CHAPTER 4

# Coordinating Services with Families

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In 1986, Part H (now Part C) of the Individuals with Disabilities Education Act (IDEA) created a statewide early intervention program available to eligible infants, toddlers, and their families. The components of the program are complex and require a commitment to a number of philosophical beliefs and programmatic features such as family-centered care, cultural competence, team process, natural learning environments, and interagency collaboration (Dunst, 2007; Hanson & Bruder, 2001). By far, the most challenging of these components is collaboration: Families, early interventionists, and other providers must plan, implement, and evaluate early intervention services and supports through the development of an individualized family service plan (IFSP) for each eligible child and family. The plan's purpose is to document the process by which an eligible child will receive what he or she needs to achieve agreed-upon outcomes and the supports a family will receive to be able to meet the special needs of their child. This component is most challenging, in part because agencies, providers, and families, as they attempt collaboratively to individualize services and supports for an eligible child, have inherent complexities (Bruder & Bologna, 1993). Most recently, an added complexity to early intervention has been the congressional mandate for accountability of the Part C program through the collection of family and child outcomes (see *www.the-eco-center.org*).

One programmatic feature to assist in the collaborative components of statewide early intervention systems is the appointment of a service coordinator for each eligible child and family. This person is responsible for overseeing all the

**TABLE 4.1. Service Coordinator Responsibilities**

- Coordinate and implement evaluations and assessments.
- Facilitate and participate in the development, review, and evaluation of the IFSP.
- Assist family in identifying available service providers.
- Coordinate and monitor the delivery of available services.
- Inform families of the availability of advocacy services.
- Coordinate with medical and health providers.
- Facilitate the development of a transition plan to preschool services.

collaborative requirements of service delivery. Service coordination is defined by Part C as assisting and enabling the eligible child and his or her family to receive the rights, procedural safeguards, and services authorized to be provided under the state's early intervention program. This function includes coordinating all services across agency lines and serving as the single point of contact to help families obtain the services and assistance they need. To be qualified to do this, service coordinators must demonstrate knowledge and understanding about eligible infants and toddlers, Part C of IDEA and its regulations, the nature and scope of services available under a state early intervention system, and the payment system and other information. Within the law, seven specific activities are the responsibility of service coordinators; these include the development, monitoring, and implementation of a child and family's IFSP and ensuring ongoing coordination with other agencies and individuals providing services to the child and family. Table 4.1 lists these activities. The remainder of this chapter addresses these specific service coordination activities in depth, after first describing research that has contributed to a deeper understanding of the function and subsequent evaluation of service coordination under Part C of IDEA.

## THE RESEARCH FOUNDATION FOR SERVICE COORDINATION

The Research and Training Center (RTC) on Service Coordination was funded by the Office of Special Education Programs (OSEP), U.S. Department of Education, to develop a model for training service coordinators under IDEA. To do this, a number of studies were conducted to identify the reality of service coordination across the country (Bruder & Dunst, 2006). Unfortunately, findings suggest that service coordination is not implemented consistently across the country (Harbin, et al, 2004). Nor is training of service coordinators required in the majority of states, and when required, the average length of training is 2.9 days (Bruder, 2005).

The RTC also conducted a second series of studies that sought to identify both the outcomes and practices of effective service coordination (Bruder et al., 2005; Dunst & Bruder, 2002, 2006). Through the use of multiple quantitative and qualitative methods of data collection, analysis, and synthesis, a series of national studies

occurred. The breadth of the findings of the studies underscored the complexity of service coordination. For example, initially, over 250 service coordination outcomes and over 2,000 discrete practices were identified by participants in the studies. These data required extensive synthesis before a convergence of the multiple data sources resulted in nine interrelated outcomes that should be achieved as a result of high-quality service coordination (see Table 4.2), and three practice categories. The categories were helpgiving, collaboration, and administration.

To integrate these data on service coordination models, outcomes, and practices, the RTC adopted the ecological framework set forth by Bronfenbrenner (1993). This orientation requires attention to be given to the multiple characteristics of a service system, suggesting that child and family outcomes of service coordination are influenced by the individuals, organizations, agencies, cultures, communities, and states involved in service delivery and system administration. In addition, the child and family exist within a series of complex contexts such as their history, values, culture, ethnicity, structure, home routines and community activities, child disability, child age, economic status, and geographic location. Likewise, service providers and coordinators possess attitudes, values, knowledge (of resources and recommended practices), previous experiences, training, and skills that they bring to the service implementation endeavor. These characteristics of both the family and service provider also influence the multiple elements of service coordination. Lastly, service coordination is also influenced by the existing system infrastructure. The infrastructure is made up of multiple organizations, agencies, and programs that can facilitate or hinder effective service coordination. Although funding is an important piece of the infrastructure, other aspects of the infrastructure are equally important (e.g., personnel development, service coordination caseload policies).

Whereas the interrelationships among these variables describe the complexity of service coordination, they also challenge any model for training and evaluation. One such model designed for this type of a system is a logic model. A logic model

**TABLE 4.2. Service Coordination Outcomes**

- Families have access to support, information, and education to address their individual needs.
- Families are able to communicate the needs of their child.
- Families make informed decisions about services, resources, and opportunities for their child.
- Agencies and professionals are coordinated.
- Children and families receive quality service.
- Children and families participate in supports and services that are coordinated, effective, and individualized to their needs.
- Families acquire and/or maintain a quality of life to enhance their well-being.
- Families meet the special needs of their child.
- Children's health and development are enhanced.

can be used to create an understanding of the interrelationships of variables that contribute to a program or program feature (e.g., service coordination). Variables can be grouped according to characteristics such as resources or inputs, activities, outputs, and outcomes (Gilliam & Mayes, 2000; W. K. Kellogg Foundation, 2001). Using the data described above, the RTC developed a logic model to show how service coordination should work. This model can guide the implementation and evaluation of service coordination for early intervention as in Figure 4.1. The test of the actual effectiveness of service coordination is how well the service coordinator implements the activities he or she is responsible for, as measured by a family, child, and system status in each of the outcomes presented in the logic model. The identified practice areas must be used in each of the discrete activities, and these will each be described. Checklists for these practices to be used for each activity are in the appendices at the end of this chapter.

## COORDINATING THE PERFORMANCE OF EVALUATIONS AND ASSESSMENTS

The service coordinator serves as the single point of contact for families when they first enter the early intervention system. At this stage, families face the unknown. Some families may have never heard of early intervention, and others may not realize that their child has developmental needs. It is the service coordinator's responsibility to take the time to develop a relationship with the family, learn about their needs and concerns, and explain the early intervention system. These steps are critical to coordinating the initial evaluation and assessment to determine a child's eligibility for early intervention.

The initial contact and intake is the first step in coordinating evaluations and assessments. It should be in person and may involve more than one meeting, over time. Taking this time enables the service coordinator to build a relationship with the family and to learn about the child's and family's needs. Accomplishing these tasks requires the service coordinator to use helpgiving practices such as treating families with dignity and respect; to be culturally and socioeconomically sensitive to family diversity; to provide choices to families in relation to their priorities and concerns; to disclose information to families so they can make decisions; and to employ communication strategies to empower and enhance a family's competence and confidence (see Dunst, Trivette, & Handy, 2007). If done effectively, the evaluation and assessment process identifies child and family needs as well as the services and supports that will meet those needs. It is critical that service coordinators approach the evaluation and assessment process in ways that are respectful and sensitive to the family's needs and concerns and that they ensure that the family fully understands the evaluation process.

Because the service coordinator is responsible for arranging and coordinating the evaluations and assessments to determine a child's eligibility and need

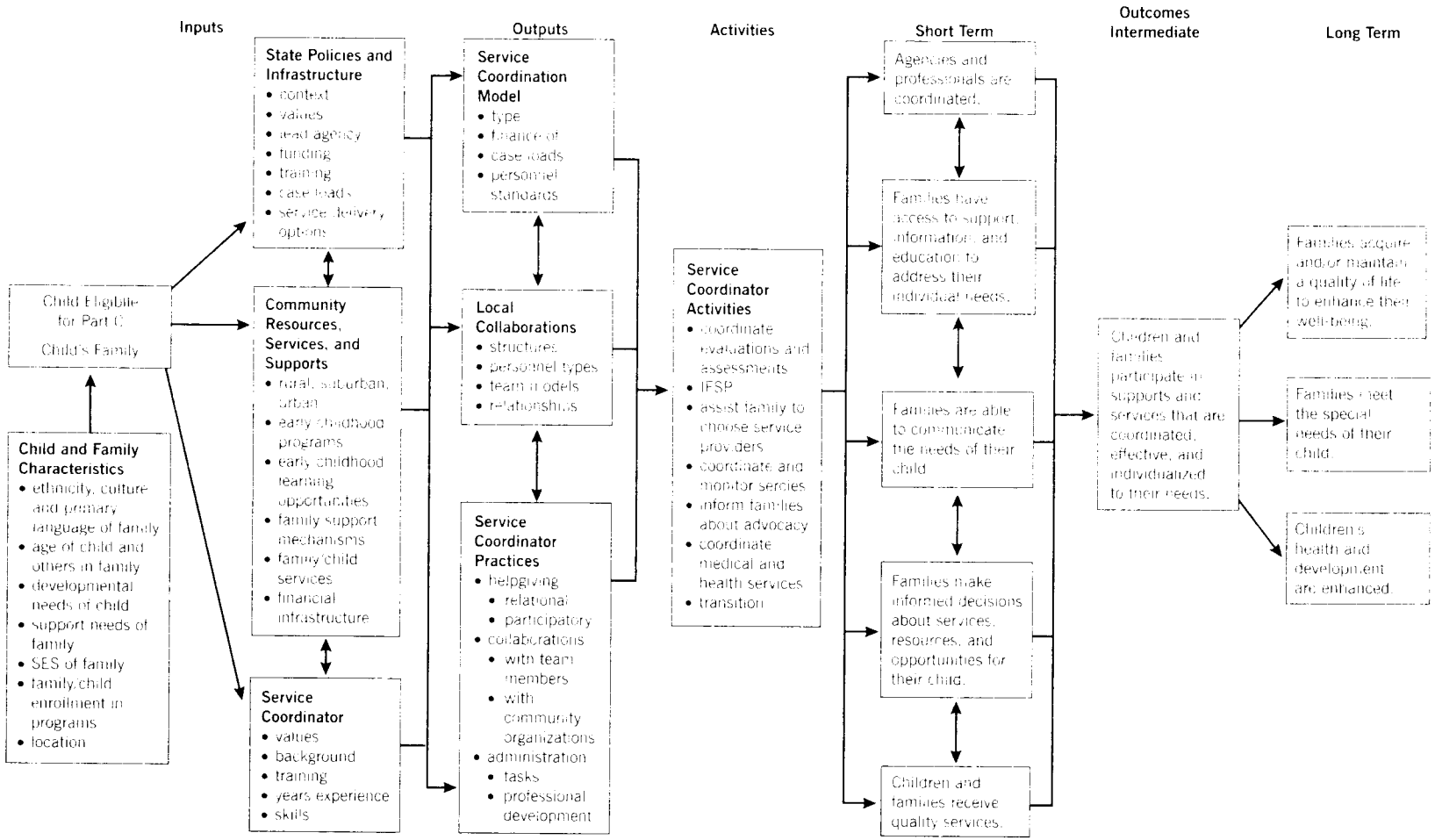


**FIGURE 4.1.** A logic model for service coordination.

for early intervention, before anything is done to the child, it is also his or her responsibility to ensure that the family is informed of their rights and procedural safeguards concerning participation in early intervention. Only then can the service coordinator begin to coordinate the actual implementation of evaluation and assessments. This coordination encompasses both the people who administer the assessment and the tools and processes used during the assessment. To qualify for services, most children will require an evaluation to determine eligibility. This assessment can serve a diagnostic function and create an accurate portrayal of the child's needs across medical, educational, and social systems. It should be noted that an eligibility assessment is not needed for children who may qualify for early intervention because they have received a diagnosis of a medical condition that qualifies as an established condition. A strong recommendation with regard to the diagnostic assessment is to focus on the process as opposed to just the product of the assessment. This practice supports the belief that it is extremely nonproductive to assess a very young child on developmental skills assigned by domain, because these domains are interdependent. Although IDEA requires that the current level of functioning of the child be reported by five domains, traditional assessment models (e.g., discipline specific, in a novel setting with contrived activities, conducted by strangers) prove inadequate when working with infants and toddlers with disabilities. Effective early childhood assessment protocols must rely on a sensitivity to the age of the child, the nature of the delay or disability, the family context, and the integration of a child's behaviors across developmental domains. This does not mean that professionals with discipline-specific expertise are not an important component of the assessment protocol, but, rather, they collaborate as a team on the assessment process and integrated assessment report, so that the child is seen as a whole, rather than domain by domain.

The service coordinator must ensure that a collaborative team process occurs before (planning), during (process), and after (reporting) an assessment. The service coordinator must identify the team members for the assessment and must develop a collaborative climate in which all can work together to obtain information about the child's development and functional abilities within the family and their community. The first challenge is to identify team members who are competent in both their discipline and in early development as well as team process and collaborative consultation. Although such competence has been advocated for many years in early intervention (cf., Bruder, 1996; Rapport, McWilliam, & Smith, 2004), evidence of the use of best practices is sparse (DEC, 1993). Nonetheless, Part C requires the use of multidisciplinary teams in the evaluation and assessment processes. The composition of these teams is then dictated by the unique needs of the child and family in relation to the purpose of assessment. For example, a diagnostic assessment may require more in-depth involvement from numerous professionals from a variety of specialized disciplines. If the objective is to present a comprehensive picture of the child's level of functioning across the five domains as required by law—motor, communication, social–emotional, cognition, and

adaptive—numerous professionals might be involved. By law, two or more must be involved for it to constitute a multidisciplinary assessment.

A functional assessment for IFSP planning can also determine the child's current level of development, but it *focuses* on the child's participation in appropriate family and community activities and routines. It may be easier to accomplish this with fewer professionals because this assessment should either occur in the places where a child typically participates or in an interview format; too many people will be cumbersome at best and overwhelming at worst. The extent to which the child participates in these activities or routines (e.g., how often the child uses a spoon during meal times), using skills from all developmental domains, is the objective of this type of assessment, as opposed to the checking off of domain-specific skills. This type of assessment should also identify adaptations, supports, and strategies to increase the child's participation and learning in those activities or routines (e.g., spoons with built-up handles). The result is a complete and accurate picture of the child's current abilities and ability to learn in a variety of activities or routines. The child's competencies and strengths, preferences, and interests should be identified because parents and professionals can use these throughout the assessment. The assessment should engage the child in interesting activities to ensure that the child's performance is maximized. A functional assessment also focuses on observations of the way the social and physical environment helps or hinders the child's functioning within a specific activity or routine to identify adaptations to the environment that might facilitate child competence and participation.

Last, an integrated assessment report should be developed by the team for both an eligibility evaluation or comprehensive assessment for program planning. Assessment information must be summarized from the recorded observations, interviews, checklists, and scales. The purpose of the assessment report is to provide a picture of the child and his or her family to help create objectives and intervention adaptations, supports, and strategies. The report should be representative of the total process and should report child and family strengths as well as needs. A further suggestion would be for the service coordinator to conduct a routines-based interview with the family to maximize the impact of the developmental assessments to be done with the child (see R. A. McWilliam, Chapter 2, this volume).

## DEVELOPMENT, REVIEW, AND EVALUATION OF THE IFSP

The service coordinator facilitates all aspects of the development, ongoing review, and annual evaluation of the IFSP. During each of these steps, the service coordinator is responsible for ensuring that everyone who is connected to the child—family, early intervention service providers, and community resources—come together to share their information and assessment results, develop child and family outcomes, and identify the services and supports needed to meet the IFSP

outcomes. The IFSP is a working document, and the service coordinator is also responsible for ensuring that the plan reflects the child's and family's priorities and addresses any additional needs that arise. It should be written in family-friendly language, focus on the child's and family's strengths, and have measurable, obtainable outcomes and goals. The IFSP must also be comprehensive and collaborative if it is going to result in positive outcomes for a child and family. The collaborative components include integrated outcomes and objectives that cross discipline and agency boundaries, including coordination of social, medical, and health needs. The recommended interventions or services must be implemented within a child's natural environment, defined as those places where the child would be if he or she did not have disabilities.

An early intervention framework that provides a model for IFSP development is the use of family-identified activity settings and routines as the context of learning. These learning contexts support a variety of subcontexts that can be used to describe the experiences and learning opportunities given to children as part of daily living. They include child and family routines, family rituals, family and community celebrations, and family traditions. Most children, regardless of their disability or severity of delay, experience many kinds of learning opportunities daily, which should form the basis of ongoing therapeutic or instructional support. The IFSP outcomes should focus on facilitating the child's independent participation within and across activities and routines, as well as the expansion to additional learning opportunities across family- and provider-identified activity settings. The framework should be used by the service coordinator during both the assessment and the IFSP meeting.

The IFSP meeting brings service providers and the family together to engage in an exchange of information and joint decision making. Every IFSP team member contributes his or her knowledge to achieve a more in-depth understanding of the issues in supporting the child and the family. The initial IFSP meeting can set the tone for all IFSP meetings that follow. The service coordinator should use the following practices for effective and productive meetings.

## Using Opening and Closing Activities

It can be helpful to begin a meeting with the opportunity for all team members to give information about themselves and their role in the IFSP process for that specific meeting. For example, an early interventionist may be the primary interventionist with one family, but with another family that person is a consultant to the primary interventionist who is directly involved in implementing the IFSP. By sharing this information, the team encourages discussion and creates a sense of equality among its members. This opportunity for sharing information among the team members is also important in helping the family to feel comfortable as they provide their perception of their role in the IFSP process.

## Identifying the Team's Mission

A productive team has a clearly stated mission. A mission statement provides the team with a strong sense of purpose. In addition, a team is more likely to achieve its goals when it establishes a systematic work style, giving the team the organization and structure it needs to produce positive outcomes. The mission of an IFSP team should be focused on supporting the family members through the development of outcomes, objectives, and recommendations for interventions that meet their needs and interests. This goal should be clearly articulated at the beginning of the meeting by the service coordinator or a family member if he or she is interested.

## Preparing an Agenda for Every Meeting

An agenda is an important tool for keeping a team focused on the same issues, and the service coordinator should develop one. A good agenda provides time for information exchange; discussion of specific task-related issues; and confirmation of the date, time, and place of the next meeting. By distributing the agenda before the day of the meeting, team members have the opportunity to prepare themselves for discussing agenda items.

## Keeping Printed Minutes of Each Meeting

Minutes enhance team communication and should be taken at every meeting by the service coordinator. The team should select the member or members who will take and distribute minutes after each meeting. While there is no one standard format for minutes, they should include

- The names of the individuals who attended.
- The issues the meeting addressed.
- Any recommendations made.
- The team members responsible for implementing the recommendations.
- Timelines for completing follow-up tasks.

## Preparing All Team Members for the Meeting

The experience with IFSP meetings may differ among team members. Unlike most of the early interventionists, family members and community service providers may have limited experience with IFSP meetings. An important task of the service coordinator is to help all team members prepare for the meeting by providing questions or issues to consider. This can help team members organize their thoughts ahead of time and facilitate their participation in discussion during the meeting.

After the family's concerns, priorities, resources, and activities and routines have been reviewed in the meeting, the next step is to translate this information into outcomes for the IFSP. Developing outcomes requires synthesizing available information and making decisions among competing priorities. It also requires negotiation, collaboration, and problem solving among team members, most importantly, the service coordinator. Although the family is the central focus of the process, team members who may have different perspectives or priorities should work together to negotiate values and priorities to reach a joint solution. The service coordinator should use and model effective communication strategies to help the team members, including the family, identify outcomes related to enhancing the development of the child.

Part C of IDEA specifies that the IFSP must include services needed to enhance the development of the child and the capacity of the family to meet the special needs of the child. To do this, IFSP outcomes should focus on the family as well as the child. Family outcomes are the changes family members want in their lives related to enhancing their child's development. Because each family is unique, the IFSP team should discuss the family's concerns, priorities, and resources, as well as activities and routines that the family desires to participate in as a family.

When writing family outcomes, it is important to include a statement of what is expected to occur or be accomplished. Moreover, family outcomes should be written in the family's language and easily understood. The Office of Special Education Programs (OSEP) in the U.S. Department of Education has recently identified three family outcome areas to be measured to assess families' progress in the Part C programs. The areas are a family's (1) knowing their rights, (2) being able to communicate their child's needs, and (3) being able to help their child learn and grow. Because these outcomes are broad and designed for accountability across large numbers of families, the service coordinator should assist the IFSP team to develop more relevant and specific outcomes with the family as needed. These could range from "The mother would like to find someone who she feels knows how to take care of Jack on Thursday nights so she can rejoin her church choir" to "The family would like to learn more about their child's disability and its implications for future development" to "The family would like to find a larger house that can accommodate the parents and three children." The first example focuses on the support the parent needs for child care and maintaining her social network. This outcome is also related to the child's development, because the parent feels that the support she gets from the church choir can help her reduce her stress. Decreasing stress and increasing support are important to the quality of caregiver–child relationships and interactions. In turn, positive caregiver–child relationships and interactions can contribute to positive child outcomes.

The second example focuses on the family's need for knowledge and information about their child's disability and how the disability can have an impact on the family's interactions with the child. Knowing the child's disability and development can help the family identify needed support and resources to take care of

their child. The third example focuses on the family's need for alternative housing opportunities. Although this family outcome does not seem to be directly related to the child's development, it is actually important for the family because it is already living in a crowded apartment and would need additional space to accommodate their child with physical disabilities who is in a wheelchair. Being able to move around freely in the house is significant for the child to increase his or her independence and learning (e.g., reaching for toys and materials he or she wants, helping him- or herself with personal tasks). The service coordinator usually is responsible for coordinating the family as well as the child outcomes.

## ASSISTING FAMILIES IN CHOOSING AVAILABLE SERVICE PROVIDERS

No one in the field of early intervention would argue that infants and toddlers with disabilities or those at risk for disability often require the combined expertise of numerous personnel, services, and agencies. The identification of appropriately trained personnel to assist a child and family, however, can be challenging. When more than one type of service provider is needed, it can be almost impossible to identify providers who share an intervention philosophy and are willing to support the family as the target of the intervention. For example, personnel having medical expertise, therapeutic expertise, and educational/developmental and social services expertise traditionally have been involved in the provision of services to infants and young children with disabilities and their families. Each of these service providers might represent a different professional discipline, be employed by a different agency, and practice under conflicting philosophical models of service delivery. In fact, at the service level, coordination can be fraught with tension because of the inherent structure of personnel preparation programs and subsequent discipline-specific practices (Bruder & Dunst, 2005). Table 4.3 contains a listing and description of the most typical early intervention providers.

The additional concern about appropriately trained service providers was also identified by the Part C state coordinators. Forty-seven of them responded to a questionnaire in which they stated that the majority of their Part C workforce, across disciplines, were undertrained to provide early intervention. In fact, only 16 states require a credential specific to early intervention competencies for anyone providing services in their Part C system (for both studies, see *www.uconnucedd.org/per_prep_center/index.html*). As a result, assessing the availability and competence of service providers to assist the family to facilitate their child's development might be the service coordinator's most difficult task.

A service coordinator practice that can assist in this activity is the identification and use of a primary early intervention provider (chosen because he or she displays the competencies necessary to facilitate the child's development) who, through a relationship with the parent and other caregivers (including child care

**TABLE 4.3. Professionals from Multiple Disciplines in Early Intervention**

| Discipline | Area of expertise |
|---|---|
| Speech–language pathologist | A speech–language pathologist focuses on a child's communication skills. He or she evaluates the quantity and quality of sounds a child makes and his or her communication strategies. A speech–language pathologist also determines whether there are physical problems that may interfere with a child's speech. |
| Early childhood special education teacher | An early childhood special education teacher focuses on a child's development across areas including social, self-help, behavior, movement, and language skills. |
| Occupational therapist | An occupational therapist focuses on a child's independence in carrying out daily living tasks (e.g., eating, dressing, toileting), and using fine motor skills. An occupational therapist evaluates a child's self-care skills, play manipulation skills, and other activities. |
| Physical therapist | A physical therapist focuses on a child's ability to move. Physical therapists have been trained to assess movement, muscle tone, muscle strengths, range of motion, and balance, as well as functional or pathological motor limitations. |
| Social worker | A social worker can provide counseling and direct a family to a broad range of community resources (e.g., church groups, private and public agencies, support groups). A social worker assesses a family's capacity to manage basic needs such as those for food, clothing, shelter, and medical care, as well as other support needs. |
| Psychologist | A psychologist assesses a family's and child's psychological status, such as the parents' stress level, coping skills, and the child's mental health. |
| Nutritionist | A nutritionist facilitates a child's development by ensuring he or she receives the quality and quantity of nutrients required to maintain health. A nutritionist assesses a child's food intake, and any feeding needs. The nutritionist can provide advice about diet and develop feeding care plans for the family. |
| Audiologist | An audiologist detects hearing problems and recommends procedures for managing a child's hearing loss. An audiologist is trained to conduct specialized evaluations that measure hearing. |
| Medical specialist | A medical specialist promotes a child's optimal health, growth, and development. A medical specialist is usually a doctor who diagnoses and treats health problems within his or her area of expertise. |

providers), integrates recommendations from other discipline-specific providers when providing intervention to the child. A service coordinator can facilitate the family's comfort level with this model by using helpgiving skills such as providing information about providers who are competent to be a primary provider.

One necessary component of the primary provider model is the use of a transdisciplinary team because it focuses on the delivery of early intervention across developmental domains as opposed to having separate interventions delivered by professionals from different disciplines (King et al., 2009). The child's interventions are implemented by the primary early interventionist, with ongoing assis-

tance provided by professionals from various disciplines. The additional team members serve as consultants to the primary early interventionist, as the primary provider serves as a consultant to the family and the community service providers. As a result, their abilities to facilitate the child's development and learning are enhanced. In deciding which professional in the team should be the primary early interventionist for an individual family, the service coordinator must consider a number of factors, including the following.

## Family Interest and Child Characteristics

The competencies of the primary early interventionist should fit the family's interest and the child's characteristics, rather than the specific skills associated with a particular discipline. Other criteria for the primary early interventionist include an open and trusting relationship with the family, an understanding of the child's needs and the activity settings he or she participates in, and an ability to provide appropriate support to the community service providers.

## The Skills and Knowledge of Individual Team Members

The primary early interventionist should have the skills to address functional development and participation within and across activity settings. In addition, the primary early interventionist should feel comfortable in his or her role as a consultant to the family. For example, a physical therapist may be selected as the primary early interventionist because he or she can provide recommendations related to a child's participation in the various activity settings available at a park, riding in a canoe, eating dinner, and taking a bath. When the child has needs in other developmental areas, the primary early interventionist should be able to attend to them as well.

## The Availability of the Primary Early Interventionist

For families and community members to feel confident and competent, the primary early interventionist must provide consultation within the activities and routines where the intervention will be implemented. The primary early interventionist must also have the flexibility to participate in a variety of activities and routines, because families might feel uncomfortable generalizing the intervention to other settings where consultation has not yet occurred.

Some interventionists might have the competency to provide consultation on child participation across developmental domains but not have the ability to observe within and across all the activities and routines identified by the family. For example, a special educator who teaches in a classroom during the day and works as an early interventionist at night has been the EI consultant to a family during the activity setting of eating dinner. The family has questions, however, about implementing the intervention during breakfast, and the interventionist has

not been able to observe the child when eating lunch at the child care program. Although the interventionist could ideally consult during breakfast on the weekend, this does not work for the child care program, which is only open weekdays. When determining who is best suited to be the primary early interventionist for a particular family, the availability of the interventionist must be considered.

Using a primary provider model and transdisciplinary team approach requires a high level of communication and collaboration among team members. The service coordinator must be able to assist the team to negotiate and problem solve. Additionally, the service coordinator must have an understanding of the professional training and expertise across all team members to facilitate role release, which is a process of teaching, sharing, and exchanging of certain roles and responsibilities among the team members. Role release allows the primary early interventionist to obtain support from other team members to carry out activities that would be normally the responsibility of other team members. In order to implement the process of role release effectively, team members must be willing to learn from the skills and expertise of other team members. Team members can learn the techniques of another discipline through activities such as asking a professional from another discipline for explanation of unfamiliar technical language or jargon; watching a professional from another discipline work with a child and discuss perceptions of what was observed; practicing a technique from another discipline and having a team member from that discipline critique that performance; working with a professional from another discipline side by side when implementing the intervention to a child; asking for help regarding the intervention; and discussing a child's performance with a professional from another discipline.

In addition, team members must be willing to share knowledge with other team members, such as suggesting adaptations or supports for a child to participate in activities and routines, recommending intervention strategies, and teaching the primary early interventionist how to support development and learning in all domains. Each team member, however, continues to be recognized as the authority of his or her own discipline. Assistance and support for this role release should be provided by the service coordinator.

## COORDINATING AND MONITORING THE DELIVERY OF AVAILABLE SERVICES

A comprehensive program can only be effective if data are collected regularly on child and family service implementation, learning opportunities, intervention strategies, and developmental and behavioral outcomes. The service coordinator serves as the single point of contact in helping the family coordinate and monitor the provision of services and supports across disciplines and agency lines. It is the service coordinator's responsibility to ensure that all services and supports (1) are

provided (or accessed) as outlined in the IFSP, (2) are delivered in a timely fashion and at times and places convenient to the family, (3) reflect current research concerning evidence-based practices, (4) are coordinated with one another, and (5) are continuously evaluated for their effectiveness. When service coordinators work to coordinate services and supports, they increase productivity and decrease stress for everyone involved. Quality service coordination ensures that everyone is working toward common goals, communicating openly, sharing effective intervention practices, and continually monitoring child and family status. As with other components, this approach requires a philosophy of coordination and integration, because services and outcomes should be measured only within a collaborative framework.

Examining child progress has two components. One is typically a part of IFSP reviews and ongoing data collection. Although snapshots of child and family progress are provided at regularly scheduled intervals, keeping track of progress continuously and across multiple activities and routines is critical to assessing whether the adaptations, supports, and intervention strategies have had an impact on the child and family.

One way to facilitate this service coordination activity is regular, scheduled team meetings in which professionals meet with the service coordinator and family to review and monitor a child's and family's progress through the early intervention service plan. Unfortunately, the reason these meetings don't occur with regularity is because of a lack of infrastructure supports such as funding for meeting times. However, both satisfaction and progress are reported in those systems where such meetings occur, and many professionals have recommended the use of such meetings to ensure ongoing collaboration and accountability. At a minimum, the IFSP biannual update meeting can be used to collect data for the federal report required of each state.

A second and more formal method of monitoring the delivery of early intervention is the annual performance reports required by OSEP for all Part C participants (see *www.the-eco-center.org*). The specific outcomes that are to be used for reporting are on Table 4.2. Unfortunately at this time, states are able to organize this Part C data collection specific to their state needs and current practices, thus creating challenges to the ultimate validity of the national effort. Nonetheless, states should avail themselves of the opportunity to design reliable and valid data systems for federal and state requirements.

## INFORMING FAMILIES OF THE AVAILABILITY OF ADVOCACY SERVICES

Families, as a rule, know their children's needs best. Gaining access to the services to meet those needs means that families sometimes have to request, even

demand, that those services be provided. An important function that service coordinators fulfill is helping families become strong advocates for their children. The term *advocacy* refers to speaking on behalf of others. Service coordinators help by informing families about advocacy services that are available to them: services that help families learn how to advocate, local and state services that can advocate on behalf of the individual family, and national organizations that advocate on behalf of children with special needs and their families in general. This is a critical activity for families who may want different, more, or fewer services than the IFSP team offers.

## COORDINATING WITH MEDICAL AND HEALTH PROVIDERS

The coordination of early intervention with medical and health providers is an ongoing activity of early intervention. All children eligible for early intervention will have been seen by a health care provider prior to entry into early intervention. As the single point of contact for early intervention, service coordinators can help families improve coordination with their health care providers. Additionally, the service coordinator can help families obtain any additional medical and health providers families need and coordinate those services with other early intervention services and supports.

Many children who receive early intervention support have more than one medical and health provider. With multiple providers, care can easily become fragmented, and it is common for providers not to communicate or send reports to one another. This is one of the reasons the concept of a *medical home* has been advocated for all children, most importantly for children with special health care needs, many of whom will receive early intervention services. A medical home ensures that medical care is accessible to all children and coordinates all of a child's medical needs. A medical home can be a clinic, a primary care physician, or a group practice. The medical home is also responsible for ensuring the competence of all who provide services to a child and that financial resources are available for families to pay for necessary medical services. Last, the medical home also provides family supports that enable a family to meet the special needs of their child. Service coordinators should, therefore, identify a medical home for each child they serve, and ensure that information from the early intervention team is provided to the child's medical home.

Coordinating with medical and health providers also requires that the service coordinator obtain information from the medical home for the early intervention team. Early interventionists and other providers need health and medical information to determine how a child's health status affects not only overall development but also how it influences interventions with the child. Families must have up-to-date information on their child's health status to participate fully in their child's care. Finally, before any service providers can provide support for a child, they

need information about a child's other needs and the services he or she already has.

## FACILITATING THE DEVELOPMENT OF A TRANSITION PLAN TO PRESCHOOL SERVICES

The importance of transition has been addressed in state and federal legislation, federal funding initiatives, and the literature. A successful transition is a series of well-planned steps to facilitate the movement of the child and family into another setting (Bruder & Chandler, 1993). Coordinating successful transitions are a major responsibility of a service coordinator under Part C of IDEA. Needless to say, the type of planning and practices that are employed can influence the success of transition and satisfaction with the transition process.

Within the field of early intervention, transition is defined as the process of moving from one program to another or from one service delivery mode to another. Other people have emphasized the dynamic process of transition, as children with disabilities and their families will have repeated moves among different service providers, programs, and agencies as the child ages. Although formal transition for young children with disabilities typically occurs at age 3 (into preschool), transition between services, providers, and programs can also occur throughout these early years. Part C of IDEA increases the potential number of transitions. For example, transition can begin for some children at the moment of birth if it is determined that their health status requires transfer to a special care nursery and subsequent developmental interventions.

Children and families in early intervention might experience a number of transitions during the child's first 3 years of life. These transitions include moving from the hospital or neonatal intensive care unit to home; from home to various community settings; and, when the child turns 3 years old, to public school preschool or other community-based resources and supports. When families were asked about the most important outcomes for service coordination as part of our research, we found that successful transitions were a primary concern. Many families talked about how difficult this process can be and how an effective service coordinator will know the local school system and encourage families to visit different types of preschool programs. Well-developed transition plans should decrease additional assessments and paperwork and ensure that there are no time lags in service provision.

Many families do not realize that their child is not automatically eligible for services and supports after they exit the early intervention program. A good transition plan pulls together people and information so that everyone is well-informed and participates in the decision making. Successful transition plans provide families with knowledge and supports to obtain needed resources. Only when families are fully informed can they make decisions in partnership with other providers regarding future placement and services.

## USING THE LOGIC MODEL TO FRAME EVALUATION

The implementation of service coordination activities may seem overwhelming, as they represent the process of early intervention for every eligible child and family. Therefore, the prospect of early intervention without a service coordinator is even more overwhelming. The attached checklists (Appendices 4.1–4.8) of practices for each activity are one means of accountability for the service coordinator, system, and family. The ultimate accountability focus, however, is the acquisition of service coordination outcomes as identified by the RTC (Table 4.2) for each eligible child and family.

As seen in Figure 4.1, the service coordination logic model has grouped the outcomes according to the immediacy of their acquisition. As with any logic model, operational measures must be used to address each one. The service coordinator should develop a series of measures that are applicable to each outcome for multiple points in the early intervention process. Interviews, checklists, and standard measures may be used together or alone, to address one outcome or all. These outcomes are embedded in the service coordination activities, practices, and state and local context, as displayed on the logic model. The measures used to document each outcome will ultimately allow an assessment of whether the intent of service coordination in Part C of IDEA is realized for families and their children.

## CONCLUSION

Service coordination is the formation of all early intervention supports and services provided to infants, toddlers, and families. When done well, service coordination can be the light that illuminates the early intervention process for families. Likewise, service coordination can be the lynchpin to the use of evidence-based practices in early intervention for all service providers. When done poorly, however, service coordination adds to the complexity of early intervention by causing a negative impact on an already cumbersome system. This chapter provided some background research about and description of each of the seven activities of service coordination in an effort to provide practitioners and families the tools they need to implement service coordination effectively.

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APPENDIX 4.1

# Coordinating Evaluation and Assessments: First Contacts

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • Early intervention (EI) philosophy | | |
| • The statewide early intervention system including eligibility criteria for children | | |
| • The difference between assessment for evaluation and ongoing assessment | | |
| • The role of the family in the assessment process | | |
| • Procedural safeguards and family rights | | |
| • Confidentiality policies and practices | | |
| **Gather information from the family about . . .** | | |
| • Family background, ethnicity, and language preference | | |
| • Family structure and composition | | |
| • Child health and development status and history | | |
| • Family resources, concerns, and priorities | | |
| • Other agencies and professionals involved with the child | | |
| • Their child's reaction to strangers (e.g., the interventionist) | | |
| **Collaborate to . . .** | | |
| • Identify methods of sharing information with others, including the family | | |

(cont.)

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Perform administrative tasks such as . . .** | | |
| • Get parent permission for the child's evaluation/assessment | | |
| • Complete and submit to system releases for information | | |
| • Complete and submit to system reimbursement information, if needed (e.g., insurance, Medicaid, family payment) | | |
| • Get and share with the early intervention evaluators records and past assessments on the child | | |
| • Gather information about the child's disability | | |
| • Get parent permission to store data | | |
| • Send a letter of acknowledgment about the family to the referral sources including the medical home | | |

APPENDIX 4.2

# Coordinating and Implementing Evaluations and Assessments

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • Valid/reliable evaluation and assessment models and tools | | |
| • The assessment protocol to be used | | |
| • The family's role in the assessment | | |
| • The assessment team and individual backgrounds of evaluators/assessors | | |
| • The assessment tools to be used | | |
| • Summary information on evaluation/assessment results | | |
| **Gather information from the family about . . .** | | |
| • The child and family activity settings/routines and the level of the child's participation within them | | |
| • The child's typical behaviors, motivation, and persistence | | |
| • Their preferred modality to receive the results summary of the evaluation/assessment | | |
| • The child's reactions to new people | | |
| • Adaptations and supports they use to facilitate their child's behavior | | |
| **Collaborate to . . .** | | |
| • Facilitate the sharing of information among team members (including the family) prior, during, and after the assessment | | |
| • Assist the assessment team in the translation of evaluation/assessment results into functional applications within family-identified activity settings/routines | | |
| • Assist the assessment team in writing up the assessment summary | | |

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Perform administrative tasks such as . . .** | | |
| • Identifying evaluation/assessment team members | | |
| • Establishing evaluation/assessment time and place | | |
| • Informing the family of the child's eligibility/non-eligibility for early intervention guidance about the next steps in the EI process | | |
| • Providing guidance on child development services for children who do not quality for EI | | |

APPENDIX 4.3

# Facilitating and Participating in the Development, Review, and Evaluation of the IFSP

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • The purpose of the IFSP | | |
| • The IFSP meeting, format, and participants | | |
| • The identification of EI services to enhance learning opportunities | | |
| • The development of timelines and criteria for services | | |
| • The evaluation criteria for service delivery and learning acquisition | | |
| • The ongoing role of the service coordinator | | |
| • The development of a transition plan | | |
| **Gather information from the family about . . .** | | |
| • Activity settings/routines for learning | | |
| • Priorities for child participation in activity settings/routines | | |
| • The identification of child learning opportunities in the home and community settings in which other children participate | | |
| • The establishment of functional, integrated IFSP outcomes and objectives to support the child's and family's strengths in identified activity settings/routines | | |
| • Time and place preferences for the IFSP meeting | | |
| • Other participants and supports necessary to have the IFSP document as much as possible | | |
| • Time and place preferences for IFSP meetings | | |
| • Comfort levels in the IFSP meeting and document | | |

| ***The service coordinator will . . .*** | ✓/× | ***Notes*** |
|---|---|---|
| **Collaborate to . . .** | | |
| • Identify IFSP meeting participants, including providers involved in the child's evaluation | | |
| • Establish meeting time, place, and agenda with the family | | |
| • Facilitate IFSP meeting | | |
| • Enable the family to speak first and often throughout the meeting | | |
| • Enable the family to negotiate for outcomes | | |
| • Develop plan for how families will access supports and resources to meet outcomes | | |
| **Perform administrative tasks such as . . .** | | |
| • Providing written notice to all involved in the IFSP meeting | | |
| • Acting as the facilitator of the IFSP meeting | | |
| • Ensuring that all forms are correctly completed, signed by, and distributed to all relevant parties | | |
| • Making a copy of the IFSP for a child's file, family, and providers and distribute accordingly (e.g. primary care providers) | | |

APPENDIX 4.4

# Assisting Families in Identifying Available Service Providers

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • The primary provider model | | |
| • The role and competencies of different professional disciplines | | |
| • Strategies for assessing the competence/effectiveness of a service provider | | |
| • The process for identifying members of professional disciplines as service providers | | |
| • Ways to integrate service providers into family and community activity settings | | |
| • Collaborative consultation and transdisciplinary teaming to integrate child's developmental needs across domains, disciplines, and daily learning opportunities and routines | | |
| • Community service providers outside of the EI system | | |
| **Gather information from the family about . . .** | | |
| • Their knowledge about different disciplines | | |
| • Their preferred time and place for intervention visits | | |
| • Their comfort level with number and frequency of providers | | |
| • Their comfort level with participating in intervention | | |
| • Their comfort level with providing feedback to the interventionist | | |

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Collaborate to . . .** | | |
| • Identify a primary service provider | | |
| • Facilitate the choosing of competent service providers for child and family | | |
| • Identify the service delivery structure: time, place, and length of intervention sessions with the family and service provider | | |
| • Identify team meeting times and communication strategies with family and/or service providers | | |
| • Identify how to integrate family's cultural traditions and informal supports within EI | | |
| • Facilitate the sharing of all relevant information (e.g., evaluations, IFSP) across service providers and the family | | |
| **Perform administrative tasks such as . . .** | | |
| • Gathering necessary documentation on potential service providers | | |
| • Contacting potential service providers | | |
| • Scheduling intervention visits to meet the IFSP outcomes | | |

APPENDIX 4.5

# Coordinating and Monitoring the Delivery of Available Services

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • Agency and provider responsibilities | | |
| • Team process and integration of learning across domains | | |
| • Effective communication strategies across service delivery teams and agency activities | | |
| • How providers should facilitate the behavior and development of the child | | |
| • Criteria by which to measure individual child and family IFSP outcomes progress | | |
| • A system for tracking the delivery of services and intervention sessions | | |
| • Strategies for requesting changes in IFSP and/or service delivery plan | | |
| **Gather information from the family about . . .** | | |
| • Their satisfaction with the IFSP and service delivery | | |
| • Their confidence in being able to facilitate their child's development as a result of intervention | | |
| • Where and when intervention sessions have occurred | | |
| **Collaborate to . . .** | | |
| • Establish and coordinate collaborative consultation and team meetings (e.g., via e-mail, phone, or in person) | | |
| • Monitor (or facilitate) the service delivery schedule | | |
| • Monitor data collection from all members of the service delivery team | | |
| • Follow interagency agreements, attend interagency meeting | | |

| ***The service coordinator will . . .*** | ✓/× | ***Notes*** |
|---|---|---|
| • Establish schedule for the sharing of information and/or formal reports on all child and family outcomes | | |
| • Establish a system for the family to provide feedback on the EI service delivery model, the providers, and child and family progress | | |
| **Perform administrative tasks such as . . .** | | |
| • Establishing data collection strategies on child and family outcomes for all service providers | | |
| • Keeping record of progress from all providers toward IFSP goals | | |
| • Coordinating the 6-month review of the IFSP | | |

APPENDIX 4.6

# Informing Families of the Availability of Advocacy Services

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • The definition and uses of advocacy | | |
| • Parent resources for advocacy/support (e.g , parent training and information, parent to parent) | | |
| • The use of mediation and due process | | |
| **Gather information from the family about . . .** | | |
| • Family involvement with resources such as PTI and parent to parent, and other support | | |
| • Family knowledge about their rights, advocacy resources, and due process | | |
| **Collaborate to . . .** | | |
| • Assist the family to access and use advocacy supports they need | | |
| • Assist the family to use conflict resolution techniques as needed | | |
| **Perform administrative tasks such as . . .** | | |
| • Assist the team of service providers to use conflict resolution techniques as needed | | |
| • Assist the family to file for mediation/due process if they are dissatisfied with the EI process | | |

APPENDIX 4.7

# Coordinating with Medical and Health Providers

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • Confidentiality and sharing of relevant information, both verbal and written | | |
| • The concept of a medical home, where care is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective | | |
| • A child's nutritional needs for growth and development | | |
| • A child's mental health needs | | |
| • Environmental hazards for children | | |
| **Gather information from the family about . . .** | | |
| • The medical care providers/medical home | | |
| • The child's physical health needs | | |
| • The child's nutritional needs | | |
| • The child's mental health needs | | |
| • The family's medical insurance/Medicaid coverage | | |
| **Collaborate to . . .** | | |
| • Facilitate the appropriate sharing of medical information/EI information between the child's service providers (EI as well as health care) | | |
| • Educate service providers about the child's medical needs | | |
| • Identify and obtain additional medical/health services that may be needed for the child | | |

| ***The service coordinator will . . .*** | ✓/× | ***Notes*** |
|---|---|---|
| **Perform administrative tasks such as . . .** | | |
| • Obtain written consent from family to receive and share development, health, and medical records | | |
| • Request child's health and medical records from the appropriate sources | | |
| • Provide health and medical providers with early intervention evaluations and progress notes | | |
| • Establish an ongoing medical/health record system for the child | | |

APPENDIX 4.8

# Facilitating the Development of a Transition Plan to Preschool Services

| *The service coordinator will . . .* | ✓/× | *Notes* |
|---|---|---|
| **Share information about . . .** | | |
| • Transition requirements of early intervention | | |
| • Community and specialized services for which child and family may be eligible | | |
| • IDEA preschool (Part B) policies, if appropriate | | |
| • The child's opportunities to participate in community early childhood programs | | |
| • The transition conference to be held at least 90 days prior to transition out of early intervention | | |
| **Gather information from the family about . . .** | | |
| • Their knowledge of their child's developmental needs, including disability | | |
| • Their knowledge of early childhood community resources for their child | | |
| • Their knowledge of preschool special education, if appropriate | | |
| • Their preference for the child's preschool placement | | |
| **Collaborate to . . .** | | |
| • Arrange visits of the family to community and/or school placement options | | |
| • Establish members of transition team | | |
| • Schedule transition team meetings at time and place preferred by parent | | |
| • Facilitate transition team meetings | | |
| • Develop a transition plan | | |

*(cont.)*

| ***The service coordinator will . . .*** | ✓/× | ***Notes*** |
|---|---|---|
| **Perform administrative tasks such as . . .** | | |
| • Obtaining written consent from family to share information with potential service providers, including evaluation and assessment information and copies of IFSPs | | |
| • Arranging a transition meeting at a time and location convenient for the family; forward current child information to future service providers prior to the transition meeting | | |
| • Notifying local education agency 9–12 months prior to child turning 3 years | | |