents, grandparents' and babysitter's homes, child care, etc.

**18. How does access to evaluations differ under this model?**

Families have access to all disciplines on the team much more regularly than they do in the current model. Therapists are providing ideas and insights to the PSP whenever needed and can go to the family's home for an assessment or evaluation any time the family and IFSP team deem necessary. In this model, families get the whole team all of the time, unlike the current model.

**19. How will billing challenges be addressed? For example, if an SLP is working on bath time or sleeping, how would they bill?**

When the PSP is chosen, the ability to bill is one of the last factors considered. Generally, it is expected that for most sessions there will be billable time to a pay source (e.g., Medicaid or private insurance). There will be a reimbursement mechanism in place from the CDSA for those instances where a provider feels the support they offered a family does not meet the standard for billing a particular service.

**20. What is the Service Coordinator's role in this new model?**

The Service Coordinator is still the main contact person for families while they are enrolled in the Infant-Toddler Program. SCs facilitate eligibility determination, assessment, and IFSP development as well as monitor the success of IFSP outcomes while the family is enrolled. They are also resource experts and help families with resource needs as they arise. As a member of the team, SCs will coordinate and

facilitate IFSP reviews and help ensure families' rights are protected while in the program.

**21. What happens to parent choice within the provider network if only one specific discipline is on the PSP team?**

The recommended team structure for an effective PSP team consists of four SCs, an SLP, OT, PT, and a developmental specialist (CBRS provider). On the pilot team, there are two developmental specialists, two SLPs, one OT, one PT, one social worker, and three sensory support staff. The team will also have access to a nutritionist, an audiologist, and psychologists when needed. Families will have choice in that the PSP for their family will match their needs as assessed by the team, of which they are a part.

**22. How do providers feel about attending weekly team meetings when this is not a billable service?**

Providers on the pilot team have agreed to attend weekly team meetings, and they will be reimbursed for this teaming time.

**23. Is there a place for part-time people in the network?**

Yes. Network providers who are serving on the pilot team are part-time, but will carry a caseload of 10-12 families. Network providers will be *essential* to all teams if the CDSA implements this model across the agency. It will be important for teams to use best practices, have ongoing support, and not be too large to be effective; therefore, it will be important for providers to dedicate at least a portion of their caseload to a PSP team. It would be difficult to include providers on teams who were only seeing two or three families at a time. This would require too many people on a team to support the number of families being served.

**24. What are you paying providers to treat families?**

Providers are billing for the services they provide to families when there is a pay source identified, just as they do now. They are reimbursed by the insurance plan at the negotiated rate. Providers also have the ability to bill the CDSA for services at the Infant-Toddler rate and are reimbursed for team meeting time by the CDSA.

**25. When working with children who have complex medical needs, how is everyone (e.g., CAP-C and nursing) included in team meetings?**

When a family's case is brought up in team meeting staffings, they are welcome to attend or participate in another way while their child is being discussed. If there are IFSP team members from other agencies who need that information, they could also participate with parent permission. These team members could be a part of all IFSP

reviews and decision-making for that specific family, just as they can in the current model.

**26. How is frequency of services determined in this pilot compared to how it happens now?**

The IFSP team determines the frequency and intensity of services just like they do in the current model. The only difference is that the PSP team will use FAB scheduling, which is more flexible and better able to meet families' needs. See question #10 re: FAB scheduling.

**27. How will families who are not native English speakers be able to participate?**

Our PSP pilot team is prepared to serve all families who come onto the team. There are currently two team members who are bilingual (English/Spanish) and three team members who are fluent in American Sign Language (ASL). If a family's primary language is something other than English, we will use the same process we have now for securing professional interpreting services to cover visits with these families.

**28. How is the team collaborating with one another so they can make the most appropriate suggestions for each child and family, and how is the family involved in this process?**

Teams meet together weekly and children are staffed on a rotating schedule at least quarterly. Anytime a team member has a question or concern about a child, they can add it to the agenda that week and get suggestions and support, including scheduling a joint visit. Families are welcome to attend or call in for the meeting. As in the current model, and in line with IDEA and NCITP, families are key participants in decision making, and they have the right to consent or not consent to the supports and services recommended by the team.

**29. How can we share information about community resources if families opt out of Part C?**

If families opt out of early intervention services or are not eligible after the referral process, SCs share information about community resources that may benefit them before closing the case. If the family wants to be referred to community services at that time, the SC facilitates the referral for the family.

**30. How will these families be prepared for Part B?**

Children enrolled in Part C services, regardless of the team they are on, go through the federally mandated transition process. SCs meet with families along with a representative from the school system when the child is between the ages of two years three months and two years nine months, and develop an individualized transition plan with the family. Families learn how Part B services work and how these services differ in focus and delivery from Part C services, as well as receive information about preschool, Head Start, and other community programs that match each family's needs and desires for their child after they exit the program. All families receive a copy

of the [Early Childhood Transitions in North Carolina: A Parent’s Guide to the Infant-Toddler and Preschool Program](#) during the transition planning process, and SCs review this handbook with families.

**31. How will families in the pilot area be accommodated if they want the “old way” of doing things?**

Families who are referred to the pilot geographic area will receive services within the PSP model. If for some reason the family is dissatisfied with this model or does not want services provided in this way, decisions about how to resolve the concern will be made on a case-by-case basis.

**32. How do we talk about billing/cost to families?**

The costs for Infant-Toddler Program services will be the same regardless of the team the family is working with. PSP services will be billed based on the rate of the service the therapist is licensed to provide. Families are still able to bill pay sources, such as private insurance and Medicaid, and they have access to the sliding fee scale. Service coordination, evaluations, and assessments are still provided at no cost to families.

**33. What are the disciplines of the PSP team members?**

1 Team Facilitator (MSW), 1 Team Administrator, 4 SCs (education, social work, counseling, speech pathology), 1 Senior Case Coordinator (education), 1 OT, 1 PT, 2 SLPs, 2 Developmental Specialists, 1 Clinical Social Worker, 2 Teachers of the Deaf or Hard of Hearing, and 1 Vision Teacher.

**34. What will the initial conversation with families look like if presented by a CDSA SC? How does it stay collaborative instead of prescriptive?**

Families will meet with their assigned Service Coordinator quickly after the referral is made. SCs explain the program, provide the [Notice of Child and Family Rights](#), [The North Carolina Infant-Toddler Parent Handbook](#), review the program philosophy, and answer questions. The pilot team is currently developing a brochure that explains the PSP model (team-based intervention) and includes brief bios of the team members. This will be shared with families at the initial visit. The SC also gathers concerns, priorities, and explores the need for resources during the initial evaluation and assessment process. All decisions about Infant-Toddler services and IFSP outcomes are based on the individualized information shared by the family.

**35. What if we receive referrals from MDs that don’t align with Early Intervention philosophy? How do we reconcile what the doctor is saying with this model, especially with newborns?**

Information about NLEPs, coaching, and PSP have been provided to all medical practitioners in the community. Community Cafés and individual meetings to share information and discuss questions have been scheduled. Partnering agencies that

currently work with pediatricians will be providing ongoing support. Pediatricians now have guidance from the *American Academy of Pediatrics* about what is best practice for Part C Services: [Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes](#).

**36. How are physician orders factored in (i.e., orders for PT, OT and ST)? How do we talk about this with families?**

When families request to have a pay source (Medicaid or private insurance) billed for services listed on the IFSP, the therapist providing the service asks for the service order from the physician, which is the current process on all teams. Families still have a right to use their insurance benefits or to withdraw permission to bill for any service. Families also have access to the sliding fee scale for services. All of these policies are included in the [System of Payments Notification](#) provided to all families.

**37. Will the PSP providers be in network for the insurance the parents have? How will that work?**

Providers who are currently working on the pilot team are in-network for multiple insurance companies, including Medicaid. The CDSA is also in-network for some insurance companies and continues to work to get added to more panels. As families help choose their PSP, they will be informed about which insurance companies are in-network for each provider. Just as service coordinators do now, they will support families in determining how they can best use their financial resources to access the services they need.

**38. What websites can families access to learn more about the PSP model?**

This pilot is based on the work of Sheldon and Rush (2013) in *The Early Intervention Teaming Handbook* offered by Brookes Publishing. Articles and resources that outline the research, procedures, and practices can be found on their website at the [Family Infant Preschool Program](#). The pilot team at the CDSA will also have a brochure to offer families that explains the program and provides bio information about team members. Several other states are also using this model. Arizona, Virginia, and Kansas are just a few of more than 20 states who are using these practices.

\*\*Additional resource: [Q&A provided by Brookes Publishing](#).