

Models of Teaming and Service Design In EI/ECSE Programs September 24, 2001

A Report from the Collaborative Teaming Work Group

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I. Overview

A review of the law and regulations regarding education of children with disabilities reveals a mandate to support children and students in each identified area of need, as well as a strong emphasis on effective teaming and program coordination. Looking specifically at services for children from birth to kindergarten age, one finds the emphasis on teaming and coordination joined with an equal emphasis on the need to design and deliver developmentally appropriate, family friendly services in an environment natural to the child.

As mandated by the 1997 amendments to the Individuals with Disabilities Education Act (IDEA '97), EI/ECSE programs across Oregon use a variety of service models (direct services, consultative services, group and individual services, inclusion etc.) to deliver Early Intervention, Early Childhood Special Education and related services. These models were designed to address differences such as urban vs. rural settings; numbers of children within a given geographic area; complexity of child, family and/or classroom needs; program resources (money, staff, and time available) and community resources. In reviewing these service models, some common questions arise:

- What service and/or team collaboration models are in use in Oregon?
- Do the service and team collaboration models in use in Oregon provide the mandated continuum of intervention services? Do they provide a consistent process for placing students on the continuum? Are processes applied fairly and equally across programs and throughout the state?
- What does the literature say regarding models of service delivery and team collaboration? What is considered "best practice" by the various experts and professional organizations?
- Do the service models used in Oregon reflect current knowledge about best practice in service design and team collaboration? What is the philosophical base for these models? Which elements of best practice are currently being applied in Oregon? Which elements could be added or improved upon?
- How do the service models support children, classrooms and families? Are service models socially and culturally sensitive? Do the models work to maximize child progress?
- How can we identify and implement service models which optimize program efficiency? What would these models look like?

This paper includes a review of what is known about service design and collaborative teaming and the models used in Oregon. It also offers a review of current research and "best practice" regarding service delivery and models of teaming. As a result of this review, recommendations are offered regarding further actions and training activities that might benefit Oregon's EI/ECSE programs. It should be noted that the recommendations come from the Collaborative Teaming Work Group and do not obligate the Office of Special Education or its Contractors to a specific course of action.

II. Recommendations Summary

The following is a list of the recommendations offered by the collaborative teaming working group. These recommendations are discussed in detail at the conclusion of the document.

1. When referring to this project, use the term Collaborative Teaming rather than transdisciplinary, multidisciplinary or interdisciplinary teaming.
2. Collect information from EI/ECSE programs regarding current service designs and satisfaction with the existing models.
3. Describe an Oregon philosophy of service design and collaborative teaming based on research and "best practice" recommendations.
4. Include statements in the articulated philosophy regarding the intent of the model of service design.
5. Include elements of the articulated philosophy in System Performance Review questions and service plans.
6. Identify existing training resources for the articulated collaborative team and service design and offer training to all Regions of the state.
7. Develop additional training and technical assistance resources as needed.
8. Ensure, to the greatest extent possible, that ongoing support for collaborative teaming is available.

III. Definitions Found in the Literature

The following are definitions found in the literature regarding team functioning. These terms are used throughout this report. They are presented first in order to familiarize the reader with the specificity of some of the wording.

Models of Teaming

- **Multidisciplinary Team Model:** A model of service delivery which includes professionals from a number of different disciplines who assess and provide parallel services but who have built-in formal mechanisms for communication. For example, each team member might conduct an independent assessment of a child's development, but members might then meet for a formal case conference to share their findings and plans. (AOTA, 1997, p. 85)
- **Interdisciplinary Team Model:** A model in which team members make a strong commitment to frequent collaborative communication. Team members collaborate to design an intervention strategy that combines the most important treatment objectives of each discipline and maximizes the potential for a positive outcome. Interdisciplinary teams use the many unique viewpoints of team members to produce integrated plans for children and families. (AOTA, 1997, p. 85)
- **Transdisciplinary Team Model:** A service delivery model in which team members make a commitment to cross traditional boundaries by teaching and learning from others. Assessment, treatment planning, and service provision are often conducted simultaneously by more than one discipline. Areas of overlap among disciplines are frequently used as the springboard for other shared activities. Allocations of duties are based on actual, rather than disciplinary, expertise. (AOTA, 1997, p. 86)
- **Collaborative Team Model:** In the collaborative model, it is assumed that no one person or profession has an adequate knowledge base or sufficient expertise to execute all the functions associated with providing educational services for students. Professionals, paraprofessionals, parents and students communicate and collaborate with one another to make meaningful decisions and to provide appropriate and effective services. All team members are involved in planning and monitoring educational goals and procedures, although each team member's responsibility for the implementation of procedures may vary. Team members can be considered as sharing joint ownership and responsibility for intervention objectives. (ASHA, Wilcox, Kouri & Caswell, 1991, p. 249)

Categories of Role Sharing

- **Role release** is a defining characteristic of transdisciplinary teamwork. Role release involves delegating tasks and teaching methods usually performed by one discipline to team members of other disciplines. This is delegation, not abdication. The team member who releases part of the role is responsible for documenting that appropriate training and supervision occur. (APTA, 2000, p.67)

- **Role Support** is continuing informal encouragement of other team members. The necessary backup to the processes of role exchange and role release. (Woodruff & McGonigel, 1990, p. 171)
- **Role Exchange** occurs when team members have learned the theory, methods, and procedures of other disciplines and begin to implement techniques from these disciplines. Role exchange is best facilitated when team members work side-by-side as buddies, and when they have sufficient indirect service time. (Woodruff & McGonigel, 1990 p. 170)

Categories of Cross-training by professionals

The following definitions are taken from a position statement on Multiskilled Personnel, published by the American Speech-Language-Hearing Association. While written from a medical perspective, these recommendations are valuable and applicable to a discussion of collaboration and role sharing. (ASHA, 1997, p. 26a) .

- **Cross-training of basic care skills**—includes routine, frequently provided, easily trainable, low-risk procedures such as suctioning patients, monitoring vital signs, and transferring and positioning patients. Identifying a facility/agency/program-specific set of patient/client-care skills that can be performed by various practitioners in that particular setting may lead to less fragmented and less costly patient/client care.
- **Cross-training of clinical skills**—involves training practitioners in one discipline to perform services traditionally regarded as within the purview or scope of practice of another discipline in an attempt to more efficiently deploy the clinical workforce to meet the needs of the patient caseload as it fluctuates at any particular point in time. Examples include training respiratory therapists to perform EEGs, or medical technologists to perform certain radiological procedures.
- **Cross-training of clinical disciplines**—involves training practitioners in one discipline to perform services traditionally regarded as within the purview or scope of practice of another discipline in an attempt to more efficiently deploy the clinical workforce to meet the needs of the patient/client caseload as it fluctuates at any particular point in time.
- **Cross-training of professional nonclinical skills**—includes skills and services such as patient education, technical writing, team dynamics/communication/leadership and such.
- **Cross-training of administrative skills**—includes programmatic activities such as quality improvement, case management, systems design and the management of clinical services.

IV. A Review of the Literature on Collaborative Teams and Service Design

The following is a summary of information found in the literature regarding research and promising practices in the area of team functioning in educational service delivery. The literature review has been divided into the following categories:

- Legal aspects of service design
- Results for children
- Effects on families
- Service Provider Attitudes
- Required Skills
- Service Design Considerations

Where possible, representative statements from the fields of EI/ECSE experts, Speech and Language Practitioners (SLP), Occupational Therapists (OT) and Physical Therapists (PT) have been included in each section. An attempt was made to offer representative citations. If significant disagreement was evident for any category, an attempt was made to represent that disagreement.

Legal aspects of Service Design: EI/ECSE programs are required by law to offer a range of services. No one approach to service delivery is appropriate for every child.

- *As used in this part, the term special education means specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, including (i) Instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings. (IDEA, Sec. 300.26)*
- *To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. (IDEA, Sec. 303.12 (b))*

Results for Children: Young children learn best when instruction is integrated throughout the day, across environments, and embedded within natural routines, providing opportunities for distributed practice of new and emerging skills. A model that focuses on empowering families and children rather than on the expertise of individual service providers is more beneficial to children. (McWilliam, Scott & Mayhew, 1999; Peck, Killen & Baumgart, 1989)

Citations from EI/ECSE and Education:

- Children in segregated classrooms receive a higher intensity and frequency of services than do children in inclusive classrooms, but no difference has been found in their developmental progress. (Bruder & Staff, 1998)

- Studies comparing integrated and segregated approaches to instruction identified no difference in child outcomes. (Cole et al, 1989; Davies & Gavin, 1994; McWilliam & Grabowski, 1993)
- When teachers are taught to embed instruction in everyday routines, children demonstrate concomitant increases in IEP-targeted behaviors. (Peck, Killen, & Baumgart, 1989)
- Effective programs are characterized by maximized instructional time (through use of natural routines, or training other adults), generalization of skill development and a comprehensive plan for achieving them. (Beninghof & Singer, 1992; Diamond, Hestenes & O'Connor, 1994)

Citations from PT/OT:

- More therapy is not always better. (Jenkins et al., 1982)
- Once- versus thrice-weekly PT and OT has not significantly affected 3- to 15- year-olds' gross motor skills, and therapy has been found to only marginally affect fine motor skills. (Jenkins et al., 1982)

Citations from SLP:

- Children receiving indirect speech-language therapy in a classroom setting better generalized target words to the home setting than did children receiving individual pull-out therapy. Use of target words was the same in both classroom therapy and pull-out therapy. (Wilcox, Kouri & Caswell, 1991)

Effects on the Families: Family attitudes, beliefs and priorities are a cornerstone of Early Intervention. Sensitivity to family issues is paramount to optimizing relationship between family and service providers, and critical to effective intervention. Families benefit most when services are provided in natural environments by a core team of service providers who can offer both formal and informal supports.

Citations from EI/ECSE and Education:

- Benefits of working with children in their natural environments include: enhancing family relationships and relationships between therapists and parents; providing the opportunity for modeling and teaching, assisting primary caregivers' efforts to improve a child's performance; improving the capacity for assessment of children's strengths and selection of meaningful outcomes. (Hanft & Wilkington, 2000)
- Interventions should emphasize mobilization of supports from informal network members rather than relying solely or primarily on formal supports from professionals and professional help-giving agencies. (Dunst, 1985)
- Support provided by early intervention practitioners was judged as most helpful and beneficial when the practitioners were identified as members of a family's informal social support network. The opposite was the case when the practitioners were identified as members of the family's formal support network. (Dunst, 2000, p.96)

Citations from PT/OT:

- Parents believe that more therapy is better. (Hinojosa, 1990; McWilliam, Young & Harville, 1996)

- Parents' preferences for in-class or out-of-class services are deeply ingrained; they are not shaken after one year's experience with the opposite model. (McWilliam, Bailey & Vandermaas, 1991)

Citations from SLP:

- There is reduced confusion for families when one primary provider is identified (Woodruff and McGonigel, 1990)

Service Provider Attitudes: Attitudes of service providers regarding models of service strongly impact their behavior and perceptions about service delivery. Educators prefer integrated therapy services when they have experience with them.

Citations from EI/ECSE and Education:

- The Proactive Empowerment through Partnerships (PEP) principles were proposed as a way of reversing pathologic thinking about families and intervention practices. The first principle emphasized strengths rather than weaknesses or deficits as the focus of intervention practices. The empowerment principle emphasized family control over and access to desired resources rather than provision of supports that were dependency-forming and competency-impeding. The partnership principle emphasized collaboration between families and practitioners rather than the use of professionally-centered approaches to intervention as a primary means of supporting and strengthening family function. (Dunst, 2000)
- Teachers and therapists prefer integrated to pull-out services when they have experience with both. (McWilliam, 1996)
- Although professionals often would like to choose therapy models on the basis of the individual child's characteristics, these actually account for only 10% of the variance in the choice, after taking into account discipline, specific interventions, caseload, family preferences and classroom characteristics. (McWilliam & Bailey, 1994)

Citations from PT/OT:

- Teachers receiving collaborative consultation (equal time discussing the child's needs, observing related behaviors and making a plan for the next time) report much larger occupational therapy contributions to the IEP goals and have more positive comments on an attitude scale than do teachers of children receiving direct service (one-on-one outside the classroom). Children in both conditions achieve a similar percentage of IEP goals. (Dunn, 1990)
- Therapists say they would like to use and do use a combination of approaches but the data show they actually tend to be very consistent in using one approach across all children and, with any one child, across sessions. (McWilliam, 1996; McWilliam & Bailey, 1994; McWilliam, Scarborough, & Chaudhary, 1995)
- Classroom staff prefers in-class, small-group PT and OT sessions to out-of-class, individual sessions. (Cole, Harris, Eland & Mills, 1989; McWilliam, 1996)
- The roles of evaluation, treatment planning, and supervision may not be delegated, but intervention may be carried out by others who are trained and supervised by a physical therapist. Although physical therapists must still determine what constitutes adequate training and supervision, therapists who resist role release due to concerns

for their liability must also consider the potential risks to children and staff when therapeutic intervention is limited to isolated treatment sessions. (Rainforth, p.57)

Citations from SLP:

- The discipline of the provider is the most powerful predictor of his or her choosing an in-class integrated approach. Special educators report using and favoring the most integrated approaches, followed by OT, and the SLP and PT (no difference between the last two). (McWilliam, 1996; McWilliam & Bailey, 1994)
- Professionals from OT, PT, SLP, and special education report that they would ideally use more integrated practices than they currently do. (McWilliam & Bailey, 1994)
- Teachers seldom attend to therapists' target goals during nontherapy time (i.e., generalization setting) and children do not display the target skills in nontherapy times if a pull-out model is used. (McWilliam & Scarborough, 1994)

Required skills: Successful collaborative teaming requires knowledge and expertise in a set of specific skills. Competence in team membership skills and collaboration should not be assumed. Comprehensive training is necessary to insure that service providers can demonstrate competence in working collaboratively.

Citations from EI/ECSE and Education:

- Establishing competency standards for (cross-disciplinary) skills across the workforce may enhance the overall quality, efficiency and coordination of service delivery...Establishing competency standards or such skills across the workforce may enhance the overall quality, efficiency and coordination of service delivery. (ASHA, 1996, p. 26a)

Citations from OT/PT:

- "Rainforth and York identified the following essential components for team members to consider when collaborating in the development and implementation of an integrated educational program:
 1. All goals and objectives belong to the learner, rather than to individual team members.
 2. All team members are responsible for contributing information and skills that will maximize learner success in accomplishing all goals and objectives.
 3. Each team member has specialized disciplinary methods and skills, many of which can be taught to other team members.
 4. Combining methods from a variety of disciplines allows team members to address the needs of the learner more successfully and in more natural contexts.
 5. Individually selected, meaningful activities are the logical and necessary focus around which team members identify and integrate effective instructional methods for each learner." (APTA, p. 65)

Citations from SLP: (ASHA, 1997, p. 26a)

- "It is the position of the American Speech-Language-Hearing Association that multiskilling is not a unidimensional concept and that it cannot be evenly applied across the diverse clinical workforce. Specifically, cross-training of clinical skills is not appropriate at the professional level of practice (i.e. audiologists or speech-language pathologists). Cross-training of basic patient care skills, professional

nonclinical skills and/or administrative skills is a reasonable option that clinical practitioners at all levels of practice may need to consider depending on the service delivery setting, geographic location, patient client population, and clinical workforce resources.

- Differing levels of clinical judgment, decision making, critical thinking and accountability for managing an identified scope of patient/client care needs are required of practitioners in different clinical disciplines. For professional-level clinical practitioners, (including audiologists and speech-language pathologists), these factors are crucial elements of the services provided. On the other hand, paraprofessional or support-level practitioners provide task-oriented skilled services on a case-by-case basis, under the direction and supervision of the professionals in their discipline. In the current service delivery system, some professional practitioners actually provide a mix of these two—professional and task-oriented—levels of service. Delegation of the task-oriented services to lesser trained (and possibly multiskilled) providers may result in greater efficiency.
- Potential benefits include enhanced opportunities for professional growth and development, expanded scopes of practice, employability and job security, focus on clinically challenging services, greater flexibility in justifying staff increases given the ability to combine staff needs across related services, and improved efficiency and coordination of clinical services.
- Risks include potential decreases in the quality and outcome of clinical services, loss of specialized clinical services, loss of autonomy, erosion of scopes of practice, loss of revenue, and reduced number of positions for some clinical service providers.
- Other important areas requiring specification are basic qualifications, educational materials, training and competency assessments.

Service design considerations: A comprehensive plan and ongoing administrative support are needed in order to implement the desired team approach. Most literature supports the need for a collaborative teaming model in which team members release part of their role as appropriate. Literature from Speech and Language Pathologists expresses concerns about such a model and emphasizes the need for clear definitions of what should and should not be released.

Characteristics of effective Collaborative Teams include:

- Shared Philosophy
- Adequate meeting time
- Sharing expertise
- Effective use of collaborative skills
- Sharing the work

(Wolery & Odom, 2000, p. 67)

Administrative support for the Team Model of Collaboration should include:

- Support Toward a Shared Philosophy
- Support for Adequate Meeting Times
- Supporting the team to work toward a common goal

- Supporting team members to share their area of expertise
- Supporting team members to use collaborative skills effectively
- Supporting team members to share the work.

(Wolery & Odom, 2000, p. 66-69)

Citations from EI/ECSE and Education:

- Interdisciplinary teams and Transdisciplinary Teams work better than Multidisciplinary teams. There are problems with the Multidisciplinary Team Model. (Jordon et al 1988 p.8)
- Logic and research suggest that the most effective intervention will involve a conspiracy by all responsible parties to provide the most responsive and developmentally progressive learning environment possible for as many of the child's waking hours as possible. (Warren, 2000)
- We now know that effective family centered help-giving is comprised of both relational and participatory elements. Relational elements include behavior typically associated with good clinical practice (active listening, empathy, etc.) and positive help giver attributions, and beliefs about family competence and capability. Participatory elements include family choice and actions based on choice, as well as help giver responsiveness to and support of family decisions. Whereas relational practices are a necessary condition for effective practitioner/family transactions, they are not sufficient for either strengthening family competence or promoting new capabilities. The latter has been found to be the case only when the family is an active participant in achieving desired outcomes. Placed in a wider web of the direct and indirect social systems influences on child, parent, and family functioning, family centered help giving mediates and moderates the influences of other intrafamily and extrafamily factors on various outcomes. (Dunst, 2000, p. 101)
- We want to implement optimal intervention strategies as early as possible. As much as possible we want these strategies to be embedded in the child's ongoing interactions at home and in childcare or preschool in order to ensure their maximal input. (Warren, 2000)

Citations from OT/PT:

- It rarely is sufficient for a physical therapist to work only with a student; physical therapists also must work with parents, teachers, paraprofessionals and other team members who can provide students with multiple opportunities to practice motor skills in as many environments as the skill is needed. Thus, another feature of integrated therapy is teaching parents, teachers, paraprofessionals and others to help students practice motor skills throughout each day, not only during therapy time. In the terminology of the transdisciplinary service delivery model, physical therapists must "release" part of their role by teaching other team members to assist students to learn motor tasks. (APTA, 2000, p. 66)
- Role release is an important part of integrated therapy because a physical therapist cannot always be available when it is necessary to reposition a student or assist a student to move from one location to another or when a student needs to perform motor tasks during educational and caregiving activities. (APTA, 2000, p.67)

- The interactive process inherent in collaborative teaming is likely to yield more comprehensive, creative, and effective solutions than those generated individually by team members. (AOTA, citing Idol, Paolucci-Whitcomb & Nevin, 1986)

Citations from SLP:

- Cross-training of administrative skills includes programmatic activities such as quality improvement, case management, systems design and the management of clinical services. As organizations down-size such responsibilities are increasingly moving from centralization in one or more "administrative positions" to distribution among clinical practitioners. Doing so may result in more efficient use of staff and better integration of these functions with clinical service delivery. (ASHA, 1996)
- Cross-training of basic patient care skills: Identifying a facility/agency/program-specific set of patient-care skills that can be performed by various practitioners in that particular setting may lead to less fragmented and less costly patient care (e.g., bedside treatment sessions do not have to be delayed waiting for another practitioner to suction the patient; home care patients' compliance with prescribed medications can be verified by clinicians already coming to the home on a regular basis; diabetic preschoolers blood sugar levels can be monitored by on-site clinicians). (ASHA, 1996, p. 26a)

V. Approaches to Collaborative Teaming in Oregon

Members of the Collaborative Teaming working group represent the membership of several other working groups from EI/ECSE and Regional Programs. They report that there are a wide variety of service design models in use in Oregon.

Some of the variation in models is desirable and a direct result of factors such as the following:

- Geography-rural vs. urban
- Number of students (critical mass and economy of scale)
- Complexity of the disability and level of service need
- Complexity of family issues
- Program resources
- Family and community cultural issues
- Resources in the community
- Staff shortages, turnover, and
- Expertise, levels of training and experience of service providers

Working Group members also report problems caused by the variation in service models throughout the state. Inconsistency among service models has been identified on the national level as well:

Recent research has documented the tremendous variability in the services received and service delivery models that are implemented for infants and toddlers with special needs and their families. Differences occur from state to state, and in some cases, community to community, in terms of which children are served, how they are identified and referred, the types of services they receive, the structure and organization of the service delivery system, the collaborative arrangements among service agencies, and the training of early intervention service providers. (Hanson and Bruder, 2001)

Decisions about who gets therapy and how much they get appears to be based on diagnosis, division of time available by the caseload size, and local custom- not on an objective or even a clinical judgement of the individual child's needs beyond his or her diagnosis. (McWilliam et al, 1995)

While individualization of services is a cornerstone of IDEA, variations in service delivery without a consistent framework for making service decisions can lead to confusion. When families transfer from one program to another, service models may be significantly different. Receiving programs sometimes feel pressured to adopt service designs which they do not feel are the best for children and families. Service design decisions can also be inconsistent within programs and may not work to serve the best interests of children with disabilities.

History of Organized Collaborative Teaming Training in Oregon

Regional and Statewide Services for Students with Orthopedic Impairments: As early as 1986 efforts were being made in Oregon to provide special educators and related service providers with training regarding team functioning and the use of interdisciplinary and transdisciplinary teams in special education. The first efforts that the Collaborative Teaming Work group is aware of were instituted by the staff of Regional and Statewide Services for Students with Orthopedic Impairments (RSOI). During 1998-90 numerous training opportunities were offered to Regional Programs OT, PT and education staff members. The focus of these trainings was on the development of child centered goals rather than IEPs and IFSPs which include goals for "PT", "OT" and "Speech". In these training sessions, participants were offered strategies for assuring that "nobody owns a goal" and that all goals and objectives in educational programs were child centered. RSOI has continued to offer annual training opportunities in this area to those who attend the Therapy in Educational Settings (TIES) conference.

Project TEAM: In 1992 *Project TEAM* was instituted by Teaching Research under a federal grant. The training was developed to provide inservice training to personnel working with young children with special needs, ages birth to eight, and their families. The project was based on the premise that collaboration of educational, related services and families are required for quality early intervention. *Project TEAM* was implemented in four counties in Oregon. These were Deschutes, Josephine, Polk and Washington counties. It is notable that many EI/ECSE programs in these counties continue to use a highly collaborative or transdisciplinary approach to service provision. To our knowledge, there was no additional training provided in other counties using the *Project Team* materials.

Other Team Training Efforts

Numerous other training opportunities have been made available throughout Oregon. There has been no effort to coordinate these efforts statewide.

Resource Materials Developed in Oregon to Facilitate Teaming Models

A variety of resource materials have been developed by providers to help guide collaborative teaming efforts in Oregon. They include the following:

- Cicirello, Nancy, Hall, Sandy, Reed, Penny, *Developing a Collaborative IEP: A workshop on developing collaborative, functional truly individualized educational plans with therapy objectives which are directly related to the student's educational goals*. RSOI, 1987: These materials were used in the state wide training efforts of the RSOI program in the 1980s and 90s.
- Pardew, M., Moore, B., Stratks E. and Bunse, C, *Project Team: Early Intervention Team Trainer Handbook*, Teaching Research, 1994

- Andersen, C., Bowser, G., Cicirello, N., Newton, A., Rich, M., Roberts, D., Subbot, S., Terzieff, I.: *Physical and Occupational Therapy in Educational Setting Settings*, RSOI, 2001: Includes a chapter on models of service delivery, performance standards for OT and PT which include collaboration and teaming skills, *Service Needs Checklists* for guiding service delivery decisions, and a description of the *Scope of School Services for OT and PT*.

Factors Which Influence Efforts for a Statewide Model of Collaborative Teaming in Oregon

The Work Group identified the following issues which impact collaborative teaming efforts in Oregon. The Work Group recommends that these issues be addressed in statewide efforts to develop a model for collaborative teaming.

- There is no clear data on the models of service design and collaborative teaming currently in use in Oregon. Further information is needed.
- There is no clear information regarding how service providers evaluate the models they are currently using. Further information is needed.
- There is no consistent service provision model across the state and no written guidance regarding how decisions about level of service might be made.
- We have no articulated philosophy about what kind of team approach we believe is best or how to make decisions about a variety of team approaches for individual children.
- Rapid turnover of staff and addition of new people to existing teams create the need for ongoing training for any model of service design which is adopted. At this time, there is no ongoing training effort.

VI. Desired Outcomes

Characteristics of the Collaborative Teaming Model

Having reviewed the literature and the history of team training in Oregon, the Collaborative Teaming Work Group has identified the following as desirable characteristics for a collaborative teaming model to be adopted in Oregon.

1. Service delivery occurs in effective contexts at developmentally appropriate levels for children;
2. Service delivery decisions are made on an individual basis for all children;
3. A family-centered approach is used for service delivery;
4. The adopted model includes a continuum of service options with a described decision making process for the team to use when planning an individual child's program;
5. Administrative Support for the model is available and ongoing; and

6. Core team members are identified based on the goals and objectives for the child and the needs of the family.

Collaborative Teaming Model Desired Outcomes

The Collaborative Teaming Work Group believes Oregon's EI/ECSE program should adopt a Collaborative Teaming Model with the above characteristics. Desired outcomes for this model include:

1. Service providers understand, use and support the model;
2. Families understand the rationale for the model;
3. Children progress in their development at the same rate or at a higher rate than with other service delivery models;
4. Service providers have the skills needed to provide services within the structure of the model; and
5. Families express a high degree of satisfaction with the service delivery models offered.

VII. Barriers to Desired Outcomes

The following are possible barriers to achieving the desired outcomes. Any actions taken as a result of this report should address these barriers in a direct and proactive manner.

1. Lack of professional preparation in skills necessary for collaboration. The following skills are needed:
 - Effective skills in communication, negotiation, conflict resolution, flexibility, and mastery of increasingly complex practice settings (Hanft & Pilkington, p.10);
 - Knowledge about which professional competencies may be effectively and safely shared with other team members; (ASHS, 1997, p. 26a)
 - Consultation skills and skills in the instruction of adult learners (File & Kontos, 1992);
 - Familiarity with case management, expertise of other disciplines, and personal styles of team members (Hanft & Pilkington, p.10); and
2. Lack of Role Support:
Primary service provider may attempt to become everything to every child and family, and, "with a sprinkling of skills from a variety of child development fields to

obliterate the distinction between solo practice and a team approach...” (Woodruff & McGonigal, 1990)

3. Resistance to Change:

- Practitioners express concerns that the model may be so rigid that it won't allow decision-making on a child-by-child basis.
- “Change grows from a perception that an alteration in structure or function is needed.” (Zaltman and Duncan, 1977) “Problems arise when staff and administration do not share similar perceptions. Thus when the change is suggested by an administrator, staff may react as if disapproval of individual or group performance is implied.” (Jordan et al 1988)
- Change (even change for the better) is more difficult if staff don't have any extra energy or time.
- Practitioners who received training and entered the field in anticipation of working one-on-one with children, find themselves faced with the challenge of unrealized expectations and a lack of confidence in their abilities when asked to take a consultant role. (Hanft & Pilkington, p.11; File & Kontos, p.228)
- Part of the reward of working with a child on an individual basis is the reciprocal relationship developed with the child and family. Seeing a child fewer times a year does not provide the same rewards as seeing a child on a more consistent basis.
- Therapists don't want to risk losing direct contact with the child and family because the therapist thinks the child may be at risk if they do not receive direct therapy.

4. Parents' attitudes and understanding about integrated therapy:

- Parents may believe that more direct service hours mean better service and more progress for their child. (McWilliam et al, 1996, p.9)
- When parents transfer from one program to another they may not understand the change in service delivery model.
- Misunderstanding of the concept of family-centered services may cause program staff to modify their ways of operating due to parent request or demands.
- Parents are not generally used to participating in a team. Especially at the EI/ECSE level, they need support and guidance to be good team members.

5. Potential for forgetting to consider the continuum of special education service models (from direct one-to-one intervention, through consultative services) mandated by IDEA to be decided on an individualized basis.

6. Documentation issues:

- Concern about increased paperwork demands for service provider role.
- Confusion about how to represent non-discipline-specific goals, and integrated therapy services on the IFSP.
- Confusion about how to bill Medicaid for collaborative services.

7. Scope of professional contracts:

- Job descriptions or contracts may not include activities such as case management.
 - Contractual agreements delineating 9 or 10-month work-year may necessitate scheduling of a second service provider to insure provision of year-round services.
 - Contracted providers from outside agencies may not share the philosophy and/or the skills of the collaborative model. When a group of providers work for different agencies, the primary program does not have control over the actions of providers who do not work for that program. The subcontractor may not be able to assure that the collaborative teaming is done effectively if the service provider is not employed by that subcontractor.
 - Concerns of practitioners regarding potential violation of professional ethics and scope of practice mandated by state practice acts when delegating activities to non-licensed personnel.
8. Licensure issues:
ODE requires authorization as Early Childhood Specialist (OAR 581-015-1105) for related services personnel who are not licensed by TSPC and who serve as EI/ECSE case coordinators.
9. Constraints of time and fiscal issues:
- “As the role of early interventionists changes to providing consultation services and as programmatic focuses in early intervention change, funding issues would likely pose an immediate hurdle.” (File & Kontos, p.227)
 - Logistical problems such as finding and scheduling time for meetings and consultation among team members (File & Kontos, p. 227)
 - Administrators may not recognize or accommodate the necessity of scheduling the additional time needed for collaborative activities, such as team meetings, and may even believe that a collaborative consultation model will free service providers to maintain larger caseloads. (Hanft & Place, p. 8; File & Kontos, p.227)
10. There is no consistent service provision model in use across the state, and no written guidance regarding how decisions about level of service might be made. Existing recommendations such as the EI/ECSE Service Needs Index are not uniformly applied.

VIII. Recommendations for Action:

The Collaborative Teaming Work Group was charged with completion of a review of the literature on models of collaborative teaming and the development of recommendations for further actions. The members of the Collaborative Teaming Work group have unanimously adopted the following recommendations for future actions.

1. Use the term Collaborative Teaming:

A wide range of authors from multiple professional organizations have defined various models of team function and service design. Many of these definitions are used differently depending on the environment and the experiences of the user. Some terms, such as *transdisciplinary* have very specific meanings and imply a degree of inflexibility that is not acceptable to many practitioners. It is the belief of the Work Group that the term *Collaborative Teaming* can best be used to describe a flexible approach to service design that is tailored to meet the needs of individual children and allows for variations in program resources and demographics.

2. Collect information from EI/ECSE programs regarding current service designs and satisfaction with the existing models.

We do not have a clear picture of the models of service design and collaborative teaming which are used in Oregon. While guidance and training has been offered in a variety of ways, there is no readily available information regarding how this guidance has been used to provide services. Without this information, it will be impossible to evaluate the current system, identify needed actions for system change or assess the results of training programs.

Additionally, information should be gathered regarding the levels of satisfaction which service providers and families experience with the current service designs. This information can be used as a "barometer" to evaluate any changes in attitude, which accompany changes in service design.

3. Describe an Oregon philosophy of service design and collaborative teaming based on research and "best practice" recommendations.

In 1988 Jeanette A McCollum and Mary-alayne Hughes reported on a study of staffing patterns and team models in infancy programs. One of their observations related to the interaction between program philosophy and service design. They stated the following.

It is clear that mitigating factors such as geographic location and availability of staff will, to some extent, determine program structure and team model. The current study, however, found no consistent relationship between team model and whether the programs were urban or rural, served small or large geographic areas or used full-time, part-time or consulting staff on their core teams. Rather the determining factor appeared to be the philosophy of the program. This was particularly true of

applications of the transdisciplinary model. While there were fewer examples of this model, the choice appeared to be not only conscious and purposeful, but also more consistently applied across program functions. Program structures grew from and supported the philosophy. In contrast, examples of applications of other team models appeared to be less of a conscious choice; the label fit the characteristics of the program rather than vice versa. (Jordan et al 1988, p 143)

It is the recommendation of the Collaborative Team Work Group that an articulated philosophy of service design and collaborative teaming be developed. The philosophy should identify principles which should be used in service design. Such principles might include concepts such as the following:

- Focus on opportunities for families to develop an ongoing relationship with service providers who are identified as part of the family support network.
- Services in the natural (least restrictive) environment to the greatest extent possible.
- Emphasis on a small core team of service providers which is augmented by others on an as-needed basis.
- Definition of appropriate role release including cross training of professional nonclinical skills and basic direct care skills which are discipline specific.
- An emphasis on role support as well as role release.

(Note: This list is not exhaustive. It is meant only to give examples of the kinds of principles which might guide a philosophy of service design and collaborative teaming.)

The articulated philosophy should also be flexible enough to take into account factors which affect service delivery such as the followings

- Geography-rural vs. urban
- Number of students (critical mass and economy of scale)
- Complexity of the disability-level of service need
- Complexity of family issues
- Program resources
- Resources in the community
- Staff expertise and levels of training and experience.

4. Include statements in the articulated philosophy regarding the intent of the model of service design.

The proposed model of service design has the potential to offer many benefits for Oregon programs. It could allow for increased consistency in programming across the state. It could reduce duplication of efforts of professionals providing service. It could aid teams in decision making regarding services for individual children.

Ultimately, it could provide increased quality of services designed to facilitate the development and learning of children with disabilities.

It is very unlikely that the service model will result in a reduced need for professional staff or be an aid in cost containment. The Collaborative Teaming Work Group believes that the model for service design should encourage collaboration and role release. Role release does not imply role "abdication". It involves delegating tasks and teaching methods performed by one discipline to members of other disciplines. The team member who releases part of a role is responsible for documenting that appropriate training and supervision have occurred.

5. Include elements of the articulated philosophy in System Performance Review questions and service plans.

Much of the literature on models of service emphasizes that administrative support and participation is an essential component of collaborative teaming. In Jordon (1988), Corinne Garland and Toni Linder list four tasks specific to administration of early intervention programs. They are listed below.

- Building a team
- Creating an environment which supports families as members of the team
- Setting goals in collaboration with that team.
- Communicating goals to those who can effect their accomplishment. (p,7)

Garland and Linder emphasize that an essential component of all of these activities is evaluation. Without evaluation and accountability activities in place, the development of a consistent model for service design will not have long lasting results. In order to develop a consistently applied philosophy of service provision, a framework for effective training and follow-along support, and program accountability is needed.

6. Identify existing training resources for the articulated collaborative team and service design and offer training to all Regions of the state.

A number of resources exist to offer training to service providers in collaborative teaming and collaborative service design. Examples include the Vermont Interdependent Services Team Approach (VISTA) developed by Michael Giangreco, Project TEAM from Teaching Research and Project Integrate from the University of North Carolina at Chapel Hill. Once a training approach is developed, accessible training should be offered in each Region of Oregon. Follow up training opportunities should be offered each year afterward for new service providers and to expand and reinforce the skills of services providers familiar with the approach.

Additionally targeted training should also be offered. Examples include:

- Training for families about the benefits and rationale of collaborative teaming.
- Training for service providers on team membership skills.
- Training for program administrators in their role in implementing the model.
- Cross-training for non-therapy staff to assure adequate skills to implement programs assigned and the limits of their role in collaborative teaming.
- Mentoring and opportunities to share strategies for collaborative teaming.

7. **Develop additional training and technical assistance resources as needed**
Specifically, it is anticipated that the development of a technical assistance paper which guides service delivery decisions will be needed. Such a document would describe in writing the decision making base which staff might use in service design for individual children. The model should include a continuum of service options with a described decision making base.

8. **Ensure, to the greatest extent possible, that ongoing support for collaborative teaming efforts is available for the project.**
It is essential that staff who have received training in a collaborative team model be consistently reinforced in their efforts to implement it. It is also essential that new staff who enter EI/ECSE programs be immediately introduced to the philosophy of service design which programs are striving to implement. The history of similar training efforts in Oregon points up the necessity for some kind of on-going administrative support for a service design model.

Change is both a personal and an organizational phenomenon.
(Edelman, 2001)

... in a climate in which staff and program evaluation for the purpose of improvement is routine and continuing, change is no stranger, nor is it to be feared. In a climate in which the team participates in self-evaluation and program evaluation, data suggesting the need for change will have been generated by the team or its members.”
(Jordan et. al. 1988)

When successful collaboration occurs, who benefits? Our research and that of others suggests that in addition to the child with a disability, the child’s family and the professionals also benefit from successful collaboration.
(Wolery & Odom, 2000)

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