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ABSTRACT

This study evaluated costs associated with implementation of Individualized Family Service Plans (IFSP) for infants and young children with disabilities at four California sites. Specifically the study examined: (1) IFSP and existing service planning process costs in time and dollars; (2) the impact of IFSP processes on agencies and families; and (3) the strategies found to be most effective in implementing IFSP processes. Data on a total of 126 children and 170 completed service planning and coordination phases were evaluated. Findings included: participants at all sites had positive attitudes toward the IFSP process; IFSP processes appeared to result in cost savings when children were dually served by multiple agencies but added costs for children eligible only for regional center services; families reported benefits from reduced paperwork, increased access to information about community resources, parent mentor assistance and support, and the aid of a service coordinator; agency staff reported benefits associated with coordination of paperwork across agencies and increased involvement of parents; and there was no evidence that the IFSP process results in increased services. Five tables provide details of the study findings. (DB)

A Study of Individualized Family Service Planning in California: Benefits and Costs.

Deborah L. Montgomery, Ruth E. Cook, Thomas B. Parrish, And Jay G. Chambers

Results of study of the Individualized Family Service Planning (IFSP) in California show multiple short-term benefits for agencies and families, with potential cost and time savings from multiagency planning.

A STUDY OF INDIVIDUALIZED FAMILY SERVICE PLANNING IN CALIFORNIA: Benefits and Costs

by Deborah L. Montgomery, Ruth E. Cook, Thomas B. Parrish & Jay G. Chambers

Introduction

In October 1986, Part H of the Education of the Handicapped Act Amendments to Public Law 99-457, was signed into law. Part H authorized the federal Department of Education to grant money to states for planning, developing, and implementing a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families. The Individualized Family Service Plan (IFSP) is the vehicle specified in P.L. 99-457, now entitled P.L. 102-119, the Individuals with Disabilities Education Act, for implementing these child and family services. Although the components of the IFSP are specified by P.L. 102-119, and accompanying regulations, there is considerable flexibility in the way in which the IFSP process may be organized and implemented.

The provision of an IFSP represents a potential major commitment of time and resources. It is the counterpart to the current processes of intake, assessment, evaluation, program planning, and monitoring that have been carried out in one form or another by various public agencies providing early intervention services, e.g., the Individualized Education Plan (IEP) from education and the Individual Program Plan (IPP) from regional centers' of the California Department of Developmental Services. The requirements for an IFSP are similar, but more detailed than those for an IEP or IPP. For example, IPPs do not require an assessment and statement of the family's resources, concerns, and priorities, nor do they require a multidisciplinary team assessment of the child; as do IFSPs. IFSPs must also contain a statement of the steps to be taken to support the transition of the toddler at age three, if appropriate, unlike the IEP. The IFSP process is also unique in that it is to be family—as opposed to child-centered. The law addresses the needs of the families of eligible children as they relate to the developmental needs of the child.

In addition to an increased family focus, the IFSP requirement entails a shorter timeline for evaluation and development of the service plan, an increased level of interagency collaboration and cooperation, a single overriding planning document and the assignment of a service coordinator who is responsible for coordinating all services across agency lines and who is the single point of contact in helping parents to obtain the services and assistance they need. These factors represent potential benefits to children with disabilities and their families to the extent that more immediate access to services and reduced duplication of effort accessing services from multiple agencies is enabled.

California's lead agency, the Department of Developmental Services, contracted with the American Institutes for Research (AIR) of Palo Alto to conduct a multi-site study to examine the impacts of implementing Individualized Family Service Plan processes within the state of California. The study project was envisioned to serve three primary purposes: (a) to provide improved estimates of the fiscal and programmatic costs and effects of implementation of the IFSP requirement of Part H relative to those of existing planning processes; (b) to identify the benefits of the IFSP process for families and agencies; and (c) to summarize other key findings regarding the implementation of efficient procedures for carrying out the IFSP requirement in the local planning areas.

The purpose of this article is to report on the major findings of the California Individualized Family Service Plan Study. The article begins with a brief description of the process for developing an IFSP document and monitoring its implementation. The study design and methodology section follows. Implementation of IFSP processes at the four pilot sites, with specific mention of some of the common challenges they shared, is then discussed. Qualitative and quantitative findings are presented, followed by implementation recommendations from participating parents and professionals, and a summary.

The Individualized Family Service Plan Process and Document

The Individualized Family Service Plan process represents major changes for families and professionals. The requirement of an IFSP for each child from birth through age two and his/her family acknowledges the importance of the family as a significant part of the early intervention implementation process. While parent involvement has been encouraged in previous agency planning processes, planning has traditionally focused exclusively or primarily on the developmental needs of the child. A family's involvement has been related more to their rights of notification and consent for their child's evaluations and services. The focus of the IFSP, on the other hand, is on evaluating the child and providing services within the context of his or her family's resources, priorities, and concerns related to enhancing the development of the child.[2] Services are to be coordinated across agencies, as appropriate, with families and professionals working in partnership with one another. Professionals are asked to focus on how the societal system will meet the family's needs in order to promote ultimate child, parent and family functioning.[3]

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Although the IFSP document serves as the legal contract between the family and the service agencies, the process required for its development is considered to be an equally, if not more important feature of the new law. Service providers are expected to form a partnership with the family built on trust and respect that becomes a viable part of each child's plan throughout the critical first few years of the child's life. The IFSP process is intended to support the natural caregiving role of families. The process for developing an IFSP consists of the gathering, sharing, and exchange of information between families and staff to enable families to make informed choices about the early intervention services they want for their children and themselves.[4]

The IFSP document is the written plan that provides the blueprint for service delivery and specifies the anticipated outcomes of these services for each child and family unit. For a child who has been evaluated for the first time and determined to be eligible, the IFSP must be completed within 45 calendar days (or longer, if in keeping with the family's desired pacing) after referral to the appropriate agency. The written IFSP must contain all of the necessary components as stipulated in the law: a description of the child's status in five developmental areas; family information including their resources, priorities and concerns; expected outcomes; the name of the service coordinator; the early intervention and other services to be provided; a plan for transition if appropriate; and the dates and duration of all services.

The IFSP is a single, overriding service plan document that in California is intended to replace the IEP from education agencies and the IPP from regional centers. The IFSP document can be changed or amended as a result of required evaluations every six months, or more frequently, if appropriate. It serves as the written contract between families and the agencies providing early intervention services during the period from birth to age three, or until the beginning of the following school year.[5]

Study Design and Methodology

The study was designed around the three objectives mentioned previously: a comparison of IFSP and existing service planning process costs in time and dollars, the impact of IFSP processes on agencies and families, and an examination of the strategies found to be most effective for implementation of IFSP processes. Pilot site selection criteria included the degree to which the site contributed to a balance of urban and rural communities and geographic distribution within the state, cultural diversity, and the extent to which the community was prepared for immediate implementation of single and multiagency IFSP processes. Support from local education agencies, regional centers, family resource centers, and a variety of other agencies providing early intervention services, was essential.

The four sites selected to participate in the study were Fresno, Merced, Orange and Santa Clara counties. As a group, these communities represent a balance of rural and urban settings and are all culturally diverse. Fresno County is primarily rural, although the city of Fresno is a metropolitan area with a population of approximately 350,000. Merced County is also primarily rural, but more sparsely populated over a geographically large area. Merced and Fresno are located in the valley of central California. Orange County, located in southern California, is primarily urban. It is the second most populous county in California with approximately two and one half million people and growing. Santa Clara County, including the city and surrounding areas of San Jose, is also primarily urban and is located in northern California approximately thirty miles south of San Francisco. Both Orange and Santa Clara counties reflect the rapidly growing ethnic diversity of much of present day California.

Each of the pilot sites assigned a site liaison to serve as the pivotal link between AIR and the participating agencies. A local working group comprised of the site liaison, representatives of participating community agencies, and parents, was assembled at each site to meet with AIR staff approximately seven times over the course of the study. This group coordinated training on data collection instruments, provided ongoing local facilitation and assessment of the project, and served as a point of contact between the agencies and AIR.

Qualitative and quantitative data were collected over an eight month period for families and agencies experiencing pilot IFSP processes, and for those undergoing the "control" or existing individual service planning procedures, IEP or IPP processes. Qualitative data collection methods involved structured surveys, pre- and post-implementation (of pilot IFSP processes for the study) telephone interviews with agency representatives, parent focus groups, and ongoing observation and communication during the regularly scheduled meetings with participating personnel at each pilot site.

Structured interviews were conducted at the beginning of the data collection period by telephone, with a total of 36 local agency representatives from the four study sites. At least one staff person from each of the participating agencies at the four study sites was asked to respond to five short-answer survey and six open-ended questions during interviews varying in length from 20 to 75 minutes. An attempt was made to interview at least one person from each participating agency who was familiar with Part H regulations. Persons with some degree of authority within the agency were sought, as well as persons with experience working directly with families. Follow-up interviews were held by telephone with each of the agency respondents directly following the data collection period.

Parent focus groups were organized for consenting parents. In addition, we contacted parents by telephone or in writing. Overall, one or more parents of each of 41 children provided feedback.

As the study was of limited duration, it was not possible to document a single child and family from initial intake through transition at age three. The methodology of data collection by phase of service was adopted to enable the largest breadth of data over a short period of time. The service planning timeline was divided into four phases to capture the complete range of activities from initial intake through transition. A description of the planning and coordination activities comprising each of the four phases documented for this study follows. These phases served as the unit of analysis from which costs were derived, aggregated and compared for the pilot and control groups. The cost and time analyses reflect time log data from 170 completed phases of service planning and coordination.

Phase I: Initial Contact—Service Plan Document. Phase I included the period from the initial referral for early intervention services to the completion of the service plan document. There were three major components for this phase: initial intake of child and family information, child/family assessment, and development of the written service plan. Phase I began at the time of an agency's initial contact with the family, either by telephone, mail, or in person. All activities related to the development of a service plan, including initial screenings for eligibility, child/family assessments, caregiver interviews, collection and review of records, consultation with professionals and the family, and the actual meeting with family members and appropriate professionals to write the service plan were included in Phase I. Phase I was considered complete when the service plan document was written and ready for implementation.

Phase II: Follow-up and Coordination. Activities in this phase included the initial setup of services, and ongoing coordination and monitoring by the case manager or service coordinator, with family input. Phase II ended when plans were being made for the more formal periodic evaluation of the service plan, which marked the beginning of Phase III.

Phase III: Periodic Evaluation. Caregiver interviews and other activities related to the required assessment of progress toward achieving the outcomes specified in the service plan document were recorded in this phase. Phase III included formal and

informal observation and assessment of child and family needs, solicitation of family input, test administration, report preparation, review of assessment results by professionals and with families, and a meeting with the family for revising and updating the service plan, as appropriate. Phase III ended when all paperwork related to the periodic evaluation was completed.

Phase IV: Transition. Phase IV included activities related to planning and executing transitions from one service agency to another. It began with initial discussions with parents regarding the child's future placements and planning for procedures to ease the child's adjustment to changes in service delivery. Activities included conferences with the family, service coordinator, and the exiting and entering service providers to review the child's program options and to develop a transition plan to set up the new services. After transition occurred, follow-up of the child's participation in and family satisfaction with the new service or program took place by phone or in person. Phase IV ended after transition and follow-up were completed, approximately two weeks after placement into the new service or program.

Staff from participating agencies at each site were instructed to randomly assign children to pilot and control groups. They were also asked to aim to balance the characteristics of pilot and control cases for each phase, in terms of the complexity and variety of conditions of the children. Pilot group children and families received IFSP service planning and control group children and families received either IEP, IPP, or both IEP and IPP service planning.

The distribution of children in the sample was evaluated periodically to determine the extent to which pilot and control groups were balanced by phase and child conditions. In some cases, staff were instructed to recruit families for particular phases or for particular child characteristics to achieve a greater balance between the pilot and control samples.

Case managers or service coordinators were responsible for collecting study information for all of the participants involved in at least one complete phase of service planning and coordination for each child and family in the study. Three basic forms were used for data collection:

(1) The **Time Log** form was used to track the time of all participants involved in service planning and coordination for each phase. It included a listing of participants' job title and agency affiliation, the date, time, description and style (telephone call, meeting, documentation, etc.) of family and professional contacts and activities, and the time spent by all participants traveling to and from meetings or other appointments. All clerical or support time related to any of the activities was also logged. Space was provided to elaborate on the nature of each activity listed, if appropriate. The time spent by children or families while actually attending programs or receiving services was not included on the time logs.

(2) The **Child and Family Information** form provided data on child conditions, agency involvement and family background.

(3) The **List of Services** form was completed for each child and included the intensity, location, style, duration, and funding source for each service listed on the service plan document.

Description of the sample

Table 1 lists the conditions of the 126 children in the sample. Classification of child conditions is based on regional center and education eligibility criteria. The sections of the table labeled "Disability Category" and "Biological or Environmental Risk Conditions" are criteria used by regional centers, and the sections labeled "Disabling Conditions" and "Need for Intensive Services" are criteria used by education agencies. The frequencies given represent the number of cases present in the entire sample. Percentages refer to the portion of the IEP, IPP, and IFSP sample of children with the diagnosed condition. In general, the sample is balanced with respect to pilot and control groups with the listed conditions. There are somewhat higher percentages of children in the pilot (IFSP) group with evidence of delay in one or more developmental areas, and with disabling conditions requiring the need for intensive services. This is corroborated by site-level staff reports that more children with somewhat more complex needs were being placed in the pilot group than in the control group, despite deliberate efforts to balance the sample.

The sample is racially and ethnically diverse, with 45% White, 37% Hispanic, 8% Asian, and 4% Black. For seventy-four percent of the families, English is the primary language spoken in the home. Translation services were needed by 26% of the families for whom information was given. Case coordinators reported that there was at least one parent with reading literacy in seventy-two percent of the families. Overall, the families had lower average incomes than those reported by the state for the 1990 census.

IFSP Implementation

The specifics of IFSP process implementation were unique to each community. However, all communities were expected to develop processes that met the requirements of the law, and were family-centered and collaborative both at the family-professional and interagency levels.

Implementation of IFSP processes presented participating agencies at each of the sites with both common and unique challenges. Familiarity with new regulations and acceptance of the philosophical perspective they represented were both imperative. Although several years of Local Planning Area (LPA) activities had begun to set the stage for implementing new procedures, actual community-wide operationalization of IFSP processes required a thorough understanding of the new law

Table 1. Total Number of Children in Sample with Listed Conditions and Percentage of IFSP, IEP and IPP Groups With Listed Conditions

	Total	% IFSP	% IEP	% IPP
Disability category				
Cerebral Palsy	13	14.8 %	3.3%	7.9%
Autism	1	1.6%	0%	0%
Epilepsy	9	6.6%	3.3%	10.5%
Mental Retardation	41	29.5%	53.3%	26.3%
Other	42	36.1%	26.7%	34.2%
Biological or Environmental Risk Conditions[1]				
1. Medical Factors				
Prematurity (<32 weeks)	22	13.1%	6.7%	28.9%
Very low birthweight (<1500 grams)	25	18.0%	6.7%	28.9%
Significantly small for gestational age	7	9.8%	0%	2.6%
Failure to thrive	14	9.8%	16.7%	10.5%
Metabolic problem	3	1.6%	0%	5.3%
Hyperbilirubinemia	1	1.6%	0%	0%
Seizure activity during 1st week of life*	7	4.9%	3.3%	5.3%
Serious biomedical insult	4	4.9%	0%	2.6%
Multiple congenital anomalies requiring specialized services	14	11.5%	10%	10.5%
History of maternal chemical exposure	2	3.3%	0%	0%
Other	12	11.5%	6.7%	7.9%
2. Clinical Factors				
Infant born to a developmentally disabled parent	1	1.6%	0%	0%

(continued)

Table 1. Total Number of Children in Sample with Listed Conditions and Percentage of IFSP, IEP and IPP Groups With Listed Conditions (continued)

	Total	% IFSP	% IEP	% IPP
Persistent tonal problems	42	36.1%	30%	34.2%
Evidence of delay in one or more developmental areas	94	82.0%	70%	68.4%
Disabling Conditions[2]				
Hearing impairment	6	6.6%	3.3%	5.3%
Visual impairment	17	18.0%	6.7%	15.8%
Language or speech disorder	38	34.4%	33.3%	23.7%
Severe orthopedic impairment	11	9.8%	10%	5.3%
Limited strength, vitality or alertness due to chronic or acute health problems	19	23%	13.3%	0%
Autistic-like behaviors	3	4.9%	0%	0%
Significantly below average general intellectual functioning existing with deficits in adaptive behavior	34	26.2%	33.3%	28.9%
Serious emotional disturbance	3	3.3%	3.3%	0%
Need for intensive services:[2]				
1. Child functioning at or below 50% of his or her chronological age level in one of the skill areas listed below, or between 51% and 75% of his or her chronological age level in any two of the five skill areas below.				
A. gross or fine motor development				
B. receptive or expressive language development				
C. social or emotional development				
E. cognitive development				
F. visual development	80	73.8%	50%	57.9%
2. Child has a disabling medical condition or congenital syndrome which the Individual Education Program Team or IFSP team has determined to have a high predictability of requiring intensive special education and services	50	59%	16%	25%

[1] From California Regional Center Prevention Service Guidelines, RC088-17, 1988

[2] From Education Code eligibility criteria

and training for agency management and all involved staff. Each local interagency work group had to reexamine existing practices, collaborate and reach consensus on an appropriate community framework for IFSP process implementation, design a new planning document, and develop plans for adhering to a shorter timeline (45 days) for completion of the document.

Staff from one of the sites described the most challenging component of implementation as the "philosophical bath" that was necessary for the whole community to be immersed in the spirit and intent of the new law. Thinking about the birth through age two population in a "fresh" way, centered within the family, and dependent on the family's concerns, priorities, and resources, was seen as paramount to effective implementation. Respect for family choice and pacing, peer parent support, and parent/professional collaboration were repeated themes that guided teams of agency representatives as they mapped out new frameworks for pilot implementation within each community.

As there were no specific IFSP process models that could be directly implemented at any pilot site, each community experienced trial and error as they progressed. The four sites regarded implementation of IFSP processes as an evolutionary process. IFSP procedures were implemented and continually refined as experience was gained.

Qualitative Findings

Qualitative outcomes that were examined included the benefits and burdens for agency staff and family members, as well as the ways in which gaps and duplication in services were impacted by IFSP process implementation. Site level surveys, pre- and post-pilot implementation staff interviews, parent focus groups, and formal and informal site visits provided opportunities to listen, probe, and begin to understand the richness and range of experiences pilot site personnel had with IFSP processes.

Repeatedly, resounding commitments to family-centered service delivery were expressed. Apprehension about the quantity of planning time required seemed to dissolve as tangible results were met with high degrees of satisfaction both among agency staff and family members. Staff with cautious reservations at the outset appeared to be swayed by the multiple benefits they perceived for families and agencies as a result of new procedures. Ninety-one percent of the interviewed agency staff described their community's experience with IFSP implementation as "positive" or "very positive."

Agency representatives were also overwhelmingly positive about the potential of IFSP processes to coordinate services across agencies and to address wholistically the capacity of families to support the development of their infant or toddler with special needs. Reducing paperwork, duplication of services, and the general burden on families were considered worthwhile goals of IFSP implementation. Increased awareness of available community resources and of the nature of other agencies' involvement with families was also perceived as beneficial to effective service delivery.

Experiences with mentor parent involvement encouraged agencies to take on more of a family-focused orientation. To some agency personnel, parent participation was first seen as somewhat threatening. However, by the end of the pilot period, many staff expressed the desirability of involving parents in plans for future IFSP process implementation.

Implementation strategies and effects

Table 2 provides a summary of what were mentioned as the most useful strategies for developing policy and procedures for IFSP implementation. Responses were given after the pilot period had ended. Forty-five percent found that a family focus and the involvement of parents had been key, and that an active and ongoing interagency group for planning IFSP procedures had accelerated their progress. Providing opportunities for staff at all levels to be involved in training and planning was mentioned as important by slightly more than one-fourth of the respondents.

Table 3 shows the reported major effects on agencies of pilot IFSP implementation. More than half of the respondents spoke about increased interaction with other agencies, and close to one-third mentioned the extra staff time that this involved. About one-quarter of the respondents stated their

Table 2. Most Useful Strategies for Developing Policy and Procedures to Implement Family-centered IFSP Processes, Reported after Pilot Site IFSP Implementation (n=31)*

Strategy	Percent of Respondents Reporting Strategy
Focusing on family needs, and involving parents in community planning	45%
Establishing an interagency group that remained active in planning for implementation	45%
Providing opportunities for staff involvement in training and planning	26%

* Percentage reflects duplicated count.

agency had increased their focus on families, and about one-fifth described a perceived decrease in duplication of services. Another one-fifth perceived no major impacts to their agency. IFSP processes were viewed as an extension of the agency's existing practices. Thirteen percent mentioned that IFSP process implementation had increased staff awareness and understanding of the requirements and implications of the new law.

Table 3. Major Effects on Agencies of Pilot IFSP Process Implementation, Reported by Agency Representatives (n=31)*

Effect	Percent of Respondents Reporting Effect
Increased interaction with other agencies	52%
Involved extra staff time	32%
Increased focus on families	26%
Decreased duplication in services	19%
No major impact—IFSP processes were seen as an extension of what the agency was already doing	19%
Increased awareness and understanding of the implications of the new law	13%

* Percentage reflects duplicated count.

Both formal and informal interviews held with agency representatives enthusiastically and repeatedly brought forth two themes. IFSP processes had the effects of increased and more effective interagency coordination, and a greater focus on family concerns. Generally, staff reported benefits associated with learning about other agencies' staff, programs, and resources. In particular, respondents said that interagency communication increased their ability to effectively assist families while decreasing duplication in services. As a result, service delivery improved, and it was felt that fewer children "fell through the cracks." Most of the respondents felt that the initial expenditure of any added time or energy was offset by benefits to families and to agencies, and that overall, time and energy were saved. Several respondents also mentioned that feedback they had received from parents had been very positive. Parents appreciated offers to be matched with parent mentors, and felt as if their concerns were being heard and addressed.

The drawback was that IFSP processes were initially time consuming to develop and implement. This was compounded by heavy caseloads and decreased budgets. Further, in some areas there were difficulties scheduling interagency meetings. However, as the projects progressed, new channels for exchange of information promoted a greater awareness of the services provided by other agencies and of potential service barriers. Although the process required some scheduling adjustments and coordination to achieve interagency participation, the result was increased effectiveness. Streamlining paperwork within and across agencies, coordinating assessments, and sharing medical records were cited as steps expected to reduce future burdens for both agencies and families.

Importance of partnerships with parents

The second theme regarding the implementation of IFSP processes was that through partnership with parents, there was a greater focus on family concerns. Agencies felt that this partnership increased their ability to best serve the child. A number of respondents mentioned the need, however, to educate parents about their role prior to the IFSP meeting. Generally, the family focus of IFSP processes was seen as a validation of the "best practice" model of service delivery most agencies already strive to provide. Some staff felt that the requirement to e' it a family's concerns, priorities and resources caused them to listen more carefully and to address the family's expressed needs. Indeed, family interviews indicated that families felt they were being heard to a greater extent than in the past.

One parent in the IFSP group who had experienced a previous IEP put it this way, "When comparing an IFSP to an IEP, I like the IFSP better because it was concerned with our whole family." A parent mentor enthusiastically stated, "I loved doing IFSPs and talking to parents. It was very positive for me and for them. Families went into the process knowing more about what was going on and feeling more self-assured and empowered. I just love the promise of this whole program." Another parent said of the IFSP, "It seems like they covered everything. I appreciate it! They even discussed our financial and emotional needs."

Families were generally satisfied with the services that had been provided, and many expressed their appreciation for whatever services they were getting. Parents expressed their desire to learn as much as they could about the early intervention system and available services as soon as possible after their eligibility was determined.

Parent mentor assistance meant families were better informed throughout the process, and professional time to explain forms and procedures was reduced. Parents who had been involved with parent support groups tended to express more satisfaction than those who had not been linked up with such support. Parent support groups or parent mentors were described as "very helpful—a lifesaver," as "a help to the whole family," as "focusing on feelings allowing you to get things off your chest," and as "very helpful in providing seminars and get togethers." Even those who did not choose to use support services said that they felt comfort in having a telephone number and knowing they could seek such support at any time.

Individualized service coordination was appreciated by parents who had service coordinators or case managers who were particularly knowledgeable about community resources. Those parents who had service coordinators or understood the concept readily verified the need for service coordination. A parent described her service coordinator as "really taking care of things, all agencies got all copies, information was clear and services were streamlined." Another said, "At the beginning, everything was a blur. A lot of people were calling. It would have been nice if just one person had been in charge and had coordinated the other callers."

Personal, face-to-face interactions with service providers were preferred by parents. Home visits were appreciated. Preparation of families and children for transitions to new services was seen as a way to alleviate much of the stress around changing services, particularly when transitions occurred at 18 and 36 months to education agencies.

The importance of parent choice and family pacing was repeated by parents and service providers. As one parent stated, "We must all remember that we are dealing with sensitive families at a crucial time in their lives when there is lots of hurt, anger, loss, and grief. Therefore we must respect each and every one of the persons we come in contact with and allow them to lead us where they want to go and assist them in getting there as fast or as slow as they are ready to move forward."

Quantitative Findings

Quantitative analyses were designed to address one of the three major objectives of the study: to estimate the costs, in time and dollars, of implementing IFSP service planning processes in comparison with previously existing IEP and IPP processes. Time log data were collected for 170 completed phases of service planning and coordination for a total of 126 families. Families were randomly assigned to pilot and control groups, although certain families were recruited to participate in the study to achieve a balance of child conditions across the four phases of service planning. Estimates of service planning and coordination costs per child were derived by combining time data with

Table 4. Mean Estimated Costs of IEP, IPP and IFSP Service Planning Processes Per Child, Age 6 to 36 Months (Excluding travel time)

	Phase 1	Phase 2	Phase 3	Phase 4	Total Estimated Cost
A. IEP Mean Costs					
Cost per child	$465	$176	$244	$315	
(sample size)	(12)	(3)	(3)	(15)	
Weighted frequency during ages 6–36 months	1	3	2	1	
Total estimated cost during ages 6–36 months	$465	$528	$488	$315	**$1,796**
B. IPP Mean Costs					
Cost per child	$222	$ 82	$ 78	$119	
(sample size)	(21)	(12)	(15)	(3)	
Weighted frequency during ages 6–36 months	1	3	4	1	
Total estimated cost during ages 6–36 months	$222	$246	$312	$119	**$ 899**
C. IFSP Mean Costs (Excluding start–up time)					
Cost per child	$296	$90	$136	$466	
(sample size)	(42)	(18)	(18)	(8)	
Weighted frequency during ages 6–36 months	1	3	4	1	
Total estimated cost during ages 6–36 months	$296	$270	$544	$466	**$1,576**

hourly salary and benefit rates for all clerical and professional personnel listed as participants on the time logs.

Costs

Due to the fact that the data collection period was limited to eight months, no single child in the study could be tracked through all four phases of service. In order to derive a single point of cost comparison for the three service delivery processes, a procedure was developed for combining the cost data from all four phases for each type of service planning process. For this purpose, cost estimates were calculated using a standardized service delivery period covering the time from initial referral at the age of six months through transition at age three. The expected frequency of occurrence and weights for each phase over this thirty month period are based on the requirements of the law and on established practice of education agencies and regional centers. Cost estimates reported here exclude the marginal cost of travel time, which was found to vary by site and population density. Also, as IFSP processes were being newly implemented at the pilot sites, data from IFSP process implementation reflected some "start-up" procedures that occurred as a result of the learning curve associated with early implementation efforts. Time and personnel directly attributable to "start-up" factors, as identified by study participants, were excluded from the estimates of IFSP process costs reported here.

Table 4 incorporates the weighted frequency for each phase of service delivery during the 30 month period from age six to thirty-six months and illustrates the total estimated cost for IEP, IPP and IFSP service planning processes.

The mean estimated cost per child of IFSP service planning over the 30 month period is $1,576. For the same period, IEP processes would cost an estimated $1,796 per child and IPP processes would cost an estimated $899 per child. For those children who would be receiving services from both education and regional center during this period, the potential estimated savings would be the difference between the cost of IFSP processes or $1,576, and the combined estimated costs of IEP and IPP processes or $2,695 ($1,796 + $899). This difference, $1,119 per child, is an estimate of the potential gain to be realized if a single, overriding document and process replace existing processes. This would apply to an estimated forty to fifty percent of all eligible children, who qualify for services from both education and regional centers.[6] For those children requiring services from education only, the potential savings average $220 per child. For children requiring regional center services only, the added cost of converting to an IFSP is estimated to be $677 per child. Table 5 illustrates these potential savings and costs.

Based on the estimated potential savings shown for scenarios A and C above, it does not appear that converting to IFSP processes will result in a net increase in cost for children who are served by education alone (IEP versus IFSP) or who are dually served by regional center and education (IPP and IEP versus IFSP). However, the reader must be reminded of the limitations and underlying assumptions that have been made in calculating these estimates. There are many factors that contribute to variations in cost for individual children and families that must be taken into consideration. Costs increase for children who are very medically involved or whose complex needs require planning input from specialists or other highly paid personnel. Children whose diagnosis is unclear and who require specialized assessments may also incur higher costs. Non-English speaking parents, or parents who may be difficult to reach by phone may increase costs. Disagreement among professionals and/or family members regarding assessment, diagnosis, placement, or recommended services can also increase costs, as more time may be necessary to reach a consensus on the service plan. Although cases fitting all of these

Table 5. Cost Comparison of IFSP and Existing Service Planning Processes

Scenario A: IEP versus IFSP	
Mean cost[1] of IEP processes per child	$1796
Mean cost of IFSP processes per child	$1576
Estimated potential savings per child	$ 220
Scenario B: IPP versus IFSP	
Mean cost of IPP processes per child	$ 899
Mean cost of IFSP processes per child	$1576
Estimated potential cost per child	$ 677
Scenario C: IPP and IEP versus IFSP	
Mean cost of IPP and IEP processes per child	$2695
Mean cost of IFSP processes per child	$1576
Estimated potential savings per child	$1119

[1] Mean Costs cover estimated service planning and coordination from six to 36 months of age.
Costs do not reflect time spent in travel or time directly attributable to IFSP start-up procedures.

scenarios are found in this cost analysis, it is not possible to say how the distribution of these types of cases in our sample align with the state as a whole, or the nation.

There appears to be a direct relationship between the mean costs of Phase I (from initial contact to development of a service plan document) and the existence of one, two, or three disabling conditions, as defined in the Education Code. In our sample of children who were assessed using education eligibility criteria, the mean cost of developing a service plan for children with one disabling condition is $286 (n=28), for children with two disabling conditions the mean cost is $307 (n=9), and for children with three or more disabling conditions, the mean cost for Phase I is $453 (n=8).

In a similar manner, costs appear to be a function of the type and number of agencies with which the child and family are involved. The mean cost of Phase I with involvement of education primarily is higher than the mean cost of Phase I with education and other agencies. It appears that when education personnel team up with California Children Services, Public Health Nursing, or Department of Social Services staff, cost savings for service planning are realized. Likewise, when regional center, education and other agencies are involved, costs are lower than when just regional center and education are involved. This finding may become an important consideration when weighing the benefits of interagency collaboration for service planning. Costs do not appear to increase dramatically when multiple agencies are involved as one might expect, and indeed, our results suggest that costs per family could actually decrease with the involvement of agencies outside of education and regional center. The decrease may in part be due to the sharing or transfer of particular duties (such as parent education or support) from education and regional center staff to staff from agencies with lower costs. In addition, reduced duplication and better coordination overall is likely to lower costs. Further research may help to clarify these relationships.

Time

Comparisons of the three service planning processes can also be made from an examination of the time spent by key participants during the four phases of planning activities. Table 6 displays the mean number of hours for professional, clerical and family time by phase. For Phases I, II, and III, the mean time for all participants using IFSP processes is lower than the combined mean times for IEP and IPP process participants. For these three phases, the professional time involved for IFSPs is less than that for IEPs, and higher than that for IPPs. For Phase IV, Transition, IFSP processes appear to take the most time. However, this may be attributable to the more comprehensive approach that has resulted from newly implemented transition plans for IFSP processes. For families whose children require services from both education and regional center, the potential time savings of an IFSP is estimated to be approximately six hours. Development of an IFSP for such a family could represent a substantial easing of the burden on family time.

Services

The services listed on IFSPs more wholistically address and document families' expressed needs, priorities and resources, but do not appear to represent major differences from IEPs or IPPs regarding the frequency and intensity for which specific services are recommended. Service providers who were interviewed reported making little or no changes in the types of services offered to IFSP families. Rather, they stated that the IFSP document provided them with an opportunity to record all of the related services that children and families were previously being referred for without written documentation on the IEP and IPP documents. Related services that were included on IFSPs and not IEP or IPPs, included such things as obtaining a used computer for the family, locating a stroller, and referring to social security offices for financial assistance. Service coordinators reported that it was very useful to have all of the agencies in each family's circle of support record their commitment for involvement on a single document. This documentation made it easier for agencies to see the "whole picture" for each family, and avoided duplication of effort that was previously caused by a lack of knowledge of the services other agencies were providing.

Recommendations from Parents and Professionals

Based on their experiences with the pilot implementation of IFSP processes, parents and professionals generated a range of recommendations for the development of local procedural frameworks and overall training plans. Parents and professionals all stressed the importance of collaboration and family focus as guiding philosophical principles. Mutual trust built through networking within a core interagency group of community planners was considered as important, if not more important, than formal written interagency agreements. Regularly scheduled meeting times and designated IFSP liaisons at each agency eased logistical difficulties.

Facilitating the transfer of information within and across agencies became a priority for all participants. Common forms and procedures for intake, release of information, assessment, and transition helped to reduce duplication of effort. Parents who were linked with more experienced parents were better informed and saved staff time. Coordination of the timing of periodic evaluations and transitions was also recommended to reduce duplication.

Effective service coordination was identified as a key area for inservice training, as this is an expansion of the agency designated case manager role for some agencies. Traditionally,

Table 6. Mean Hours of Participant Time per Phase

PHASE	Participant Type	IEP	IPP	IFSP
I. Intake—service plan document	Professional	13.6	7.0	10.0
	Clencal	0.9	2.6	1.9
	Family	8.3	4.4	6.6
II. Follow-up/coordination	Professional	5.9	3.0	3.3
	Clerical	0.2	0.2	0.4
	Family	5.4	1.8	1.1
III. Periodic evaluation	Professional	7.6	2.9	4.9
	Clerical	0.02	1.0	1.0
	Family	3.4	2.5	3.6
IV. Transition	Professional	9.4	4.5	15.2
	Clerical	0.6	0.4	0.3
	Family	4.9	4.3	7.9

case management has implied that children and families are "cases" to be "managed" or passive recipients of resources and services. Family-centered service coordination, in contrast, "focuses on facilitating the achievement of families' outcomes in ways that reflect their values, beliefs, and chosen levels of involvement with early intervention."[7] The IFSP service coordinator is responsible for coordinating all services across agency lines and serves as the single point of contact in helping parents to obtain the services and assistance they need.[8] Knowledge of and access to community resources, including parent mentor services, was thought to be critical for service coordinators. The need for inservice training on the role of the IFSP Service Coordinator was recognized by many of the participating professionals in the study.

In addition, professionals recommended that mechanisms need to be developed for monitoring the mandated maximum two-day referral to an appropriate agency upon identification, and for providing "follow-along" for at-risk children. Procedures necessary to monitor timeline requirements and to provide a "fast-track" for services will also require refinement.

Other inservice needs focused on understanding the spirit and intent of the law, and the specifics of IFSP procedures. Sensitivity to cultural diversity and familiarity with family systems theory were considered essential. Active approaches for learning how to assess family concerns, priorities and resources were recommended. Training in the specifics of the parent mentor role was also recommended. Collaboration with professional organizations and state licensing boards was suggested as a way to reach underinvolved professionals.

An advisor to this project, who is a parent of a child with disabilities, summed up a key theme that was echoed by the parents and professionals we interviewed for this study: "Trust and respect are the key issues to focus on. Letting go of old practice and opening up to change in a positive manner will help us move forward in a collaborative model."

Summary

This study has recorded the process outcomes and costs of parents and professionals forging new frameworks for early intervention service planning. Participants at all of the pilot sites remarked that they did not wish to return to their "old" ways of doing business. Their positive response speaks to the value and promise for both families and agencies of implementing a statewide, comprehensive, coordinated multidisciplinary, interagency program of early intervention services.

A number of tentative conclusions can be drawn about the implementation of IFSP processes in California thus far. IFSP processes appear to result in cost savings when compared to the combined cost of service planning from education and regional center for children who are dually served by these agencies. In addition, the resulting interagency planning appears to reduce costs for agencies and time and effort for families. However, for children who are eligible for regional center services only, the IFSP adds costs. This is because the IFSP process encompasses more detailed requirements than the IPP process, such as family assessment and multidisciplinary team assessment for the child. Overall, we see no reason to predict substantial changes in cost through conversion to Individualized Family Service Planning.

In addition to the cost and time benefits of multiple agency IFSP processes, families and agencies both report other advantages. Families benefit from reduced paperwork, increased access to information about community resources, parent mentor assistance and support, and the aid of a service coordinator who is a single point of contact across agency lines.

Agency staff report benefits associated with increased knowledge of community resources and heightened communication with staff from other agencies. Agency staff were also appreciative of opportunities to streamline paperwork across and within agencies. Acceptance of common intake and assessment forms and procedures is expected to save even more time and effort and contribute to better coordination of services across agencies. In addition, staff considered the involvement of parents in all phases of planning and implementation to be essential.

The IFSP process does not appear to result in increased services. Rather, services for children and their families may actually decrease with more attention to family-directed pacing and choice, and the generation of a greater range of non-agency service alternatives.

This study explored the costs and benefits of Individualized Family Service Planning in its early stages of implementation in California. The results show multiple short-term benefits for agencies and families, with potential cost and time savings from multiagency planning. However, given the limited sample and duration of the study period, it will be important to examine further the development, implementation, and effects of IFSP processes as they continue to evolve. Studies of the short and long-term costs and benefits of Individualized Family Service Planning will be of great interest as Part H continues to extend its reach across the country.

Endnotes

1. The California Department of Developmental Services contracts with community-based programs and services through regional, non-profit corporations known as Regional Centers for the Developmentally Disabled. Twenty-one regional centers provide a full range of services to developmentally disabled individuals (and their families) throughout their lifespan. Genetic evaluation and counseling are provided to individuals at-risk for having a child with a developmental disability, and prevention services are available to children who are at high-risk (from birth to age three) and their families to prevent developmental disabilities.
2. U.S. Department of Education 34 Code of Federal Regulations Part 303.344(b), Early Intervention Program for Infants and Toddlers with Disabilities; Final Rule, July 30, 1993.
3. Carl J. Dunst, Carol M. Trivette, & Angela G. Deal (1988). *Enabling and empowering families.* Cambridge, MA: Brookline Books.
4. Beverly H. Johnson, Mary J. McGonigel, & Roxane K. Kaufmann, (Eds). (1989). *Guidelines and recommended practice for Individualized Family Service Plan.* Bethesda, MD: Association for the Care of Children's Health, p.1.
5. U.S. Department of Education 34 Code of Federal Regulations Part 303.3(d), Early Intervention Program for Infants and Toddlers with Disabilities; Final Rule, July 30, 1993.
6. From discussions with study site personnel and members of the Project Advisory Committee, it was estimated that approximately 50% of all regional center eligible infants or toddlers also require special education services. A 1990 study for the California Department of Developmental Services by Jay G. Chambers and others cites a survey published in 1989 which shows that approximately 42% of the two year olds served by the regional centers are also served by education agencies.
7. Mary J. McGonigel, Roxane K. Kaufmann and Beverly H. Johnson (1991). A family-centered process for the Individualized Family Service Plan. *Journal of Early Intervention*, 15, p.72.
8. *Individualized Family Service Plan: Guidelines for Pilot Sites.* (1992). Sacramento, CA: Department of Developmental Services, p.17.