



Worksheet For Selecting The Most Likely Primary Service Provider

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This CASEtool includes a description of how to use the *Worksheet for Selecting the Most Likely Primary Service Provider* (PSP). The worksheet is based on an approach to teaming using a multidisciplinary, geographically-based team, where one member is selected as the primary service provider, receives support from other team members, and provides support to the parents and other care providers using coaching and natural learning environment practices to strengthen parenting competence and confidence in promoting child learning and development. The worksheet is initiated by a team as soon as possible during the Individualized Family Service Plan (IFSP) process to assist in identifying the best match for who will serve as the most likely primary service provider for an individual child and family. The worksheet also supports teams in determining the presence of role gap, role overlap, and need for role assistance.

INTRODUCTION

The purpose of this CASEtool is to describe how to use the *Worksheet for Selecting the Most Likely Primary Service Provider* (PSP). The term *most likely* is used in the worksheet because the final decision of who will serve as the PSP is not made until the Individualized Family Service Plan (IFSP) meeting when all IFSP team members are discussing the service delivery options (i.e., who and how often). The worksheet is completed by a geographically-based team using a primary service provider approach to teaming. A geographically-based team is a group of early intervention practitioners consisting of minimally an early childhood or special educator, occupational therapist, physical therapist, speech-language pathologist, and service coordinator(s) responsible for all referrals to an early intervention program within a predetermined area defined by a specific geographical boundary. The worksheet supports teams in determining the presence of role gap, role overlap, and need for role assistance and is organized by four interdependent factors prioritized by the order of consideration in the process for determining the most likely PSP. Each factor provides inclusion and exclusion criteria to assist the team in determining which team members should remain as options for serving as the most likely PSP. The reader is referred to Shelden and Rush (2007; 2010) for additional information about a primary service provider approach to teaming.

This paper includes a brief overview of PSP approach to teaming practices, a description of the *Worksheet for Selecting the Most Likely Primary Service Provider*, and guidelines for using the worksheet. The worksheet and instructions are included in the appendix.

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A PRIMARY SERVICE PROVIDER APPROACH TO TEAMING IN EARLY INTERVENTION

Prior to 2008, the National Early Childhood Technical Assistance Center (NECTAC) formed the *Workgroup on Principles and Practices in Natural Environments* to develop agreed upon practices for supporting infants and toddlers with disabilities and their families. Specifically, the workgroup was charged with reaching consensus on the mission, key principles, and practices for providing early intervention in natural environments. The workgroup was comprised of individuals representing multiple perspectives including state level policy makers, Part C coordinators, faculty from institutions of higher education, early childhood researchers, early intervention practitioners, parents, as well as state and national training and technical assistance providers representing all of the key disciplines involved in early intervention (i.e., early childhood special education, occupational therapy, physical therapy, psychology, service coordination, speech-language pathology). Key principle 6 states, “the family’s priorities, needs, and interests are addressed most appropriately by a primary provider who represents and receives team and community support” (Workgroup on Principles and Practices in Natural Environments, 2007, p. 7). Principle 6 also delineates concepts that support the use of a primary provider such as formalized communication mechanisms, opportunities for joint visits, and shared responsibility for achievement of Individualized Family Service Plan (IFSP) outcomes.

Use of a PSP is most commonly associated with a transdisciplinary model of team development in which one member of the team is chosen to serve as the primary service provider to work directly with the child. A distinguishing feature of transdisciplinary teamwork is the concept of role release, or teaching the skills traditionally associated with one discipline to another team member who functions in direct service capacities working directly with the child (Woodruff & McGonigel, 1988). The need for a teaming approach using a PSP is based on the fact that focusing on services and multiple disciplines implementing decontextualized, child-focused, and deficit-based interventions has not proven optimally effective (Campbell & Halbert, 2002; Dunst, Bruder, Trivette, Raab, & McLean, 2001; Dunst, Trivette, Humphries, Raab, & Roper, 2001; McWilliam, 2000). The use of a primary service provider has been identified as a practice that can be used with young children and their families (American Occupational Therapy Association, 2009; American Physical Therapy Association, 2010; American Speech-Language-Hearing Association, 2008a; 2008b

Pilkington, 2006; Sandall, Hemmeter, Smith, & McLean, 2005; Vanderhoff, 2004; Workgroup on Principles and Practices in Natural Environments, November, 2007).

In a primary service provider approach to teaming in early intervention, the PSP acts as the principle program resource and point of contact between other program staff, the family, and other care providers (i.e., the team). The PSP mediates the family’s and other care providers’ skills and knowledge in relation to a range of needed or desired resources (i.e., child learning, child development, parenting supports). A primary service provider approach to teaming is characterized by the team members’ use of coaching practices to build the capacity of parents, other primary care providers, and professional colleagues to improve existing abilities, develop new skills, and gain a deeper understanding of how to promote child learning and development within the context of interest-based, everyday learning opportunities as well as provide parent support (Dunst, Bruder, Trivette, Raab et al., 2001; Rush & Shelden, 2005; Shelden & Rush, 2007; 2010).

Whereas, Woodruff and McGonigel (1988) describe the six linear phases of transdisciplinary team development, in a primary service provider approach to teaming, the process is based on four foundational interdependent components: (1) role expectation; (2) role gap; (3) role overlap; and (4) role assistance. These components refer to individual team member involvement when using a PSP approach as opposed to the discipline represented by each person.

Role expectation refers to three minimal areas of competency when practicing in Part C and using a primary service provider approach to teaming. The first requisite is the expectation that each team member will be an evidence-based practitioner. This includes being knowledgeable of the evidence to support practice in his or her own discipline, early intervention (Part C federal regulations and the Mission and Key Principles for providing early intervention in natural environments), and early childhood development (beyond the areas of development typically associated with a particular discipline). The second condition is that every team member is competent in providing parent and parenting support. Parent support is defined as assisting families related to identification, use, and evaluation of needed resources such as transportation, housing, crisis intervention, and medical services. Parenting supports involve evidence-based information, techniques, strategies, and approaches that assist parents in meeting identified needs related to topics such as toileting, supporting positive behavior, helping a child sleep through the night in his or her own bed, and/or expanding a child’s repertoire of foods. Finally, the third

requirement of role expectation is that all team members know how to mediate parents' and care providers' abilities to support child learning and development by using evidence-based adult learning and interaction methods (i.e., coaching) (Rush & Shelden, 2011).

Role gap is the circumstance in which the PSP or another team member realizes that the primary provider does not have all of the needed knowledge and skills to adequately support a child's learning or implement necessary parent/parenting supports. This may occur at the time in which the PSP is being selected or while serving as the primary service provider for a particular child and family. When role gap occurs as the PSP is being identified, individual practitioners may opt out of serving as the primary provider or the individual practitioner and team may determine that role gap will be bridged through the process of role assistance from other team members. Role gap may also occur while a practitioner is serving as the primary provider. This might happen when a child makes substantial progress in a particular developmental area, or when a parent encounters a new or unexpected situation requiring knowledge and expertise beyond the primary provider's training and experience. Another role gap that a team may experience is when the entire team is lacking an area of expertise or knowledge (e.g., assistive technology alternatives for a child with hearing impairment or vision loss). In these instances, role assistance is required either for the primary provider or the entire team.

Role overlap is the situation in which multiple team members feel confident and competent to fill the role of the PSP for a particular child and family. Role overlap maximizes flexibility and efficiency for teams in the selection of the PSP. When role overlap occurs, role assistance would most likely take the form of colleague-to-colleague coaching opportunities, conversations during team meeting, and joint visits with the family. As team members work together for longer periods of time, role overlap occurs more frequently. This occurs not necessarily because team members are releasing or exchanging intervention techniques or strategies, but due to collective experience implementing evidence-based practices in early intervention and shared conversations at team meetings, observations during joint visits, and supporting one another over time.

Role assistance is (a) the ongoing direct support provided by the team or a specific team member to the PSP; and (b) focused learning opportunities for the team at-large and individual team members to fill an identified role gap. Role assistance is provided through regular team meetings, joint visits between the PSP and another team member, colleague-to-colleague coaching conversations,

and coursework, training, and other professional development activities. When any team member identifies that additional support is needed, role assistance should be provided. If an evidence-based intervention is perceived to be too complicated, new, or beyond the scope of practice of the PSP, then role assistance is required. This is not to say that any time a PSP feels uncomfortable or challenged that a joint visit is required. Role assistance, however, should be prompt and could be in the form of a one-on-one or small group conversation, joint visit, coaching during a team meeting, or additional in depth training for an identified role gap situation.

HOW TO CHOOSE THE MOST LIKELY PRIMARY SERVICE PROVIDER

The most likely PSP is identified based upon four categories or types of factors. The categories of factors are considered in a specific sequence and have multiple levels of complexity. The four types of factors are (a) parent/family, (b) child, (c) environmental, and (4) practitioner.

Since the child must always be considered within the context of the family in which he or she lives, parent/family factors are the family's priorities and requests for services to support their child's learning and development. Since families are often referred by a physician this would also include a prescription for a specific therapy that a family might present to the early intervention program. Other parent/family factors include the family dynamics (i.e., how the family defines itself, how the family members interact with one another, etc.), as well as characteristics of individual family members (e.g., primary culture, language, diagnosis or condition), and availability of the family to participate in early intervention services.

Child factors include specific characteristics that are unique to each child deemed eligible for the program. These factors are the child's diagnosis or condition as well as any needs identified by the family or other team members during the evaluation and assessment process. Other child factors include child-specific interests (i.e., toy trains, new puppy, favorite blanket) and activity settings (e.g., snuggling with grandma, eating snack at child care, playing on the slide at the park) in which the child currently participates and/or needs to be involved.

The third type of factor to consider when identifying the most likely PSP is environmental factors. Environmental factors include the natural learning environments of the child and family such as the child's home, locations within the community (i.e., church, park, grocery store),

or the preschool or child care setting if applicable. Also included as an environmental factor are safety considerations such as presence of animals, health risks (i.e., second-hand smoke), and locations that could present potential risks or harm to the early intervention practitioner. Another environmental factor that is considered during the selection process is the distance of the child and family's natural learning environments from the early intervention program. Due to the impact of the drive time on the practitioner's ability to schedule visits with each child and family, the distance factor should be discussed prior to final selection of the primary service provider.

Practitioner factors include, first and foremost, the knowledge and expertise of each individual practitioner as it relates to the parent/family and child factors. Both professional and personal expertise should be taken into account during this discussion. For example, if a particular child has feeding issues, then the person(s) on the team with specialized skills related to feeding should be considered as most likely PSP. Personal knowledge and expertise may be matched with a family's interests, activity settings, and lifestyle (e.g., outdoor activities, farm life, home-schooling, sports activities, etc.). Practitioner factors also include the primary provider's assigned area of service within a geographic region. For example, if a team has multiple speech-language pathologists (SLP), for sake of efficiency, they may be assigned to a specific area within a county or school district to decrease drive time. In these instances, the SLP serving the area in which the child resides would be considered as the most likely PSP. Also included as a practitioner factor is the billability of the service being provided. For those programs required to obtain third party payment, billing is a required consideration.

In special circumstances a practitioner factor could also be a prior relationship with a family. For example, if a family has an older child who participated in the early intervention program, then the person who worked most closely with the parent or care provider at that time may be the best choice to become the PSP. In this situation, the relationship may already be established, and the primary provider and family already know how to work with one another, therefore the PSP will also be familiar with the family's interests, routines, and activity settings. Since the PSP is competent and confident in child development, parenting supports, and coaching, and also knows when to seek support from other members of the team, the team member with a pre-existing relationship may be the best choice. Similarly,

all other factors being equal, a practitioner may have developed a special rapport with the family during the early steps in the IFSP process. Because of this bond, the family may feel more comfortable with this team member fulfilling the role of the PSP.

A final practitioner factor for identifying the most likely PSP that is a reality for most teams is availability. If a team member's schedule is essentially full and he or she does not have time available for another family then he or she may not be an option to be the primary provider. If, however, he or she is the best and only person who should be the PSP for the family, then the team will have to determine if some adjustments can be made to enable him or her to provide support to the new child and family. If the best person on the team cannot be made available and no other team member has the knowledge and skills necessary to support the family, the team may have to identify a resource outside the team. Rarely does a team have to seek outside resources as adjustments can usually be made within the team for the family to have the best possible primary service provider.

The worksheet may be used beginning at the initial visit through all steps in the early intervention process up to and including the IFSP meeting. When used early in the process, the worksheet assists in the selection of evaluation team members and the person(s) most appropriate for conducting the functional assessment. The items listed on the worksheet are intended to be (a) information gathered throughout the early intervention process up to and including the IFSP meeting, as well as (b) discussion points for the team as part of the conversation about who on the team would be the very best *most likely* primary service provider.

The worksheet can be conceived as a funnel. At its widest point, all team members with the exception of dedicated service coordinators are eligible to be a primary service provider. The discussion and selection process involves the consideration of the four sets of factors described previously now further divided into three tiers. These tiers are used by team members as filters to determine the most likely PSP(s) at each tier until the best, most likely PSP emerges as well as any supports the PSP might need from a secondary service provider (SSP) (i.e., joint visitor) through joint visits.

CONCLUSION

The *Worksheet for Selecting the Most Likely Primary Service Provider* facilitates a systematic and objective process during which a team identifies the best

possible person to serve as the primary provider for an eligible child and family. The worksheet also guides the team in considering the need for the involvement of other team members to support the PSP, child, and family members. The information considered during completion of the worksheet is shared with the family to support their involvement in making the final decision of who will serve as the PSP, which occurs during the IFSP meeting.

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APPENDIX

WORKSHEET FOR SELECTING THE MOST LIKELY PRIMARY SERVICE PROVIDER ADMINISTRATION PROCEDURE

The first step in the process of selecting the most likely primary service provider (PSP) is to list all of the members of the core team in the shaded box in the upper left corner of the worksheet because all core team members are always potential PSP. The box does not include the service coordinators since in a program with dedicated service coordination the service coordinators do not serve in the role of PSP. In a program in which service coordination is also a role of a service provider, then those individuals would be represented in the shaded box by their discipline.

Beginning at *tier 1* and *parent/family factors*, the team lists and discusses the parents' priorities for the child. Rather than a list of skills the parents would like for the child to learn, the priorities are written and discussed as participation-based IFSP outcomes that include the context in which it would be most helpful for the child to be participating. Context is critical because this assists in determining the PSP. The team also considers any specific *parent/physician requests* with equal weight of other team members. For example, if the family/physician believes the child needs occupational therapy, then an occupational therapist should remain as an option for most likely PSP unless another factor in tier 1 or possibly tier 2 would indicate that another team member would be a better, most likely PSP. Factors on the worksheet are then used to explain to the family how the options for the most likely PSP were identified. The team then moves to **child factors** in tier 1 and shares the *child's diagnosis or condition*, if applicable, as well any of the *child's needs* gathered up to this point. The team keeps the long-term perspective of the child in mind rather than only what he/she might need right now, also discussing the *child's interests and activity settings* identified thus far. Next, the team moves to the **environmental factors** in tier 1 and circles on the worksheet the *natural learning environments* identified to date during conversations with the family. Finally in tier 1, the team moves to the **practitioner factors**. Of the original core team members listed in the shaded box in the upper left corner of the worksheet, the team determines who has the *professional knowledge and expertise* based on his/her discipline perspective and experience as well as *personal experiences* to assist the parents in achieving their priorities for the child based on the child's diagnosis, condition, and/or needs as well as the current natural learning environments.

Often, more than one team member could be the most likely PSP at this point after considering all of the aforementioned tier one factors. The team lists the names of the most likely PSP(s) in the shaded section on the worksheet. Based on the long term perspective, if a team member has been excluded as the best, most likely PSP, but will be needed to support the PSP and family

at this point, the team lists his/her name as a SSP option on the worksheet. If only 1 team member is listed as the most likely PSP in tier 1, then the team has successfully identified the most likely PSP. The team then writes this person's name in the darker shaded box at the bottom of the worksheet labeled "Most Likely PSP." If that team member currently has a full schedule and is unavailable to be considered as the most likely PSP, then the team must work together to consider possible options to free up time for this individual to serve in the primary provider role. The team then determines what role gaps, if any, exist. That is, the team ascertains what additional knowledge and skills will perhaps be necessary to help support the PSP and family related to the parent priorities as well as the child's diagnosis/condition, and needs. The team lists the role gaps in the box identified as such on the worksheet. Next, the team decides who may be needed to serve as a secondary service provider (SSP) to support the PSP during one or more joint visits and lists this person's name in the last box on the last row of the worksheet. If more than one team member is listed in the most likely PSP area at the end of tier 1, the team has role overlap. This means that more than one person currently has the ability to serve as the most likely PSP, therefore the discussion continues as the team proceeds to tier 2.

Tier 2 begins with the team considering the **parent/family factors** of *family dynamics* and individual parent or care provider characteristics. Examples of family dynamics include, but are not limited to multi-generational households, parents who are divorced and have joint custody, foster families, reunification efforts with a child's biological family, or parents with differing opinions about childrearing and/or intervention. If a team member has more experience working families in similar situations, he or she would continue to move forward as a possible most likely PSP.

In tier 2, the team also considers *individual parent or care provider characteristics*. The first characteristic the team considers is the primary language of the parent/family. If the primary language (other than English) is spoken by one or more of the most likely PSP listed in the gray box on tier 1, then those team members continue to be considered by the team as the most likely PSP and proceed through tier 2. If none of the identified most likely PSP from tier 1 speak the family's primary language, then an interpreter will be needed and all of the potential PSP will continue through tier 2. The next parent characteristic considered is parent knowledge/expertise. For example, if the parent is a grandparent raising the child, a foster parent, or a teen parent, these could be factors to assist with deciding the most likely PSP. If a parent has prior knowledge or experiences, this could "rule in" or "rule out" certain team members who were

still in consideration for most likely PSP. The final parent characteristic that could potentially impact the most likely PSP through tier 2 is a parent diagnosis or condition. For example, if the team knows the parent has a mental health issue, then perhaps a member of the team still in consideration has experience working with parents who have a similar diagnosis. This team member would proceed through tier 2 whereas others could be taken out of consideration at this point.

The team next considers the **environmental factors** in tier 2. *Personal safety* may be an issue, and if so, should be discussed. No individual team member should feel that his or her personal safety is at risk. By the same token, the entire team should ensure that individual values, biases, or preferences do not result in misinterpretation of an environmental situation as a threat to personal safety. At this point, if multiple team members are still in consideration as the most likely PSP, then perhaps gender could be a factor in determining the most likely PSP or the availability of another team member to go with the most likely PSP would need to be considered. The team also considers the *distance* between the family's home, child care, or other natural environment in which the parent would want direct supports from the program office. As an example, if one of the remaining most likely PSP has very few hours available for a new family and the family currently being discussed would require a one hour drive each way, then other most likely PSP should remain in consideration as a result of the discussion in tier 2.

The final set of factors to be considered in tier 2 is practitioner factors. When programs have more than one of a particular discipline, sometimes these individuals are assigned to *particular areas of the geographic region* in which the core team supports. For other teams, certain team members may go to a certain part of the catchment area on certain days. In these cases, the primary service area may help to determine who should or should not continue to be considered as the most likely PSP. If an early intervention program relies on *billing* and one team member still in consideration for most likely PSP is able to bill a third party payer for his/her services, then this would continue to keep him/her as an option for PSP. In contrast, if someone cannot bill for the service, then the team may decide to (a) no longer consider this person as an option, or (b) use alternative funding for services, so this person remains in consideration. Finally, the *filters of prior relationships* and *rapport* are considered. If a team member is still in consideration and provided supports to this family for a previous child, then that team member may move forward in the selection process. Similarly, if the parent and a team member established strong rapport during the process from initial contact to IFSP meeting, then this, too, should be a consideration if all other factors are equal between this individual and other possible PSP.

At this point, the team lists the names of the remaining most likely PSP(s) in the shaded section in tier 2 as well as any other SSP options. If only one most likely PSP remains, then the team has identified the best can-

didate. The team writes this person's name in the darker shaded box at the bottom of the worksheet labeled "Most Likely PSP" and determines what role gaps, if any, exist. Then the team determines who may be needed to serve as a secondary service provider (SSP) to support the PSP during one or more joint visits and lists this person's name in the last box on the final row of the worksheet. In situations when more than one person is listed in the most likely PSP area in tier 2, the team continues to have role overlap, therefore discussion will need to continue to tier 3.

The team discussion proceeds in **tier 3** with the **parent/family factor of availability**. The team considers all of the days and times when the parent and/or child care provider is available to meet with the remaining team members who could be the most likely PSP. If these days and times are possibilities for one or more of the remaining team members at this point, then that team member moves forward in tier 3 as a candidate for the most likely PSP. Next, the team concludes the discussion of most likely PSP with the **practitioner factors of availability**. Similar to the discussion of the availability of the parent and other care providers, the team considers the availability or possible availability of the remaining most likely PSP. If so, the individual(s) moves forward as the most likely PSP. Some teams may typically consider availability as a first factor in determining who on the team could be the most likely PSP. The reason practitioner availability is the last factor considered with this worksheet is because the goal of the team is to be able to provide the very best PSP the team has to offer to every family. The potential very best person should not be eliminated without considering all of the other factors, then all factors being equal between team members at the end of tier 3, availability can be a consideration. If only one most likely team member is remaining and unavailable, then the team's conversation moves to finding a way to enable that team member to be the most likely PSP for the child/family or move back up through the tiers to see if another team member should be reconsidered for the possibility of most likely PSP.

The team lists the names of the most likely PSP(s) in the shaded section in tier 3 and if only one most likely PSP remains, then the team has identified the most likely PSP. The team determines what role gaps, if any, exist and decides who on the team will be the best person to serve as a secondary service provider (SSP) to provide role assistance to the PSP if needed. Role assistance can be provided through one-on-one conversations, during team meetings, and via joint visits. The team then writes this person's name in the last box on the last row of the worksheet. If more than one team member is listed in the most likely PSP area in tier 3, the team continues to have role overlap. At this time, the remaining individuals determine who is willing to potentially serve as the PSP. If for any reason the parent was not present during this discussion, the team should present the suggestion for the most likely PSP and review the worksheet sharing the information previously discussed with the parent.

The overall process for using the worksheet to select the most likely PSP and possible SSP takes less than 10 minutes in most circumstances. Once teams

work together over time, the conversations become faster and the worksheet simply serves as an outline for the conversation.

Core Team as Options for PSP

EC _____
 OT _____
 PT _____
 SLP _____
 Other _____

PRIMARY SERVICE PROVIDER APPROACH TO TEAMING

**WORKSHEET FOR SELECTING
 THE MOST LIKELY PRIMARY SERVICE PROVIDER**

| | <i>Most likely PSP(s) identified based on:</i> | | | | <i>Most Likely PSP Optional Selected</i> | SSP Options Selected (list) | |
|---------------|--|--|--|---|--|-----------------------------------|--------------------|
| | Parent/Family Factors | Child Factors | Environmental Factors | Practitioner Factors | | | |
| Tier 1 | List Priorities with contexts Parent/physician Request | List Diagnosis/Condition/Needs (Long term view) List Interests/Activity Settings | Natural Learning Environments (circle) <ul style="list-style-type: none"> • Home • Community • Preschool • Child Care • Other | Knowledge/Expertise (personal/professional) | Role Overlap | ↓ | |
| Tier 2 | Family Dynamics Individual parent/caregiver characteristics <ul style="list-style-type: none"> • Language/culture • Knowledge/expertise • Diagnosis/condition • Other | | Safety Distance from program office | Primary service area in geographic region Billability Prior relationship Rapport | | | |
| Tier 3 | Availability | | | Availability | | | |
| Notes: | | | | | <i>Most Likely PSP is:</i> | Role Gap? If so, explain: | Role Assist (SSP): |