DATA REPORT:
SERVICE COORDINATION POLICIES AND MODELS

Purpose

The Individuals with Disabilities Education Act (IDEA, 1987) requires that services for infants and toddlers with delays, disabilities or risks be coordinated at both the direct service and system levels. To facilitate the coordination of services, IDEA included a provision requiring the appointment of a service coordinator for each eligible child and his or her family. A service coordinator is responsible for assisting a family in coordinating services across agencies and people, assisting in obtaining needed services, and helping a family to understand and exercise their rights.

IDEA requires the provision of service coordination but does not specify how it should be implemented. Therefore, state policy makers are free to decide which models of service coordination to use in their states. Five broad models of service coordination have been identified: 1) *Independent and dedicated* - the role of the service coordinator is dedicated to service coordination only and the agency providing service coordination is independent from service provision; 2) *Independent but not dedicated* – the agency providing service coordination is independent from service provision, but the service coordinator performs other responsibilities (such as system entry tasks) in addition to service coordination; 3) *Dedicated but not independent* - the service coordinator provides service coordination only in an agency that also provides intervention services; 4) *Blended* – the service coordinator also provides developmental intervention; 5) *Multi-level blended and dedicated* – children and families with the most complex service coordination needs are assigned a dedicated service coordinator, while intervention

service providers carry out service coordination tasks in addition to providing intervention for children and families with less complex needs.

Despite which service coordination model is selected, state policies provide the foundation and direction for how service coordination is implemented. Research studies in other professional areas, as well as policy studies related to early intervention, reveal a crucial link between policy *specificity* and *clarity* and the success of implementation. Studies also demonstrate the importance of the *values* of the policy stakeholders, as well as the values inherent in the policies (Harbin, McWilliam, & Gallagher, 2000).

This study was designed to provide a better understanding of:

- The perceived values of four important stakeholder groups regarding service coordination.
- The perceived similarities in the values held by these important groups.
- The current models of service coordination.
- The role of the parent in service coordination.
- The level of policy specificity undergirding service coordination.
- The approaches to monitoring and evaluating service coordination.
- The funding of service coordination.
- The general approach to service provision in which service coordination is embedded.

Method

Participants

Part C coordinators in each of the 57 U.S. states and territories and the District of Columbia were recruited to participate in the study. Since we were seeking the perceptions of a single individual per state, we determined that the Part C coordinators were likely the most knowledgeable individuals concerning the multiple aspects of service coordination policy within their states, as it is their responsibility to possess the most complete policy picture of Part C. Part C coordinators in 50 states and five territories completed and returned surveys, resulting in a 100% return rate for states and a 71% return rate for territories. Part C coordinators in American Samoa and Palau did not respond to requests to participate. This report addresses only the responses by the Part C coordinators in the 50 states and the District of Columbia. The results of responses from the Part C coordinators in the U.S territories of Guam, Virgin Islands, Puerto Rico and Northern Mariana Islands will be contained in a separate report.

Recruitment. The following steps were taken to recruit participants: 1) the Part C Coordinators Association officers agreed to assist in planning and conducting this study; 2) project staff attended a national meeting for Part C coordinators, explained the purpose of the study, and asked for input from Part C coordinators regarding content of the questions to be included in the instrument, as well as suggestions regarding the mode of distribution (mail, e-mail, fax or phone); 3) the announcement of the study appeared in the Part C coordinators newsletter; 4) project staff consulted with the officers of the Part C coordinators national organization in the development of the survey; and 5) the survey was then sent by both regular mail and e-mail, along with a demographic form and an informed consent form to the Part C coordinators in all 57 U.S. states and territories and the District of Columbia.

Demographic Information. The amount of experience of the Part C coordinators ranged from 0 years to 13 years, with a mean of 4.5 years and a standard deviation of 3.62. Therefore, some of the Part C coordinators (N=14) are new to their jobs, having been a Part C coordinator for one year or less; while others (N=12) have 8 to 13 years of experience. All of these Part C coordinators have worked in Part C in some position (not necessarily as coordinators) for 2 to 18 years with a mean of 9.27 years (standard deviation of 3.97). In general, this group of state Part C coordinators is experienced, with an average of a little more than 18 years of experience working with young children. The professional backgrounds of many of the Part C coordinators are special education (30%) and education (16%). The professional disciplines of other state Part C coordinators are social work (11%); occupational therapy, physical therapy, or speech therapy (11%); psychology (11%); administration (5%); and public health (5%). Other backgrounds reported by the Part C coordinators are government, child development, parent/program management, and law.

Survey Design

The survey instrument collected the perceptions of the Part C coordinators about multiple aspects of service coordination. The survey items were developed to reflect critical variables identified in studies of service coordination, interagency coordination, and policy implementation. The following individuals reviewed early drafts of the survey and made suggestions regarding the clarity of items as well as items to be added: 1) the officers of the Part C Coordinator’s Association (Part C coordinators in Connecticut, Indiana, and North Carolina) and the Part C coordinator in Massachusetts; and 2) Sue Mackey-Andrews, who constructed a survey for the Part C Coordinator’s Organization that addressed a wide range of topics.

The survey contained a combination of 30 multiple choice and 3 Likert-style questions. Some of the multiple choice questions required respondents to select only one response, while other questions allowed respondents to select multiple relevant answers. The survey questions were grouped into 7 sections: values undergirding service coordination; approach to service coordination; policies; monitoring; evaluation; funding; and broad organizational structure and approach to service delivery in which service coordination is embedded. A copy of the survey can be found in Appendix A of this report.

The survey was piloted in four states: Connecticut, Indiana, Massachusetts, and North Carolina. Each of these states have a different approach to service coordination, thus allowing us to ensure the questions were designed to properly assess the varied service coordination approaches. Based upon the answers to pilot questions, as well as suggestions regarding revisions and additions to questions, we developed the final version.

The Part C survey was distributed as an e-mail attachment the week of April 17, 2000 to the Part C coordinators. The survey was mailed or faxed to states and territories unreachable by e-mail. Follow-up for the survey was conducted through telephone calls and e-mail. An e-mail message was distributed to the Part C Association Listserv on May 17 thanking the first 16 states for returning their survey and informing the remainder of the states that they would be receiving a phone call to discuss methods of facilitating the return of their survey. Subsequently, follow-up telephone calls were made to each state that had not submitted a survey. Following the reminders, four additional states submitted completed surveys. A second e-mail message was posted to the Part C Association Listserv thanking the 20 states for returning their surveys promptly. After persistent follow-up, eight additional states returned completed surveys. A third e-mail was sent to the Part C Association Listserv on May 30 extending thanks to the 28 states

that returned completed surveys. Between May 30 and October 30, telephone contact and e-mail reminders from center staff and the principal investigators continued, resulting in a total return of 55 Part C surveys by the end of October. All 50 states and five of the seven territories completed and returned surveys. An average of four contacts were made to each state prior to receiving a complete survey.

Data Analysis

We used descriptive statistics (means, standard deviations, frequencies and percentages) to describe the results from the Part C coordinator surveys from the 50 states and the District of Columbia (herein the District of Columbia will be included in the category of state). In addition, we grouped some conceptually similar items in order to better understand and describe broader types of values and service coordination approaches.

Results

The findings are grouped into the following topics: 1) satisfaction with the way the service coordination model is working, 2) values, 3) service coordination model, 4) policies, 5) monitoring, 6) evaluation, 7) funding, and 8) broad approach to service delivery.

Satisfaction

State Part C coordinators were asked to rate how well they believe the service coordination model in their state is working using a scale of 1 (not at all working) to 7 (working extremely well). The mean level of satisfaction across the nation is 4.84 shown on Table 1.

Table 1

Level of Satisfaction with Service Coordination Model Across States and Territories

	Working Not At All 1	2	3	Working Somewhat 4	5	6	Working Extremely Well 7
Number	0	1	3	16	17	11	3
Percent	(0%)	(2%)	(6%)	(31%)	(33%)	(22%)	(6%)

Sixty-seven percent (N=33) of the Part C coordinators at the time of the study perceived that their service coordination model was working in a somewhat average or slightly better than average fashion (ratings of 4 or 5). Only 20% (N=11) believed their service coordination model was working fairly well (rating of 6), while 5.5% (N=3) believed their model was working extremely well. Seventeen states (33%) are considering or are currently in the process of changing their service coordination model.

Values

We asked Part C coordinators to rate how strongly four stakeholder groups (lead agency, state ICC, other state agencies, and local providers) held six broad values related to service coordination (measured over 17 items). A 4-point scale on the possession of the values was utilized with 1 = not at all, 2 = a little; 3 = some, and 4 = a lot. The Part C coordinators also had the option of selecting a don't know response, when they were not sure about the possession of a particular value by a particular stakeholder group.

In general, Part C coordinators reported that they were *most* knowledgeable about the values held by the lead agency and *least* knowledgeable about the values held by other relevant state agencies. The mean number of don't know responses reported by Part C coordinators for each group were: 1) lead agency = 1.65, 2) state ICC = 5.24, 3) other relevant state agencies = 7.94, and 4) local providers = 5.12. Part C coordinators indicated through their ratings that their lead agency held similar values to them regarding service coordination, as indicated by the ratings listed on Table 2. The means across the four groups differed on each of the individual items though data suggested that the lead agency and the state ICC were the most similar in the values they had for service coordination.

Although the means differ across groups, the pattern of responses in regard to the most strongly held, and the least strongly held, values was similar across groups. For example, among the most strongly held values, all groups were rated highly as seeing that service coordination facilitated better outcomes for children and their families and that resources were more efficiently used when they were integrated. Conversely, there are two values that were reportedly held less frequently across all four groups: 1) agencies participate in service coordination because they don't want to be left out; and 2) competition results in better services.

Table 2

Cross Group Comparison of Service Coordination Values

	Lead Agency	State ICC	Other Agencies	Local Providers
ENHANCES OUTCOMES				
Reduces frustration and confusion for families	3.78	3.38	3.02	3.30
Achieves better outcomes for children and families	3.80	3.44	2.94	3.34
Facilitates community integration	3.70	3.26	2.70	3.00
REDUCES GAPS AND OVERLAPS				
COMPLIANCE				
Compliance with federal legislation is sufficient	2.76	2.48	2.24	2.44
SYSTEMS PERSPECTIVE				
Integrates services into coherent whole	3.69	3.30	2.83	3.02
Fragmented system requires families to be dependent	3.10	2.54	2.24	2.62
Resources more efficient if integrated	3.84	3.40	2.96	3.00
Linchpin	3.74	3.33	2.63	2.78
Can get more resources	3.42	3.13	2.66	2.62
SERVICE COORDINATION IS LOGICAL BUT DIFFICULT				
Difficult to get people to do their part	2.79	2.42	2.44	2.82
Don’t want to be left out	1.15	1.02	1.09	1.19
Want to protect scarce resources	1.80	1.38	1.59	1.68
SERVICE COORDINATION IS NOT ORGANIZATIONALLY EFFICIENT				
Not organizationally efficient	2.02	1.85	1.94	2.17
Lead agency needs to be responsible for all	1.82	1.48	1.39	1.62
Competition results in high quality services	1.29	1.26	1.51	1.36
Service coordination is at expense of direct service	1.30	1.28	1.55	1.80

One of the most heartening findings was that the values relating to enhanced outcomes for children and their families were rated among the highest by all four stakeholder groups. Table

3 contains a comparison of the types of values held by the four stakeholder groups and three types of values that address the purpose of service coordination: 1) compliance, 2) reduce gaps and overlaps, and 3) enhance outcomes. Interestingly, enhancing the outcomes for children and their families was the highest rated purpose attributed to all four stakeholder groups. Table 3 also contains values that address the organizational strengths and weaknesses of service coordination: 1) not organizationally efficient, 2) logical but difficult, and 3) systems perspective. Of these three types of values, all stakeholder groups, according to Part C coordinator's perceptions, had values that were consistent with a systems perspective. Part C coordinators reported that in general the other stakeholders held similar values to them, but to a lesser degree.

Table 3

Types of Values: Cross Group Comparison of Means

Values	Lead agency	State ICC	Other agencies	Local providers
Enhances outcomes	3.76	3.36	2.87	3.21
Reduce gaps and overlaps	3.66	3.30	2.71	2.98
Compliance	2.76	2.48	2.24	2.44
Systems perspective	3.56	3.14	2.66	2.81
Service coordination is logical, but difficult	1.91	1.69	1.71	1.90
Not organizationally efficient	1.61	1.50	1.47	1.74

Service Coordination Models

We asked Part C coordinators to describe several aspects of their service coordination model including: 1) service coordination during system entry; 2) whether there is continuity of the service coordinator from system entry to service provision; 3) the role of the service coordinator; 4) the agency providing service coordination; 5) the agency responsible for ensuring that a service coordinator is selected; 6) criteria used to select the service coordinator; and 7) the use of parents as service coordinators. Slightly over 50% of the Part C coordinators indicated that a system entry coordinator helped coordinate intake activities for children and their families (see Table 4). The most common response under other was that local programs used different approaches – no single approach is used.

Table 4

Approach to Service Coordination During System Entry

	Frequency	%
A system entry service coordinator helps coordinate intake activities.	27	53%
A member of the intake team is assigned to coordinate intake activities, as well as perform other intake activities.	10	19%
No one is officially engaged as an intake coordinator, but the tasks of coordination are picked up unofficially by one of the team members until eligibility is determined.	6	12%
Other	8	16%

Fifty-three percent (53%) of the Part C coordinators (N=24) indicated that a family member could serve as a service coordinator for children and families other than their own during the system entry process (intake, assessments, and IFSP development).

Part C coordinators were given four options and asked to select the option that best described what happened in their state in regard to the service coordinator role after intake. Twenty nine percent (29%) (N=15) indicated that the same service coordinator remained with a child and family during intake and IFSP development and then continued on as the service coordinator during service provision. Interestingly, another 29% indicated in the other response that a combination of approaches was used in their state. Of the states that used a combination of approaches, 5 states used a combination of options 1, 2, and 3 listed in Table 5. Five other states used a combination of options 2 and 3, and one respondent indicated that option 2 was most often used in urban areas and option 3 was most often used in rural areas.

Table 5

Continuity of Service Coordination Between Intake and Service Delivery

	Frequency	%
The system entry or intake coordinator transfers service coordination responsibilities to another service coordinator who assists with IFSP development and eventual coordination of services.	9	18%
The system intake coordinator assists with IFSP development and then transfers service coordination responsibilities to a new service coordinator designated on the IFSP when service delivery begins.	10	20%
The same service coordinator facilitates the intake process, IFSP development, and is then listed on the IFSP as the service coordinator.	15	29%
The service coordinator is first selected at the time of the development of the IFSP.	2	4%
Other	15	29%

The Part C coordinators were asked to select one of seven options that best described the role of the individual designated on the IFSP to provide service coordination (see Table 6). Each

of the following two options were chosen by 27% of the Part C coordinators: 1) an individual who is dedicated to providing service coordination only – no other service or services; and 2) all six options are allowed and used within the state. Ten Part C coordinators selected the other option. These coordinators also indicated that their state used a combination of two or more options listed in Table 6. Thus in 47% of the states, there was variability in the nature of the responsibilities of the service coordinator.

Table 6

Role Played By Service Coordinator

	Frequency	%
Individuals provide service coordination only – no other service.	14	27%
Individuals provide service coordination, in addition to intake and evaluation services.	3	6%
Individuals provide developmental intervention services (e.g., non-therapies), in addition to service coordination.	4	8%
Individuals provide developmental intervention or therapies in addition to service coordination.	6	12%
Individuals provide any type of services from any agency, in addition to service coordination.	0	0
For children with mild-to-moderate needs, service coordination is provided by the interventionist, while children with multiple needs receive service coordination from an individual who provides service coordination only.	0	0
In our state, all of the above are allowed and used.	14	27%
Other	10	20%

Part C coordinators were given seven options describing which agency provided service coordination. The greatest number of Part C coordinators (N=14) indicated that service

coordination was provided by a local or regional private program or providers who are contracted by the lead agency, and these service coordinators also provided developmental intervention and therapies. Once again, the second highest choice selected by Part C coordinators was other, which was chosen by 9 coordinators (17%). However, when options 2 and 3 were combined, it indicated that over one-third of states (N=20) used an agency (whether under the direct auspices of the lead agency or contracted by them) that provided both service coordination and developmental intervention and therapies. This is delineated on Table 7.

Table 7

Agencies Providing Service Coordination

	Frequency	%
A local or regional agency or entity that is separate from (independent of) the agencies providing intervention services (e.g., language, cognitive, social, etc.) and therapies (e.g., OT, PT).	7	14%
The lead agency at the local level, which also provides intervention services and therapies.	6	12%
Local or regional private programs and/or providers contracted by the lead agency, which also provide developmental intervention services and therapies.	14	27%
A state agency other than the lead agency is responsible for providing service coordination.	2	4%
Any agency can provide service coordination.	7	14%
State lead agency directly provides service coordination.	3	6%
In our state, all of the above are allowed and used.	3	6%
Other	9	17%

In about 40% of the states (N=19), the lead agency was responsible for ensuring that a service coordinator was selected for each eligible child and his or her family. The other two choices most frequently selected by Part C coordinators included: 1) the agency that provided service coordination (N=12); and 2) the agency that provided intervention (N=12). Fifty percent (50%) of the states indicated that service coordination varied not only across communities, but within communities as well. In 18% of the states, the agency providing service coordination varied from locality to locality. Only 22% of the states utilized the same agency in all localities to provide service coordination.

The state Part C coordinators indicated that families were able to select a service coordinator in only 10% of the states (N=5). Two of the options selected by the coordinators demonstrated a partnership between the family and the professionals in the selection of a service coordinator. Forty-seven percent (47%) of the states (N=24) selected one of these two options. One Part C coordinator from a rural state indicated that a majority of the state programs had only one person who served as a service coordinator within a community. Approximately one third of the Part C coordinators (31%) indicated that the selection of the service coordinator was determined locally.

In 18 states, the family can be designated as the service coordinator as long as they work in tandem with a service coordinator employed by an agency. In about one-third of the states (N=17), the family could never be designated as the service coordinator. In 9 states the family was allowed to be the designated service coordinator for its own family; while in 10 states families could serve as coordinators for other families. Sixty-six percent (66%) of the respondents (N=31) reported that families were never paid for performing service coordination duties. The remaining states (N=16) reported that families could be paid if they served as the

service coordinator for another child and his or her family, but would not be paid for acting as their own child's service coordinator.

Part C coordinators were presented with 11 criteria used in regard to the selection of service coordinators using a Likert scale of 1-4 and asked to rate each as 1= never used, 2= seldom used, 3= usually used, or 4= always used. For each criterion, there were some states that never used a particular criterion, while other states indicated that they always used the same criterion. The criterion selected as the most frequently used by the most states was the appointment of the individual who was already serving as a service coordinator for another child in the family. Twenty-three percent (23%) of the Part C coordinators (N=12) indicated that parent choice was always used, while 42% (N=21) indicated that it was usually used as a criterion for the selection of a service coordinator. However, selection of the individual with whom the family was most comfortable was used by almost half of the states. The two criteria selected as used least frequently by Part C coordinators were: 1) family's connection with social services; and 2) family's prior involvement with another agency or provider.

Table 8

Comparison of Criteria Used in Selection of Service Coordinators Across State

Criteria	Mean of Likert Scale 1-4	Standard Deviation
Individual who is already serving as a service coordinator for another child in family.	3.29	.71
Parent choice.	2.84	.90
Geographic proximity to family.	2.80	.84
Caseload of service coordinator/service provider (e.g., who has an opening).	2.71	.82
Individual who has expertise on the child's most prominent needs.	2.67	.80
Individual with whom family is most comfortable.	2.61	.79
Individual who has expertise on the family's most prominent needs.	2.52	.71
Projected amount of time agency and/or provider has with family, including child.	2.35	.95
Projected amount of time agency/provider has with child.	2.33	.98
Prior involvement with an agency/provider.	2.20	.92
Any connection with social services.	1.70	.76

States appeared to be evenly divided among the three choices given to Part C coordinators in regard to whether or not paraprofessionals can be service coordinators. In 18 states, paraprofessionals were not allowed to serve as service coordinators; while in 19 states they were allowed to do so. In the remaining 14 states, paraprofessionals could only serve as a service coordinator in collaboration with another professional.

Parent Training and Information Organizations were used by 90% of the states (N=45) to provide information and support to families. States rarely used PTIs to assist in identifying families to serve as service coordinators. Only 4 states used none of the five options presented on Table 9. In the other category, 4 Part C coordinators indicated that PTIs assisted in training; one coordinator reported that PTIs provided assistance in advocacy for families. Another coordinator indicated that PTIs assisted with interagency collaboration, perhaps as part of a local ICC.

Table 9

Use of Parent Training and Resource Centers

	Frequency	%
As a resource in identifying parents who can provide information and support for families.	45	88%
As a resource in finding parents who can assist in developing materials for families.	30	59%
As a resource in finding parents who can assist in training service coordinator.	23	45%
As a resource in identifying families to participate in monitoring activities.	20	39%
As a resource in finding parents to act as service coordinators.	6	12%
None of the above.	4	8%
Other	7	14%

Policies

The answers to multiple topics frame the answer to the question, What is the nature of states' policies? These topics included: 1) amount of specificity and detail; 2) inclusion of philosophy and desired outcomes of service coordination; 3) the issue of multiple service coordinators; 4) service coordination within interagency agreements; 5) authority of service coordinators; and 6) caseload. Part C coordinators were asked to rate the level of specificity of their state's service coordination policies on a scale of 0= not sure, 1= same amount of specificity as federal policies, 2 = slightly more specific than federal policies, 3= somewhat more specific, or 4= much more specific. In general, thirty-seven percent (37%) to slightly over half (57%) of the Part C coordinators reported that various aspects of their state's policies contained about the same amount of specificity as the federal policies on service coordination. However, approximately one-fourth of the states' (24%) policies were deemed much more specific than federal policies regarding describing how the service coordinator *performed tasks.* Seven (7) Part C coordinators responded that they were not sure about the level of specificity in regard to one of the following: 1) the description of *who* provides service coordination (N=1); 2) description of how the service coordinator *performs tasks* (N=1); and 3) description of *competencies* needed by service coordinators (N=3). Table 10 contains the means of the Part C coordinators' responses regarding of service coordination policy specificity.

Table 10

Amount of Policy Specificity Regarding the Service Coordinator

How do your state's policies compare with the amount of **specificity and detail** contained in the federal policies in the following areas:	Mean	Standard Deviation
Description of who provides service coordination.	1.74	1.10
Number of roles and tasks included.	1.76	1.00
Description of the roles and tasks performed.	1.94	1.08
Description of how service coordinator performs tasks.	2.02	1.07
Description of competencies needed by service coordinators.	2.20	1.36

According to Part C coordinators, over half of the states' policies specified a *stated philosophy* (63%), as well as the *desired outcomes* (57%) of service coordination. However, 59% of the Part C coordinators (N=30) indicated that their states' policies were *silent* in regard to the issue of multiple service coordinators. Twenty-three percent (23%) prohibited the existence of multiple service coordinators. The remaining 9 states (18%) indicated that their policies provided guidance on how the situation of multiple service coordinators should be addressed. Additionally, 71% of the Part C coordinators (N=36) indicated that their states' policies did not address the need for service coordination for multiple children in a family as shown on Table 11. For example, eight (8) coordinators (16%) reported that a Part C service coordinator could serve all eligible Part C children, but only service coordinators from other programs could serve non-eligible Part C children in a family. Three (3) states' policies allowed the Part C service coordinator to serve all children in a family being served by other agencies

that require a service coordinator, whether the children were Part C eligible or not. Only 1 state allowed a service coordinator from another program to serve all the children in a family, including a Part C eligible child. One (1) Part C coordinator selected other and indicated their state's policy allowed local agencies to serve families in a way that best served a family's needs.

Table 11

Policies Related to Service Coordination for Multiple Children in the Family

	Frequency	%
Our state policies do not address this situation.	36	71%
Our state policies allow one Part C service coordinator for all children in the family who are Part C eligible and service coordinators from other programs for non-eligible children.	8	16%
Our state policies allow the Part C service coordinators to serve all children in the family regardless of whether they are Part C eligible or not. (Family had only one service coordinator – someone from Part C.)	3	6%
Our state policies allow the service coordinator from another program to serve all children in the family. (Family has only one service coordinator – someone from another program.)	1	2%
Our state policies allow multiple Part C service coordinators and coordinators from other programs.	0	0%
Other	2	4%

Interagency agreements are one of the primary tools to guide the actions of staff from different agencies. Thirty-five percent (35%) of the state Part C coordinators (N=18) responded that their state policies addressed this issue only in a general way. Interestingly, another 31% of the Coordinators (N=16) indicated that their interagency agreements did not address service coordination across agencies. The combination of these two categories indicated that interagency agreements in nearly two-thirds (66%) of the states provided little or no specificity

to guide staff from various agencies. However, 7 states provided very specific instructions in their interagency agreements regarding service coordination across agencies. Over two-thirds of the states (73%) did not specify the authority of the service coordinator to coordinate services for children and families across agencies. The other responses included: 1) the state interagency agreement does not address this issue, but local interagency agreements often do; 2) the interagency agreement includes the authority to secure services, but not authority over personnel. Ten (10) coordinators (20%) indicated that their states' interagency agreements provided authority for service coordinators over personnel in multiple agencies. Table 12 displays the areas in which service coordinators were given authority as specified in interagency agreements in these 10 states.

Table 12

Types of Authority Contained in Interagency Agreement

	Frequency	%
Amount of service.	4	40%
Types of service.	4	40%
Choice of providers.	4	40%
Termination of service providers if services do not meet standards.	3	30%
Intervention practices used.	2	20%
Other	2	20%

Forty-seven percent (47%) of states' policies specified or suggested the caseload size for service coordinators. Across these 24 states, the suggested caseload was a mean of 38 with a

standard deviation of 17.73. The minimum caseload reported was 9 and the maximum reported was 70. The greatest number of states (N= 4) reported a caseload of 35.

Part C coordinators indicated that in 11 states (22%), Part C service coordinators never supported families receiving TANF to facilitate their transition from welfare to work. The largest number of states (N=34, 68%) reported that service coordinators sometimes supported families receiving TANF. Five (5) Part C coordinators reported that service coordinators always supported families receiving TANF. The coordinators selecting the sometimes and always choices (N=39) were asked to indicate whether this support is included in the IFSP, another indication of the nature of coordination of key services across agencies. Table 13 includes the responses provided by 33 of these 39 Part C coordinators.

Table 13

Inclusion of TANF Support in IFSP (N= 33)

	Frequency	%
A service written on the IFSP.	12	37%
A service independent of IFSP services.	5	15%
Varies from child to child.	5	15%
Varies from one locality to another.	11	33%

Part C coordinators were also asked whether service coordinators provided support to families whose children qualified for Title V, Services for Children with Special Health Care Needs (CSHCN). Respondents indicated a stronger relationship with Title V than with TANF. Fifty-nine percent (59%) of the states selected sometimes and 37% selected always. Only 4% of

the coordinators responded never. Table 14 describes whether the support is included on the IFSP in these 47 states.

Table 14

Inclusion of Title V Support on IFSP (N= 40)

	Frequency	%
A service written on the IFSP.	22	55%
A service independent of IFSP services.	5	12.5%
Varies from child to child.	6	15%
Varies from one locality to another.	7	17.5%

Service Coordination Monitoring at the Local Level

Sixty percent (60%) of state Part C coordinators (N=30) reported that the process, problems, and/or outcomes of service coordination were a major focus of monitoring at the local level (see Table 15). An additional 34% (N= 17) indicated that monitoring of service coordination occurred, but it was not a major focus of monitoring. The remaining 6% (N= 3) reported that service coordination was not addressed in local monitoring.

Part C coordinators were given several options regarding who conducts local monitoring. Table 15 presents the array of entities used to conduct local monitoring. The largest group of states (N= 15, 31%) were reported as using only the state lead agencies to conduct monitoring. It is interesting to note that at the time of the study only 16% of the states included representatives of multiple agencies in monitoring a service (e.g., service coordination) that crossed agencies.

Fifty-two percent (52%) of the states reported that families were included on their monitoring team.

Table 15

Who Monitors Local Service Coordination

	Frequency	%
State lead agency.	15	29%
State lead agency and families.	5	10%
State representatives from multiple agencies.	1	2%
State representatives from multiple agencies and families.	2	4%
State and local representatives from lead agency.	6	12%
State and local representatives from lead agency and families.	7	14%
State and local representatives from multiple agencies.	1	2%
State and local representatives from multiple agencies and families.	12	24%

Evaluation

Fifty-seven percent (57%) of the states (N=29) collected additional evaluation data. The two methods most frequently used to gather data were surveys and interviews. Twenty-three (23) states used surveys with families served by the program. About half that many states administered surveys to service coordinators (N=11), service providers (N=11), and to multiple stakeholders from multiple agencies (N=10). Interviews were most often conducted with service coordinators (N=17), families (N=16), and service providers (N=15). Focus groups were used less frequently but with the same targets as discussed above: families (N=10), service

coordinators (N=9), and service providers (N=8). Outcome measures were rarely used; however, in some states they were used with families (N=4), lead agency stakeholders (N=3), service providers (N=3) as shown on Table 16.

Table 16

Service Coordination Evaluation Methods and Audiences (N= 29)

	Survey	Interviews	Focus Groups	Outcome Measures
Families served by program	23 (82%)	16 (57%)	10 (36%)	4 (14%)
Parent and/or advocacy groups	6 (21%)	5 (18%)	5 (18%)	2 (7%)
Service coordinators	11(39%)	17 (61%)	9 (32%)	2 (7%)
Service providers	11(39%)	15 (54%)	8 (29%)	3 (11%)
Program administrators	6 (21%)	8 (29%)	3 (11%)	2 (7%)
Stakeholders – lead agency	5 (18%)	3 (11%)	2 (7%)	3 (11%)
Stakeholders – multiple agencies	10 (36%)	6 (21%)	3 (11%)	1 (4%)
Community	5 (18%)	4 (14%)	4 (14%)	0 (0)
State ICC	4 (14%)	5 (18%)	2 (7%)	1 (4%)
LICC	5 (18%)	5 (18%)	3 (11%)	1 (4%)

In determining the effectiveness of service coordination for children, coordinators reported using the following: IFSPs (N=35 states), parent report (N=37), and child outcome measures (N=19). States also used the following mechanisms for evaluating service coordination for children: state databases, fee for service claims, focus groups and interviews, and self-study.

Funding Sources Used for Service Coordination

Part C coordinators identified three primary service coordination funding sources used by states: 1) federal Part C funds (80% of the states, N=42); 2) the lead agency (69% of the states, N=37); and 3) third party payers (51% of the states, N=28). Thirty-three percent (33%) identified another state agency as a primary funding source. The state agencies listed most frequently were: Developmental Disabilities and Mental Retardation, and Health. Twenty-one percent (21%) of the coordinators (N=11) selected other when given the opportunity. The other sources listed as primary funding sources for service coordination included: local funds, county funds, Title V, Child Care Block Grant, and HCBF waiver. The greatest number of states (65%) obtained funds for service coordination from a combination of state and federal funds. Very few states (N=4) used non-governmental funds as a substantial funding source. A few states (N=5) listed local or county funding as contributing substantially to service coordination.

Service Delivery Approach

System Entry. Part C coordinators reported 8 different approaches to system entry. The greatest number (N= 13) of coordinators (25%) reported that system entry varied from locality to locality. A similar number of coordinators (N= 12) indicated that system entry was conducted by service providers from the lead agency. In fourteen (14) of the states, system entry was performed by a separate agency, program, or entity as described on Table 17.

Table 17

Responsibility for System Entry

	Frequency	%
Varies from locality to locality.	13	25%
Service providers from the lead agency.	12	24%
Lead agency contracts with a variety of entities across the state to perform intake or system entry tasks only.	9	18%
Lead agency contracts with private providers to conduct intake, as well as service delivery.	7	14%
Lead agency contracts with a separate entity, which is consistent across the state, to perform the intake function.	5	10%
One of the other public agencies, other than the lead agency, performs intake.	2	4%
An interagency team performs all of the system entry of intake functions.	2	4%
Other	1	2%

The two most frequently selected approaches to the provision of developmental intervention and therapies were the use of private programs (N=22) and use of multiple agencies (N=24). The use of regional programs, either to provide services directly (N=16) or to contract with local programs or providers (N=20), was used by a significant proportion (70%) of the states. (See Table 18.)

Table 18

Provision of Therapies and Developmental Intervention

	Frequency	%
Multiple agencies have responsibility for providing developmental intervention and therapies.	24	47%
Private programs.	22	43%
State contracts with regional programs and they, in turn, contract with local programs and/or individual providers.	20	39%
Programs under the direct authority of the lead agency.	13	25%
State contracts with regional programs and they provide direct services.	16	31%
State employs individuals for service provision directly.	6	12%
Other	2	4%

Coordinated Service Delivery. Part C coordinators selected from six options describing the amount of coordination in their service system: very little (#1) to an integrated collaborative service system (#6) as described in Table 19. These categories were previously described by Harbin and West (1998). Thirty percent of the states (N=15) fell into one of the three most collaborative models. Of these 15 states, the greatest number of states (N=10) used model #4, as opposed to the more collaborative models #5 (N=4) and #6 (N=1).

Table 19

General Approaches to Coordinated Service Delivery

	Frequency	%
1. The lead agency provides the bulk of the early intervention services; thus, there is little coordination needed with other agencies	2	4%
2. Although the lead agency makes most of the decisions about the design and functioning of the system, several agencies exchange information about each agency's efforts and initiatives; the agencies have begun to coordinate some of their activities, such as child find.	15	30%
3. There is a core of agencies and/or programs providing services that are cooperating to ensure continuity across programs in how developmental intervention is provided. Although other agencies may attend meetings, the focus is on the developmental intervention of young children with disabilities.	18	36%
4. The lead agency provides leadership to a variety of health, social, and education agencies that contribute fairly equally to decisions regarding the design and implementation of a service system that meets an array of child needs and potentially family needs as well. This group of agencies is also attempting to actively integrate the system of services for young children with disabilities with the system of services for children at risk of adverse outcomes.	10	20%
5. A strong and cooperative LICC provides the leadership and the vehicle for a wide variety of health, social welfare, mental health, job training and education participants to collectively contribute equally to decisions. Public and private providers and agencies work as closely as if they were part of a single program. Many or most intervention activities are cooperative endeavors. The focus of the system is on meeting the diverse needs of children with and at risk for disabilities, as well as the diverse needs of their families. Some initiatives of the LICC focus on improving the well–being of all children in the community.	4	8%
6. The LICC (or other interagency/inter-sector community group) is prominent in the design of a comprehensive system to meet the needs of all young children and their families within the community. This initiative focuses on the entire development of the children and the support of their families. The individual agencies are seen as secondary and the LICC is viewed as primary in importance in decision–making.	1	2%

Summary

As a linchpin of service delivery, it is imperative that we gain a better understanding of the states' approaches to and policies to support service coordination across the country. State Part C coordinators' responses to a set of 33 survey questions provide the following major findings:

- Service coordination models were reported to be working somewhat to slightly more than somewhat (mean of 4.8 on a 7 point scale).
- Seventeen (17) states were considering changing their service coordination model.
- All key stakeholders possessed positive values that would facilitate effective service coordination, and, in general, the values appeared to be similar. However, the level of strength, or the degree to which these positive values were held, was often reported to be less than optimal.
- There was a lack of specificity in lead agencies' policies regarding the description of aspects of the service coordination role.
- Interagency agreements also lacked specificity and failed to address key issues such as the use of multiple service coordinators.
- Interagency agreements often failed to provide sufficient authority for service coordinators to coordinate services across agencies.
- There was variability within some states on many components of their service coordination model. Several states allowed localities to make these policy decisions.
- IFSPs often failed to include supports and services provided by TANF. Service coordinators were often not providing support to families receiving TANF to facilitate their transition from welfare to work.

- Although states had a stronger relationship with Title V, Children with Special Health Needs, not all states' service coordinators provided support to children eligible for this program, nor was it always included in the IFSP.
- Only 25 states specified the caseload a service coordinator could have, which ranges from 9 to 70, with a mean of 38.
- On a continuum of coordinated service delivery ranging from 1=very little coordination to 6=a highly collaborative system for all young children and their families, the majority of states (N=35) were using one of the 3 models on the lower end of the continuum (level 1, 2, or 3).

Discussion and Implications

Part C of IDEA is intended to improve the conditions of infants and toddlers with disabilities, as well as their families, by reforming a fragmented and limited service system. The requirement of service coordination for individual children and their families is seen by many as one of the most important tools included in the legislation to accomplish this reform. The use of federal and state policies as vehicles to modify and reform the delivery of services has historically encountered many challenges, including: (a) lack of shared values and vision; (b) professional resistance and the lack of desired skills; (c) the lack of policy and system models to guide in the adequate implementation of federal and state policies; and (d) the lack of sufficient leadership to envision and build a comprehensive, coordinated system. The two linchpins of family centeredness and collaboration need to permeate or be incorporated into the factors above.

Values. The importance of strong values that view service coordination as essential seems critical to establishing a climate that is conducive to collaboration and service

coordination. As reported by the Part C coordinators, most states possess this value, but not as strongly as is needed for optimum implementation. In addition, the literature also discusses the importance of a shared vision among key stakeholders. Once again, there appears to be a modest level of shared values among stakeholders across the states. Clearly, more work needs to occur at the state level, in order to establish the level of shared values necessary to guide an adequate approach to service coordination. However, in most states, policy makers can build upon the existing positive values.

Infrastructure. An adequate infrastructure to support effective service coordination must contain several elements that are thoughtfully designed. Among these are policy specificity leading to continuity in implementation; adequate authority for service coordinators to perform their tasks and responsibilities; and a multi-agency organizational design that facilitates service coordination at the system and direct-service level.

Results of this survey indicated that state policies lack specificity in many critical aspects of service coordination. In addition, state policy in many states allows major approaches to, and policy decisions about, service coordination to be determined at the local level. The federal government elected to let the states make these decisions, and now many states are electing to let the localities make the critical decisions. While this satisfies the desire of many localities for autonomy, it certainly also raises the policy issue of equity. In addition, the lack of policy specificity has been linked to inadequate implementation. Perhaps this is one of the reasons service coordination is working only moderately well in so many states.

According to the results of this survey, interagency agreements seemed to contain even less specificity than the lead agencies' policies. The lack of clearly specified agreements among agencies regarding service coordination seems like a substantial barrier to adequate

implementation. The lack of authority accorded to service coordinators would seem to make it extremely difficult, if not impossible, for them to perform the responsibilities required of them by law.

In essence, the IFSP becomes the interagency/ inter-provider agreement at the direct service level. The intent of the legislation is for children and families to have all services coordinated into a cohesive whole. Based upon study results, it seems that states are not always integrating and coordinating all of the needed services for children and their families. It appears that states are doing a better job at coordinating services to meet the health care needs of children than they are at coordinating welfare services. Perhaps this is a reflection of the fact that the lead agency in some states is the Health Department. There is considerable progress needed in many states to make sure the services and supports from other agencies needed by a child and their family are included on the IFSP. This is important, since the IFSP guides service delivery to individual children and their families.

The organizational structure for service delivery can facilitate or impede a service coordinators' ability to coordinate services across agencies. According to survey results, many states have developed an organizational framework that is both limited in the breadth of services it includes and in the amount of coordination that is used. These organizational limitations could easily be linked to the lack of coordination with both TANF and Title V, Children with Special Health Needs.

Leadership. The role of leadership is an important ingredient in the successful development of a service delivery model (which includes service coordination) at both state and local levels (Harbin et al., 2000). It is possible that Part C coordinators and other stakeholders in leadership roles need additional information in order to improve their states' policies and

infrastructure, in addition to providing leadership in developing shared values. Part C coordinators would benefit from adequate state models and technical assistance that address all elements needed to establish an adequate infrastructure for service coordination.

Conclusion

Part C of IDEA created dreams and expectations that children and families would no longer be subjected to fragmented service delivery, nor would the burden fall to families to search out and locate relevant and available services to meet their children's needs. The results of this survey indicate that we may have made progress in coordinating services for individual children and families. We have made little progress, however, in developing an adequate infrastructure to guide service coordination. More progress is needed before the original dreams inherent in IDEA are met and families are no longer frustrated and burdened by fragmented and inadequate services.

References

Harbin, G. L., McWilliam, R. A., & Gallagher, J. J. (2000). Services for young children with disabilities and their families. In J. P. Shonkoff & J. P. Meisels (Eds.), Handbook of early childhood intervention. New York: Cambridge University Press.

Harbin, G. L., & West, T. (1998). Early intervention service delivery models and their impact on children and families. Chapel Hill, NC: Early Childhood Research Institute on Service Utilization, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.