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SERVICE COORDINATORS USE OF ROUTINES TO DEVELOP EARLY INTERVENTION OUTCOMES: A STUDY OF KENTUCKY'S IFSPS

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Current legislation and recommended practice have a primary focus on Early Intervention that meets the priorities set forth by families with children who have disabilities. Many theories and current research emphasize the importance of delivering services in a way that supports families to enhance the development of their children through models that reflect the recommendations. Although there are multiple contributions to what is recommended for family-centered philosophy and practice, one single document, the IFSP, guides the delivery of services.

Using the content of 91 IFSPs from the state of Kentucky, 8 indicators were analyzed along with service coordinator demographics. This tool was used to determine the frequency of identified unsatisfactory routines that were used as the foundation for outcome development, if service coordinator demographics impacted this process and if certain domains lent more opportunity for inclusion in outcomes. In addition, frequency of sibling inclusion in priorities, concerns, outcomes and strategies were analyzed.

Findings indicate that approximately 50% of the routines identified as unsatisfactory were used in outcome development. Significant interactions between service coordinator demographics were discovered as well as a strong correlation between routines and domain. Sibling interaction is discussed as well as limitations and future research.

KEYWORDS: Individualized Family Service Plans, Early Intervention, Family Routines, Service Coordinators, IFSP Outcomes

Julie Harp Rutland

July 5, 2007
SERVICE COORDINATORS’ USE OF ROUTINES TO DEVELOP EARLY INTERVENTION OUTCOMES: A STUDY OF KENTUCKY’S IFSPS

By

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THESIS

Julie Harp Rutland

The Graduate School
University of Kentucky
2007
SERVICE COORDINATORS’ USE OF ROUTINES
TO DEVELOP EARLY INTERVENTION OUTCOMES:
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THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master’s of Science in the College of Education at the University of Kentucky

By

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2007
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Early Intervention Legislation

In 1975, the U.S. Congress passed Public Law 94-142, the Education for All Handicapped Children Act. This Act ensured all children with disabilities, aged 6 to 17, a free appropriate public education, including special education and related services designed to meet their unique needs. Since its inception, Congress has reauthorized and amended P.L. 94-142 to expand, now including ages 3 to 21, and improve early intervention services. In the 1986 reauthorization, Congress established a program that added provisions for statewide implementation of early intervention (PL 99-457, Part H). Early intervention, or Part C of what is now known as the U.S. Individuals with Disabilities Education Act (IDEA) (P.L.108-446), is a federal grant program that assists states in operating comprehensive statewide programs for infants and toddlers with disabilities and developmental delays, and their families. Early intervention has four primary goals: (1) to reduce educational costs by minimizing the need for special education through early intervention, (2) to minimize the likelihood of institutionalization, and maximize independent living, (3) to enhance the development of infants and toddlers with disabilities, and (4) to enhance the capacity of families to meet the special needs of their young children (NECTAC, 2006). In order for a state to participate in the program, a lead agency must be appointed to receive the grant and administer the program; an Interagency Coordinating Council (ICC), including parents of young children with disabilities, must be designated to advise and assist the lead agency; and that agency must ensure that early intervention will be available to all qualifying infants and toddlers with disabilities and their families.

Under the IDEA, "infants and toddlers with disabilities" are defined as children from birth through age 2 who need early intervention services because they either 1) are
experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: cognitive development, physical development, communication development, social or emotional development, adaptive development; or 2) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. The definition may also include, if a state chooses, children who are at risk of having substantial developmental delays if early intervention services are not provided (34 Code of Federal Regulations §303.16). States have some discretion in setting the criteria for child eligibility, and, as a result, definitions of eligibility differ significantly from state to state. Although states have latitude in determining criteria for eligibility, once a child is determined eligible according to a state’s criteria, the Individualized Family Service Plan and appointment of a service coordinator are mandatory.

Service Coordination

IDEA requires that a service coordinator be appointed for each eligible child and family. States vary in the way they choose to implement service coordination. In some states a dedicated model of service coordination is used in which the service coordinator for any given family does not provide any other early intervention service, only service coordination. In other states, service coordination may be provided by a service provider, such as a special instructor or therapist. Furthermore, the model of service coordination may vary within some states. However the model, the service coordinator acts as a supportive, knowledgeable, advocate and is responsible for assisting families in understanding and exercising their rights and procedural safeguards. Research has demonstrated that this relationship between families and their service coordinators is important to successful early intervention (McWilliam et al., 1995).
The service coordinator also facilitates needed early intervention services. Currently, there are seventeen early intervention services that IDEA mandates of participating states: assistive technology services/devices, audiology, family training (including counseling, home visits and other support), health services, medical services, nursing services, nutrition services, occupational therapy, physical therapy, psychological services, respite care, social work services, special instruction, speech language pathology, transportation and related costs, vision services and other early intervention services. In addition to the coordination of services, the service coordinator also plays an important role in the development and implementation of the Individualized Family Service Plan.

*Individualized Family Service Plan*

The Individualized Family Service Plan (IFSP) is required by IDEA to assist families in the development of outcomes for their child and family. The IFSP functions not only as a written plan, but as a process to guide supports and services for each infant or toddler. This written plan, which is developed by the family and a multidisciplinary team of service providers that have been selected based on their ability to contribute to the child and family outcomes, serves to articulate information pertaining to the child and family, and must include several elements. One element is a statement of the child’s present levels of cognitive, physical, communication, social/emotional and adaptive development.

Present levels of cognitive development, or cognition, encompass a wide array of mental abilities that are often referred to as intelligence (Witt, Elliott, Kramer, & Gresham, 1994). The present level of development within the cognitive domain includes statements related to attention, memory comprehension, and reasoning. Another area of
development addressed in the IFSP is physical development. Statements of physical
development include vision, hearing, general health status, and motor skills. Motor skills
can be broken down into two categories; large motor and fine motor. Skills such as
climbing, walking, crawling and rolling are large motor activities, with grasping,
pinching and holding items representing fine motor (Cook & Kilgo, 2004). Additionally,
present levels of communication and social/emotional development must be written.
Communication development is integral to functioning in every day routines. The
primary function of communication is a symbol system to communicate and can include
verbal and nonverbal ways of communicating. Statements of communication
development may include both receptive and expressive language including speech,
gestures and facial expression (Crais & Roberts, 2004). Social/emotional development is
based on appropriate social behaviors within a particular ecology. Statements of
social/emotional development may be the establishment of acceptable styles of
interacting and securing relationships with peers and family members (Odom, Schertz,
Munson, & Brown, 2004). Finally, the adaptive domain is one that crosses over all the
other domains. Once referred to as self-care or self-help skills, adaptive development is
now defined within IDEA in much broader terms (P. L. 102-119). Adaptive behaviors
may be stated as the demonstration of age-appropriate skills across a range of
environments and can include dressing/undressing, eating, toileting, grooming, and
appropriate independent functioning in typical community settings (Sandall, McLean, &
Smith, 2004).

An additional requirement of the IFSP is a statement of the family's resources,
priorities, and concerns relating to enhancing the child's development. IFSP teams should
use the identified priorities and concerns to develop measurable outcomes, corresponding
strategies, procedures, and timelines for achieving the child and family outcomes. In addition, statements of specific early intervention services that are necessary to meet the unique needs of the child and the family must include the frequency, intensity, length and method of delivering such services. Natural environments in which early intervention services will appropriately be provided, including “a justification of the extent, if any, to which the services will not be provided in a natural environment” (Special Focus Issue, 1999, p. 15) must be clearly stated. Initiation of services and who will be responsible for service coordination and implementation of the plan are also stated on the IFSP. And finally, transition services and the steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services must be included in the written plan.

Once developed, a meeting of the IFSP team must be held at least annually to determine progress and make revisions, based on information from current evaluations, ongoing assessments and other pertinent information from the IFSP team. Additionally, the IFSP must be reviewed with the family at 6-month intervals. It is the responsibility of the service coordinator to ensure that these necessary meetings occur at times and places that are convenient to the family and must be arranged with enough advance notice to allow families and other team members to plan to attend. Early intervention providers must explain to families the contents of the IFSP and obtain families’ informed, written consent for those services, as families have the right to accept or decline services.

Background Theory and Philosophy

As important as which services are provided on the IFSP, is how they are provided to the child and family (Hanft & Pilkington, 2000). How services are provided is based on ideology that has contributed to current recommended practice in early
intervention. Early intervention is grounded by a strong theoretical and philosophical foundation (Bronfenbrenner, 1979; Knowles, 1984; Maslow, 1954). The theories and philosophies that are the basis for early intervention focus on not only the child as the learner, but the child within a family, and the systems and factors that impact their lives.

*Maslow’s Hierarchy of Needs*

One theory that has strong implications on early interventionists’ understanding of factors that impact families is Maslow’s Hierarchy of Needs. Maslow’s (1954) theory is based on the assumption that humans have within them an innate hierarchy of needs as depicted in Figure 1.

Starting from the bottom, the categories in the hierarchy are physical needs, safety needs, social needs, esteem needs and self-actualization needs. Maslow placed physical needs such as food, water and sleep, which represent the most basic needs, at the bottom of the hierarchy. According to Maslow people only move up the hierarchy once needs in a previous level have been met. Therefore, when physical needs have been met, it is possible to move to the next level of safety needs. Following safety needs, social needs may be addressed, which include a sense of love and belongingness through friendships, family relationships and organizational memberships. Next, as theorized by Maslow, esteem needs and then finally self-actualization needs can be met. In some contexts, a person may not remain in one category because a need in one of the lower categories arises. Furthermore, if individuals attempt to meet a higher need, but a lower need immediately arises, they will refocus on the lower need until it is met.

The Hierarchy of Needs gives a clear description of how factors in our society affect families and how they may prioritize services such as early intervention (Maslow, 1954). Maslow’s theory, when applied to early intervention, suggests physiological needs
such as food, water, shelter and warmth must be met before the family can focus on intervention strategies suggested by a specialist. Findings show that identifying and addressing families’ most basic needs is the beginning of family empowerment, which is necessary for successful outcomes in early intervention (Patrick, 2004). Therefore, gaining this necessary information about a family’s needs is pertinent to providing a family with the supports needed to feel empowered and to enhance their capacity to meet the needs of their young child (Bailey, 2003).

**Ecological Systems Theory**

A second theory that has impacted the field of early intervention is Bronfenbrenner’s Ecological Systems Theory (Bronfenbrenner, 1979). Bronfenbrenner’s theory explains both the relationships between different social units and the broad impact of these social supports (1979). In early intervention this theory applies to the understanding of child development within the context of the relationships in the child and family’s environment. This theory, depicted in Figure 2, defines

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*Figure 1. Adapted from Maslow’s (1954) Hierarchy of Needs*
complex “layers” of the environment, each having an effect on a child’s development. Bronfenbrenner depicts these layers as concentric, with the child and family in the innermost circle. The child and family unit is nested in a broader circle of informal social units that consist of relatives, friends, neighbors, childcare providers and other close acquaintances. The previous units are then nested in larger social units, which include neighborhoods, churches, social organizations, childcare center, and so forth. Still further, the previous units are embedded in much larger social systems consisting of governments, and other decision-making bodies that could potentially affect the child. A fundamental tenet of the Ecological Systems Theory is that there is interaction both within and between levels so that events occurring in one unit will impact what occurs in another unit. The interaction between factors in the child’s immediate family/community environment and the society in which they live steers their development. As changes or conflict in any one layer impacts the other layers, indirect influences bear upon a child’s development as much as do the more direct influences. As Bronfenbrenner (1979) states, “A person’s development is affected profoundly by events in settings in which a person is not even present” (p.3).

To study a child’s development then, one must look not only at the child and the immediate environment, but also at the interaction of the larger environment as well. Bronfenbrenner’s ecological systems theory focuses on the quality and context of the child’s environment. A parent’s work schedule is an example of how a child may not be directly involved at a particular unit within the nested units, but certainly feels the positive or negative impact of such an influence. Within these environments or units, factors such as financial status, work satisfaction, self-concept and basic needs impact the types of support required for a family.
Adult Learning Theory

Because the focus of early intervention is the broader context of family and not only children, providers’ interactions with adults are as important as their interactions with children. Designed to better understand the education of adults, Adult Learning Theory (Knowles, 1984) was first introduced by Malcolm Knowles in the 1970’s and is based on the following assumptions: adults are self-directed learners, life experience and knowledge contributes to adult learning, adults learn when they perceive a need to know something; and learning must be relevant.

Knowles suggests that as self-directed learners, adults are resistant to decisions and strategies that are determined without the participation of the adult learner. This
results in feelings of ill will rather than an open mind to learn. Furthermore, life
experiences, including work-related activities, family responsibilities, and previous
education, are assumed to contribute to their learning. As a person matures he or she has
a growing number of experiences that become resources for learning. Using these past
experiences, adult learners become open to learn only when they feel the new knowledge
will enhance their current life situation. Adults only learn when they perceive there is a
reason to know something. Finally, the adult learning theory assumes learners are
motivated by intrinsic factors (Knowles, 1984). That is, they learn what they want to
learn based on what is important to them at that particular time in life.

Because the focus of early intervention is on the whole family, both child and
adult learners must be supported. In response to Adult Learning Theory, early
interventionists should consider what is important to families and provide information
that meets those needs. By valuing the experiences of families and providing intervention
that is designed to be functional within the context of their typical daily routines, early
interventionists place the focus on the family as a whole.

The common thread in the aforementioned foundational theories of Early
Intervention (Bronfenbrenner, 1979; Knowles, 1984; Maslow, 1954) is the recognition of
the family’s roles, priorities and concerns as important and relevant. This knowledge
contributes to the provision of supports that are functional and enhance the family’s
ability to promote the development of their child. Without careful attention to these
important characteristics of a family, the success of early intervention is likely
compromised (Dunst, 1985).

Families and Early Intervention

In response to research and shaped by its foundational theories and philosophies,
the role of families in early intervention has shifted since Congress first included language on families in early intervention legislation (PL 99-457, Part H). Families are now a key focus of the federal early intervention legislation for young children with disabilities, with the phrase “infants and toddlers with disabilities and their families” being used repeatedly. By emphasizing the family in Part C of IDEA, legislation redefined the family, not just children, as recipients of services in recognition of their critical role in a child’s development. However, services have not always reflected this expectation. Early intervention has evolved in its view of families, starting with a professional centered approach, moving to a family focused approach, and finally arriving at family centered practices.

**Professional Centered Approach**

Historically, early intervention used discipline-based, normative perspectives with assessment and intervention that focused heavily on developmental milestones. The desired outcome of these professional-centered approaches was to increase the number of developmental skills and milestones based on norm-referenced and criterion-referenced instruments (Atkins-Burnett & Allen-Meares, 2000). Professionals each focused on their own discipline and acted as the experts, determining the needs of the family from their own perspective. Families were not seen as capable, active participants in the provision of intervention, thus requiring help from professionals in the implementation of intervention (Dunst, Johanson, Trivette & Hamby, 1991).

**Family Focused Approach**

Over the past decade, the role of the family has evolved, with family involvement as key to the success of outcomes (Kontos & Diamond, 2002). The family-focused approach views families as an integral part of the intervention team. In this approach
professionals and families collaborated together to determine what is needed to help the family function in a manner that enhances the development of their child. However, families were still viewed as needing the professional for advice and guidance in order to meet their needs. For many professionals, this shift from professional-centered, to family-focused services challenged their training and current methods, but the need for families to be involved in the planning of goals and objectives has been widely accepted (Dunst et al., 1991).

**Family Centered Approach**

The field of early intervention has evolved further and now views a family-centered approach as recommended practice (DEC Task Force on Recommended Practices [DEC], 1993). The family-centered approach involves a set of beliefs, principles, values and practices for supporting and strengthening the capacity of families to promote and enhance the development of their children (Dunst, 2002). The tenets of family-centered philosophy include the recognition and respect for (a) the family as the expert on the child; (b) the family as the ultimate decision maker for the child and family; (c) the family as the constant in the child’s life with providers only being a temporary relationship; (d) the families’ choice in amount of participation (e) the family’s priorities and concerns as the propeller for goals and outcomes; (g) differences in cultural beliefs and values; and (f) the need for families to have a collaborative and trusting relationship with service providers (Baird & Peterson, 1997). With an emphasis on family and child strengths, such practices are driven by the priorities and concerns of the family with the professional’s role being one of an agent to promote the strengths, capabilities and decision making of the family (Dunst et al., 1991). Family centeredness involves treating families with dignity and respect, individualizing services to meet their needs, and
sharing information so that families can build both formal and informal networks of support.

Research indicates that the family-centered approach yields better outcomes for children than the traditional child-centered approach (Dunst, 1985). Family-centered approaches use models that conceptualize and implement early intervention focusing on the child within everyday settings and social relationships. Additional research has shown that when using family-centered practices there is a higher level of parents’ well-being (Dunst, Bruder, Trivette & Hamby, 2006), which positively impacts child outcomes. Further findings show that families consider the quality of the support to be more important than the quantity of supports, with informal supports such as family, friends and relatives having an equal or greater impact as more formal supports provided by professionals (Dunst, 1985).

**Siblings**

Sibling interactions consume a large part of many families’ everyday routines. Therefore, as early intervention must recognize the interdependence of the child and family (Bruder & Dunst, 2005), siblings are an important component to intervention strategies. In earlier years, parents were not seen as the professionals in the field of early intervention (Dunst et al., 1991). However, the entire family is now understood to support and contribute to a child’s development in many ways (Dunst, et al.). Siblings spend a significant amount of time together, and during early childhood children spend more time interacting with older siblings than with peers. As a result of their greater shared experience, siblings may be more aware of each other’s strengths and weaknesses and, thus, can be very effective teachers and learners. Siblings’ interactions are also more resistant to disruption by antagonistic behaviors. This tolerance for antagonistic behavior
may allow children to refine their skills at negotiation and conflict resolution, two important mechanisms of cognitive development (Azmitia & Hesser, 1993). Young children may receive more explanations and feedback from their siblings than their peers because they feel more comfortable asking them questions and requesting an active role in the problem-solving process. Also, young children may be more likely to challenge their siblings than they would their peers or adults. This type of interaction and participation could improve the sibling’s teaching ability and the learner’s understanding of the task. Effective guidance produces effective learners and increases cognitive learning (Fry, 1992).

Lam (1992) compared children with siblings to children without siblings and found that children with siblings exhibited more autonomy and greater independence. This difference could be in part due to sibling interaction and instruction. Vygotsky (1978) argues that a transfer of responsibility, that is, the process wherein the teacher gradually relinquishes control of the task to the learner so that he or she eventually controls the task and is solving the problem independently, is a key element of effective guidance. Two studies, (Azmitia & Hesser, 1993; Widmer & Weiss, 2000) found that siblings are more likely to allow this transfer of control than are peers. Azmitia and Hesser (1993) speculated that siblings would be more likely than peers to transfer responsibility to the learner. This transfer is not because of their own goals of enhancing their sibling’s performance, but because the young child is more likely to pressure a sibling to give up control than the child would pressure a peer or adult. In general, the positive quality of their interactions and the high degree of mutual imitation suggest that they enjoy each other’s company and are quite interested in each other’s behavior. Although there has not been a great deal of focus on the role of siblings in intervention,
they certainly play a significant role in each other’s lives and may provide intervention for many years to come (Schwartz & Rodriquez, 2001).

Because of the impact of sibling interaction and the importance of parent involvement in the development and implementation of outcomes, family-centered philosophy is considered to be best practice in the field of early intervention. Although many professionals concur with family centered practices, and the research supports this approach, service delivery has not always reflected this philosophy (Dunst et al., 1991).

Changes in Service Delivery

Although families were recognized by the legislation when early intervention was first added in 1986, the family-centered philosophy has continued to evolve. Along with these gradual changes in philosophy, changes in service delivery have also shifted toward a more family centered approach. This focus on family-centered practices represents a major change in early intervention.

Paradigm Shifts in Teaming

There are multiple approaches IFSP teams can take in supporting families to achieve outcomes. Three primary models of teaming have emerged in early intervention literature over the past 20 years (McGonigel, Woodruff & Roszmann-Millican, 1994): multidisciplinary teaming, interdisciplinary teaming and transdisciplinary teaming. Each of these models of teaming reflects different assumptions about working with families, and the shift from multidisciplinary teaming to transdisciplinary teaming parallels the shift to family-centered philosophy.

Multidisciplinary teaming is a model of service delivery in which professionals from different disciplines work independently of one another (Heward, 2006). Each team member conducts assessments, plans interventions and strategies and finally delivers
services. This approach focuses on the individual developmental domains rather than the child as a whole. However, domain specific approaches may mean multiple assessments, multiple visits and difficulty in communication due to several team members dividing their time between many professionals (McWilliam & Scott, 2001). This approach emphasizes domain specific needs, rather than the child as a whole.

Similarly, interdisciplinary teaming consists of professionals conducting discipline-specific assessments, and providing the therapies related to their discipline (Heward, 2006). However, the interdisciplinary team meets to share information and develop intervention plans. This sharing of information is what distinguishes the multidisciplinary model from the interdisciplinary model (McWilliam, 1996).

Finally, the transdisciplinary model, which is considered recommended practice for teaming in early intervention, is characterized by role release in which providers teach others to use their discipline specific strategies (Hanft & Place, 1996), and one primary provider takes the responsibility of the most frequent contact with the family. Members of transdisciplinary teams conduct joint assessments, share information and strategies across disciplines and develop outcomes that are not discipline focused. Members of this type of team work collaboratively to benefit the child and family with a shared focus. This practice allows the family to develop a relationship with one professional rather than many (Atkins-Burnett, 2000) and can lead to less frequent visits by multiple providers, which can damage a family’s feelings of support and negatively impact child outcomes (Dunst, 1999). Families need support in a way that empowers them to enhance their child’s development within their natural environments and everyday routines and activities (Jung, 2003), with supports such as emotional, informational, and material provided by a primary service provider rather than many providers (Bronfenbrenner,
Change in Location of Service Delivery

Paralleling the changes in teaming and family involvement, the language in IDEA was strengthened regarding families in 1997, requiring a change in the location of service delivery for many early intervention programs in the country. Specifically, the words “natural environments” were added to the previously existing legislation (Individuals with Disabilities Education Act [IDEA], 1991). Natural environments, as defined in IDEA (1997), are “settings that are natural or normal for the child’s age peers who have no disability” (34 CFR Part 303.18), meaning that services should be provided in the home, child care setting, local park and other environments that are a normal part of the child’s and family’s routine. The purpose of this law is to discourage the type of intervention environment that separates children with disabilities from their peers without disabilities (McWilliam, 2000).

Studies have shown that when working with children, natural settings are more effective than providing intervention in a separate therapy or instruction room (McWilliam, 1996). Research has concluded that natural environments provide rich learning experiences (Bruder & Dunst, 1999); however, this type of service delivery requires interventionists to transition from a more self-contained, rehabilitative setting to a more flexible and non-controlled setting (Hanft & Pilkington, 2000).

When selecting these natural environments, it is important to consider where the child and family spend much of their time and use the typical activities and interactions that occur within these familiar places as the context for intervention. Unfortunately, the legislative language on natural environments as the context for service delivery has been interpreted by many as location of services, rather than how services are delivered.
Shifts in Methods of Service Delivery

Probably the greatest shift in service delivery has been the change in type of support provided by interventionists. The intent of the 1997 Individuals with Disabilities Education Act (IDEA) revision was to change not only where the services are provided, but to impact the approach of intervention to one of supporting caregivers rather than providing domain specific direct services (P.L. 99-457). Research indicates that supporting families and caregivers in their typical daily routines and activities empowers families to meet the needs and enhance the development of the children in their care and leads to better outcomes (Dunst, 1999; McWilliam, 1995). Thus, the focus of home and community visits moves from providing direct services to providing support to caregivers. In doing so, the literature indicates that child-initiated instruction, social interactions with peers and intervention in the context of everyday routines provide more opportunities for learning and are just as effective, if not more effective, as methods that serve children in segregated environments (McWilliam, 1996). Because the location of services now includes places such as family rooms, child-care facilities, playgrounds, and church, the methods of service delivery must shift to meet the needs of the families in these natural environments (Hanft & Pilkington, 2000). Direct interventions that are not already a part of everyday activity settings and impose upon the natural routines of the family are potentially harmful (Dunst et al., 2006).

Based on research and recommended practice (DEC, 1993), services should be much broader than direct instructional support with a focus on the ecology, or relationships, of the family, including outcomes determined by the priorities and concerns that occur during typical routines and daily activities. Furthermore, research over the past
decade has led to a set of common service delivery practices that yield positive outcomes for children and families. Three of these include 1) providing consultative support, in most cases, rather than direct services, 2) basing intervention on family priorities and concerns, and 3) using the natural routines as a source of learning opportunities (Bailey, 2003; Dunst et al., 2006; McWilliam & Scott, 2001).

Consultative Family Support

Consultative support refers to the exchange of information between the provider and the family of a child with disabilities (McWilliam, 1995). This exchange of information and intervention strategies allows families to maximize the many learning opportunities available throughout their day. Through the use of a consultative approach, the child will have many more hours of opportunity for learning compared to the one to four hours of direct service (Jung, 2003).

McWilliam and Scott (2001) describe a consultative model for the delivery of early intervention that is based on a framework of the provision of supports rather than the typical provision of services. This model not only focuses on the delivery of services, but encompasses the entire process including intake, assessment and service delivery. The expected outcomes for such a model are parental confidence in their roles, lower family stress and positive outcomes for the child, including health and development. The authors place less emphasis on direct services and emphasize three types of support that interventionists should provide: informational, material, and emotional.

Informational support involves providing information on the disability or condition of the child, services and resources that address specific outcomes, goals and family functioning, typical child development milestones and intervention strategies (McWilliam and Scott, 2001). When providing this type of support to families, it is
important to consider using a method that will best meet the unique needs of the family. Next, material supports may include finding resources for basic needs, adapting or developing materials for daily routines or even financial resources. Then, finally, emotional support includes positive, responsive interactions such as talking to families in a friendly manner and maintaining a positive attitude about the child and family. Psychological services, counseling, orientation to the whole family, building social networks and facilitating parent groups, are all examples of emotional support.

**Family Priorities and Concerns**

As defined, family priorities, or the ways in which they prefer early intervention, and family concerns, areas that family member identify as problems, are key elements to early intervention (McGonigel et al., 1994). Furthermore, recommended practice suggests that outcomes be derived from the priorities and concerns of families (DEC, 1993). During IFSP meetings families’ priorities and concerns that are directly and indirectly related to the child’s development should be documented on the IFSP. Then, strategies that occur within the context of everyday routines should be developed to reflect these priorities and concerns. Intervention that is designed in response to the priorities and concerns of families empowers families to enhance the development of their child with a disability (Hanft & Pilkington, 2000).

**Routines Based Intervention**

Children, when participating in the regular routines and daily activities in their natural environments, have many opportunities to learn (Dunst, Bruder, Trivette, Raab, & McLean, 2001). These activities and routines, when not interrupted, provide many occasions for teachable moments (Cripe & Venn, 1997; Rule, Losardo, Dinnebeil, Kaiser, & Rowland, 1998) in which parents can promote their children’s development.
Researchers agree that the many opportunities that parents and caregivers have in a given day, can impact a child’s development far more than the weekly visits from service providers (Dunst et al., 2001; Hanft & Pilkington, 2000; Jung, 2003; McWilliam, 2000). “What young children need is exposure to communication, mobility and play, gradual independence in activities of daily living, and nurturing interactions with family members, everyday, in their usual places and situations” (Hanft & Pilkington, 2000, p.7).

Research supports the use of a model of service delivery that focuses on the family’s daily routines as the context for intervention. Dunst et al. (2006) support these outcomes in a recent study looking at delivery practices in the natural environment. The focus of this study was on the subtle difference in delivering services in a natural environment and using the natural environment for learning opportunities. In both the state and national samples, families who received services through a delivery model that used the natural environment of the individual family for learning opportunities reported more positive feelings when they perceived having control over the supports, resources and services that were provided. In addition, more positive feelings of parental competence, well-being and judgment regarding child progress were reported. However, as reported in state surveys, families who received services in the natural environment, but not in accordance with routines and everyday activity settings, reported negative well-being (Dunst et. al., 2006), all of which support the notion that direct services are usually not the type of support needed or wanted by families.

Traditional tools such as standardized tests and checklists do not provide the necessary information to clearly define priorities and concerns, therefore hindering the development of outcomes that are functional for the child within the context of family living (Dunst & McWilliam, 1998). Tools that collect this information support families
in identifying their priorities and concerns. By using processes such as a routines-based assessment (McWilliam, 1992) or the Asset-Based Context Matrix (Wilson, Mott & Batman, 2004) a framework is provided for assessing family routines, interests, interactions and participation in everyday activities and obtain information that may be used to embed interventions in the typical routine of families and caregivers.

Early Intervention Research to Practice Gap

Although research and recommended practices (Dunst, 1999; DEC, 1993) indicate that services should be delivered in a way that supports the family’s ability to implement intervention and maximize daily routines, many barriers exist that prevent this type of service delivery from being implemented fully (Guralnick, 1997). Studies show (Harbin et al., 1998; Jung & Baird, 2003; McBride & Peterson, 1997) that unfortunately, services are not reflecting the shifts in recommended practice in the field of Early Intervention.

Provider Misconceptions

One barrier to this type of service delivery is that professionals carry many misconceptions about families and services. For example, some doubt the capability of families’ skills and initiative to fully participate in the early intervention process (Beckman & Bristol, 1991; Minke & Scott, 1995). In addition, early intervention providers have expressed concerns about uncertainty of responsibilities and roles of early intervention team members (Bailey, Palsha, & Simeonsson, 1991) and the amount of time and resources required to meet the expectations of the family-centered service model (Mahoney & O’Sullivan, 1990). Another contributing factor is professionals’ not understanding or accepting families’ views that differ from their own (Minke & Scott, 1995; Murray & Mandell, 2004). Examples of other concerns include families not
receiving state-of-the-art services, child-care providers not having the expertise to implement the services and the belief that segregated programs are natural environments for children with disabilities (Shelden & Rush, 2001).

*Lack of Preservice Preparation*

A second barrier to the implementation of high quality early intervention services is the lack of preservice preparation. Professionals entering the field are still using direct, multidisciplinary approaches that are not involving families as an intricate part of the team (Harbin et al., 1998; Jung & Baird, 2003; McBride & Peterson, 1997). One contributing factor is that pre-service programs may not involve a diverse population of families throughout coursework in an effort to embed a family centered philosophy in practice (Murray & Mandell, 2004). Barriers such as language and cultural differences of a family impact their level of participation in early intervention (Bennett, Zhang, & Hojnar, 1998). Furthermore, evidence shows that the providers in the field of early intervention such as occupational therapists, physical therapists, early childhood special educators and speech-language pathologists are not receiving content in their personnel preparation programs that include family centered practice, teaming, natural environments and service coordination (Bruder, 2005; Washington, Schwartz, & Swinth, 1994).

*Insufficient Service Coordinator Training*

In addition, indications show that there is a need to train service coordinators in family centered IFSP writing (Bruder, 2005; McWilliam et al., 1998). Evidence shows that despite dramatic changes in recommended practice, the IFSPs have reflected very little change since 1986, when the IFSP was first mandated (McWilliam et al., 1998). In a national study (Bailey, Hebbeler, Scarborough, Spiker & Mallik, 2004) nearly 1 of 5
caregivers of children in early intervention was not aware of the IFSP document. For those that were aware of the IFSP, only 64% reported collaborating with the team to determine the kind of services needed and even less (43%) reported collaborating to determine the amount of services received. Furthermore, research over the past decade has acknowledged that IFSP conferences often fail to focus on the development of outcomes that are based on the family’s priorities and concerns. Studies that have examined the outcomes on IFSPs (Boone, McBride, Swann, Moore, & Drew, 1998; McWilliam, Ferguson, Harbin, Porter, & Vaderviere, 1998) found that providers were focusing primarily on child outcomes rather than the family as a whole. In one study of 78 IFSPs, from two states, a content analysis was conducted looking specifically at the use of lay language and only 50% of the outcomes were derived from family priorities and concerns (Boone et al., 1998).

In another study that analyzed content in 120 IFSPs (Jung & Baird, 2003) service coordinators with high experience had the lowest ratings on IFSP quality. Unfortunately, service coordinators with high levels of experience were also less likely to attend training on current recommended practice. Therefore, the service coordinators with the most experience may be less likely to have current information on recommended practice in IFSP writing.

Although we know research supports family centered practices within the context of everyday routines, it is also important to know if the priorities and concerns that are derived from those routines are being used in developing outcomes, thus leading to effective services. Little research exists that examines whether families’ priorities and concerns, and routines are considered when developing outcomes.
Purpose of this Study

As recommended practice suggests that outcomes be derived from family routines (Sandall, McLean, & Smith, 2004) and both recommended practice and requirements of the IFSP recognize the importance of addressing priorities and concerns in outcomes, there is a need to investigate IFSP writing to determine the extent in which service coordinators use routines to develop outcomes. The purpose of this study is to understand how service coordinators use family routines, including siblings, to develop outcomes and strategies for early intervention. Specifically, this study will examine: a) if families’ routines, priorities, and concerns are used as the foundation of IFSP outcome development; b) if the type of routines have an effect on whether it is addressed in outcomes; c) the extent siblings are used in outcomes and strategies; and d) if service coordinator demographics affect IFSP writing.

Method

Participants

Participants in this study were service coordinators, those responsible for IFSP writing, in Kentucky’s early intervention system, First Steps. First Steps is administered by the Department for Public Health within the Cabinet for Health and Family Services. At the time of data collection, Kentucky had approximately 219 primary service coordinators and 36 initial service coordinators, and all were required to attend training on family-centered IFSP writing and the use of the state’s new IFSP form. All service coordinators attending the training were invited, without incentive or requirement, to participate in a study of how service coordinators write IFSPs. Those choosing to participate totaled 185 and represented all of the 7 regions in the state.
Instrumentation

IFSP Routine Utilization Tool

Using a Microsoft Access database, the researcher developed the IFSP Routine Utilization Tool, which contains 8 items. Scoring of the 8 items and collection of service coordinators’ demographic information were completed using the IFSP Routine Utilization Tool. Indicators chosen were based on recommended practice and current literature supporting use of everyday routines as the source of intervention (Dunst et al., 2001; Hanft & Pilkington, 2000; Jung, 2003; McWilliam, 2000). Development of the tool involved creating a first version then making additions and changes to support consistency in rater scoring. The first version was used on several IFSPs and as clarification was needed, deletions and further explanations were added to the instruction manual. The instruction manual provides detailed directions for reporting each of the indicators along with data collection from the questionnaires. The instruction manual can be found in Appendix A.

The 8 IFSP indicators analyzed were 1) number of routines, 2) routine type, 3) unsatisfactory routines (USR), or routines identified by families as ones in which they are “not at all happy”, 4) USRs that match a family priority or concern (P/C), 5) P/C that are derived from USRs that match an outcome, 6) primary domain addressed, 7) siblings included in the routine, and 8) siblings included in outcomes and strategies. Each of the 8 items is described below. As indicators 2 – 6 build on one another, an answer of “no” resulted in the tool automatically defaulting to a “no” answer for the remaining of the first 6 indicators. The sibling indicators are independent of the previous six and are not specific to routines, but to individual IFSPs.

Individual routines on each IFSP were identified and assigned a number for both

26
identification and data collection. As defined, a routine is a time of day or event that recurs within the typical day of a family (McWilliam & Scott, 2001). Routines are unique to each family, but can fit into routine types that may include but are not limited to meals, play, nap, and community outings.

The Kentucky IFSP form has an added section to which addresses family and child routines. Each routine has a section that asks families to rate the routine as “very”, “somewhat” or “not at all happy” with how that routine goes. For the purposes of this study, unsatisfactory routines (USR) were those routines that parents identified as ones in which they felt less than “very” happy. Any indication of dissatisfaction with a particular routine, including written comments or any box checked other than “very” deemed the routine as unsatisfactory.

Family identified priorities and concerns are described by families in the context of their typical daily activities and what is important to them to continue enjoying or to be able to enjoy those activities. These may include favorite outings of the family or those in which they would like to participate, things that are challenging or are not working well and anything else related to the child and family that they view as important. Unsatisfactory routines that are directly related to a priority or concern were considered a match. In addition, a statement of the measurable results or “outcomes” expected to be achieved for the child and family must be included on the IFSP. The outcomes section includes strategies, procedures and timelines to determine progress. Outcomes that are directly related to a priority and concern reported by the family were considered a match.

Although all areas of development have an interwoven nature, the field of early intervention divides development into broad sections or domains. Cognitive, motor, social-emotional, communication and adaptive domains represent these broad sections of
development. For the purpose of this study, key behaviors and skills have been assigned to particular domains to determine the primary domain addressed in each outcome. A synthesis of routine indicators and defining activities are shown in Table 1.

The last indicators focused on siblings, as reported by parents, and written on the IFSP, in either the routine, or priorities and concerns section, and then again in the related outcomes. As the literature explains, sibling interaction consumes a large part of everyday routines and siblings are seen as effective teachers (Azmitia & Hesser, 1993). Therefore, if siblings were mentioned in the routines or priorities and concerns section, there is then an opportunity for siblings to be included in strategies that address the outcomes.

**Procedure**

**Data Collection**

The mandatory 1-day IFSP training for service coordinators was conducted by technical assistance teams in each of the state’s seven districts during the fall of 2004. The purpose of the in-service was to train service coordinators to use Kentucky’s new IFSP form to facilitate family-centered IFSP meetings. The new IFSP form included significant revisions, most notably, the inclusion of a page to facilitate an interview with families on their routines (See Appendix B). Those who chose to participate were asked to submit a newly completed IFSP to their technical assistance team 3 months after the training. All IFSPs were submitted between the months of November, 2004 and February, 2005. Service coordinators were asked to remove all information that could identify themselves, other providers, or families from the IFSPs before submitting. Technical assistance teams checked each IFSP and removed any remaining identifying information before submitting to the investigators. One hundred and eighty five service
Table 1

*Routine Indicators, Behaviors and Defining Activities that are described as Domain Specific*

<table>
<thead>
<tr>
<th>Domains</th>
<th>Routine Indicators and Defining Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Problem-solving abilities, reasoning, acquisition of knowledge, understanding games and the instructions, thinking and talking about objects and people who are not present.</td>
</tr>
<tr>
<td>Motor</td>
<td>Including both large muscle skills; basic body movements, such as lifting over the head, rolling over, crawling, walking, climbing stairs; and small motor skills, such as grasping, releasing and drawing.</td>
</tr>
<tr>
<td>Social/Emotional</td>
<td>Peer/sibling interactions, engaging in play, using appropriate behaviors when interacting with others, temper tantrums.</td>
</tr>
<tr>
<td>Adaptive</td>
<td>Personal care skills such as dressing/undressing, eating/feeding, toileting, grooming (e.g., hand washing, face washing, brushing teeth), appropriate functioning in community environments, such as restaurants, neighborhoods, stores, doctor visits, church and recreational areas; Self-directed behaviors, such as independent play/self occupation, demonstrating caution and self regulation, such as sleeping adjusting/transitioning to new environments and situations.</td>
</tr>
<tr>
<td>Communication</td>
<td>Expressing wants and needs, interact verbally with others, gesturing, signing and non-speech sounds, such as laughing.</td>
</tr>
</tbody>
</table>

coordinators voluntarily submitted IFSPs for inclusion in the study. The IFSPs were coded in a manner that contained no names; therefore, it was not possible to determine which service coordinators responded, nor was it possible to identify the child and family receiving services. However, the code contained an identifier to determine representation
of all 7 regions. In addition to the IFSPs submitted, each participating service coordinator was asked to complete a questionnaire of demographic information. Sixty-two percent, 114, of the 185 participating service coordinators submitted both the questionnaire and a new IFSP within the 3 months as matched by corresponding codes. Criteria for data collection included only those IFSPs that had completed routines, priorities and concerns and outcome sections. As questionnaires were separate, missing data would not be cause for exclusion. Of the 114 submitted IFSPs, 15 were missing data. For example, outcomes pages were missing, routines were not listed, and priorities and concerns were not listed. Therefore coding was completed on 87% of 114 IFSPs submitted (n = 99). In addition, questionnaires were missing 11 responses to data reported in each of the 4 items analyzed: years of experience, level of degree, field and level of disability. However, this is not to say that 11 questionnaires were missing, only that 11 of each item was missing from the total (n=99) questionnaires belonging to IFSPs that were coded. Demographic information was reported on all questionnaires.

**Rater Training**

For this study, two raters examined the IFSPs and corresponding questionnaires. The researcher (rater 1) had 13 years of experience in early childhood education and 3 years of experience in early intervention. Her experiences included program administration, special instruction and 12 years as a parent of a child with disabilities. The second rater is also a parent of a child with disabilities and is a professional in a field that is not related to early care and education. The raters had no contact with the service coordinators or the families to whom the IFSPs belonged. Service coordinators that chose to participate were asked to submit both the IFSP and the Service Coordinator Questionnaire to the Technical Assistance Team member in their region. Of the 99 IFSPs
received, 10 were reserved for training the second rater with training completion set after a minimum of 80% inter-rater agreement (Landis & Koch, 1977) had been met on 4 consecutive IFSPs. The second rater was trained by the researcher (rater 1) using sample IFSPs and an instruction manual that contained specific examples and descriptions for each indicator. After the researcher’s explanation of the process and demonstration of the tool, the second rater rated two IFSPs, which were previously rated by the researcher (rater 1). During this first opportunity to use the tool, questions, concerns and discussions were allowed to further the second rater’s understanding of the instructions. The second rater then independently rated two IFSPs. Any differences in rating were discussed and consensus on rating was reached. Training was completed after 4 more IFSPs were rated with the inter-rater agreement above 80%.

The IFSPs remaining after training (n=91) were then analyzed. Although the researcher rated all of the remaining IFSPs, both raters rated 10 of those IFSPs in order to measure inter-rater agreement. Using Analyze-it for Excel, inter-rater agreement was evaluated using Cohen’s (1960) kappa. Weighted kappa was selected as it calculates the degree of agreement between two raters when evaluating the same sample and it takes into account the agreement occurring by chance. An acceptable level of kappa was set at .80 (k= .80-1.00) (Landis & Koch, 1977). Kappa was above .80 for each IFSP item; therefore training was complete (see Table 2). As Cohen’s kappa is highly sensitive to numbers, such agreement on a small sample size indicates that the kappa agreement would likely increase with a greater sample size.

Scoring

Once a family routine was rated by the parents to be less than satisfactory, the routine was analyzed to determine the extent of association to family identified priorities
and concerns. Priorities and concerns derived from unsatisfactory routines were then rated as to their association to outcomes. Of the outcomes that are identified as related to family priorities and concerns that are derived from an unsatisfactory routine, indicators of the prominent domain addressed were analyzed to determine if particular domains lent more opportunity for a routine to be addressed in an outcome. Sibling indicators were IFSP specific and were scored independent of routines, priorities and concerns, and outcomes.

number of routines.

Raters used information provided in both the routine column and the “what goes well and what doesn’t go well for your child and family?” column to determine the number of routines addressed. Routines were numbered to identify each one individually beginning with 1 and continuing in numeric order. The routine number provided a means to identify particular routines within each IFSP.

routine type.

Routines for each IFSP were individually coded for analysis. Raters used the routine column and the “what goes well and what doesn’t go well for your child and family?” column to assign a routine type to each individual routine. Routines were categorized as one of the following: morning/wake-up, mealtime, playtime, naptime, personal hygiene (e.g., bathing, brushing teeth, washing hands, diaper changing), toileting, bedtime, community (e.g., church, restaurant, shopping), dressing and transitions.

unsatisfactory routines (USR).

The IFSP Routine Utilization Tool asks “Is the routine unsatisfactory?” with an option of “yes” or “no” as the response. Raters evaluated each routine for indication of dissatisfaction, including written comments and the check boxes in which anything other
Table 2

*IFSP Items and Inter-rater agreement*

<table>
<thead>
<tr>
<th>IFSP Items</th>
<th>Cohen's Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Type</td>
<td>0.98</td>
</tr>
<tr>
<td>USR</td>
<td>0.97</td>
</tr>
<tr>
<td>PC</td>
<td>0.90</td>
</tr>
<tr>
<td>Outcome</td>
<td>0.81</td>
</tr>
<tr>
<td>Siblings Mentioned</td>
<td>1.00</td>
</tr>
<tr>
<td>Siblings Observed</td>
<td>1.00</td>
</tr>
<tr>
<td>Domains - Adaptive</td>
<td>0.90</td>
</tr>
<tr>
<td>Domains - Cognitive</td>
<td>1.00</td>
</tr>
<tr>
<td>Domains - Communication</td>
<td>1.00</td>
</tr>
<tr>
<td>Domains - Motor</td>
<td>1.00</td>
</tr>
<tr>
<td>Domains - Social/Emotional</td>
<td>0.86</td>
</tr>
</tbody>
</table>

*Note.* Cohen’s Kappa acceptable level (k = .80 – 1.00)

than “very” deemed the routine as unsatisfactory. If the selected response was “no,” the rater then proceeded to the siblings section. If “yes” was selected the rater proceeded to examine the USR for a match in the family priorities and concerns (PC).

*usrs that match a family priority and concern (PC).*

Both pages of the IFSP labeled as Family Identified Priorities and Concerns were
examined to find evidence of a match to the identified USR. If there was evidence of a match the rater selected “yes,” if no match was evidenced the rater selected “no” and proceeded to the sibling section of the tool. Recommended practice suggests that outcomes be derived from the routines, priorities and concerns of families (Sandall, McLean, & Smith, 2004). Of the PCs that were found as a match to the USR, there were further examined to match those PCs to an outcome (O).

*pcs that match an outcome (O).*

Each individual outcome and corresponding strategies were examined for evidence of a match to the PC that was rated. If there was evidence of a match the rater selected “yes”; if no match was evidenced the rater selected “no” and proceeded to the sibling section of the tool. Once the outcome was identified as developed based on PCs that were a match to a USR, the primary domain addressed within each was identified.

*primary domain addressed.*

Outcomes that were identified as a match to both priorities and concerns, and unsatisfactory routines were analyzed to determine the primary domain addressed. Domains addressed were categorized by the following: Cognitive, Motor, Social-emotional, Communication and Adaptive. The rater then selected a domain by checking the box with the primary domain addressed in the outcome.

*siblings.*

In addition to the previous indicators, two indicators that focus on siblings were coded. The first indicator was the documentation of siblings as reported by parents and written on the IFSP in either the routine or priorities and concerns section. Then secondly, for those routines or priorities and concerns in which siblings were included, related outcomes and strategies were investigated for documentation of siblings.
**Questionnaire**

In order to determine if demographics contributed to IFSP writing, service coordinators were asked to complete a demographic survey that contained questions about a) years of experience, b) education level, c) college degree, and d) if the child had multiple or severe disabilities (See Appendix C). The only identifier found on each questionnaire was an individual code for one of Kentucky’s seven technical assistance team districts.

**Analysis**

As related to family routines, priorities and concerns used as the foundation of outcome development, frequencies were reported for the following indicators on the IFSP Routine Utilization Tool: USRs to total number of routines, routine type, USRs that directly related to a P/C, P/Cs that are derived from USRs that match an outcome and outcomes that match USRs.

Pearson Chi-square association was conducted to determine if linear associations existed between the type of routine and domain addressed had an effect on whether it was addressed in outcomes. The criterion for significance was set at the .05 level. Minitab 15.1 was used for analyses.

Frequencies reported for siblings were specific to individual IFSPs and not routines. To determine the extent that siblings were used in outcomes and strategies, the frequency was reported for the total number of IFSPs that included siblings in the routines, priorities or concerns sections. Of those IFSPs that reported siblings in routines, priorities or concerns, the frequency was reported for siblings mentioned in outcomes and strategies.

Service coordinator demographics were reported next. Frequencies were reported
for service coordinators’ college major, level of degree and level of disability of the child. Mean and standard deviation, and the median and range were reported for service coordinators’ months of experience. Using general linear models, multivariate analyses of variance (MANOVA) were used to determine if identified USRs, P/Cs derived from USRs, and outcomes derived from USRs were significantly impacted by the level of disability of the child or service coordinators’ college major, level of degree or years of experience. Data were collapsed for years of experience: (low = 0-35 months, medium = 36-83 months, high = 84 months +) separating the sample into 3 approximately equal sample sizes. For those variables that were altered by demographic information, one-way analyses of variance (ANOVAs) were used as a follow up to determine if significant relations existed. The criterion for significance was set at the .05 level for both the MANOVAs and ANOVAs.

One-way analyses of variance (ANOVAs) were used to determine if identified USRs, that led to outcomes were altered by the type of degree reported by the service coordinator. Hsu’s multiple comparisons tests were used to calculate and control for family error rates when the ANOVA test was statistically significant.

Results

IFSP item ratings

Are Family Routines, Priorities and Concerns Used as the Foundation of Outcome Development?

A total of 619 routines were analyzed with 38% (234) found to be unsatisfactory routines (USRs). Twenty four percent (56) of the USRs were meals and 21% (49) were rated as play. Bedtime routines represented 14% (32) and community routines 10% (24)
of the total routines reported. The remaining routine types each represented less than 10% (73) of the total routines: personal hygiene (9%) (22), dressing (7%) (17), nap (6%) (14), morning wake-up (6%) (13), transitions (2%) (5) and toileting (1%) (2).

priorities/concerns and outcomes.

USRs that were found to be directly related to a priority and concern (PC) represented 69% (162) of the total USRs analyzed. Of those PCs that were derived from USRs, 72% (117) were directly related to an outcome (O). Therefore, 50% of the total USRs analyzed were addressed in outcomes.

Does the type of routine have an effect on whether it is addressed in outcomes?

Of the routines that led to outcomes, Chi square analyses revealed there were no statistically significant correlations between the type of routine and motor, communication, social/emotional and cognitive domains. The data did reveal, however, that there was significant linear correlation between routine type and the adaptive domain (p-value=0.00). Analysis of the Chi-square test revealed that of the routines identified as meals (36), 81% (29) were rated as the adaptive domain. Additionally, 75% (9) of all dressing routines, 75% (6) of all hygiene routines and 83% (5) of all bedtime routines were reported as adaptive (see Table 3).

To what extent are siblings used in outcomes and strategies?

The sibling indicator was IFSP specific and not related to individual routines. Siblings were mentioned in routines, priorities or concerns in 46% (42) of the 91 IFSPs. Of those that mentioned siblings, 36% (15) involved siblings in the outcomes and strategies.

Questionnaires

Do service coordinator demographics affect IFSP writing?
### Correlation between Adaptive Domain and Routines

<table>
<thead>
<tr>
<th>Routine Type</th>
<th>Adaptive Domain</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>$n$</td>
<td>$n$</td>
<td>$%$</td>
</tr>
<tr>
<td>Bedtime</td>
<td>6</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Community</td>
<td>11</td>
<td>7</td>
<td>64</td>
</tr>
<tr>
<td>Dressing</td>
<td>9</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Hygiene</td>
<td>8</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Meal</td>
<td>36</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Play</td>
<td>37</td>
<td>27</td>
<td>73</td>
</tr>
</tbody>
</table>

Service coordinators reported years of experience ranging from 6 months to 23 years and 7 months with a median of 4 years and 4 months. The mean was approximately 5 years 3 months with a standard deviation of 47.05 months. This suggests that the expectation for the general population of service providers would be approximately 1 to 9 years of experience. Although 21 service coordinators reported more than 7 years of experience, 29% of the service coordinators had less than 3 years of experience. Most service coordinators reported having a bachelor’s degree (58%) or master’s (25%) degree, with
15% reporting having other types of degrees or certifications. Twenty-five percent of the service coordinators reported having degrees in social work, and 21% reported degrees in nursing. Nearly equal percentages were reported from service coordinators in the field of education (13%) and those in non-related fields (14%). Additionally, 9% reported the field of early childhood and 1% reported family studies. The level of disability reported was 48% for children having severe and/or multiple disabilities and similarly those not having severe and/or multiple disabilities was reported as 49%, with 3% of the children reported as “not sure”.

Using general linear models, multivariate analysis of variance (MANOVA) did not show a statistical significance in the years of experience of service coordinators, level of education or level of disability of the child. However, it did reveal that the type of degree reported by the service coordinator had a significant effect (p=0.003) on USRs that led to outcomes (see Table 4). Certain degrees showed higher instance of using routines to

Table 4

MANOVA Results for Interaction Between Service Coordinator Demographics and Outcomes

<table>
<thead>
<tr>
<th>Demographics</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Experience</td>
<td>1</td>
<td>0.717</td>
<td>0.489</td>
</tr>
<tr>
<td>Education Level</td>
<td>1</td>
<td>1.133</td>
<td>0.345</td>
</tr>
<tr>
<td>Degree</td>
<td>1</td>
<td>2.769</td>
<td>0.003*</td>
</tr>
<tr>
<td>Multiple Disabilities</td>
<td>1</td>
<td>1.812</td>
<td>0.166</td>
</tr>
</tbody>
</table>

*p < .05.
develop outcomes. Based on the significant interaction effects shown in the MANOVA, further investigation using one-way analysis of variance (ANOVA) revealed that there was statistical significance in type of degree held by the service coordinators (p=0.000). Additionally, Hsu’s MCB test was run to identify fields that have the greatest impact in writing outcomes that were derived from USRs. Specifically, clinical psychology (UCL=0.7240), occupational therapy (UCL=0.5240), social work (UCL=0.1793) and sociology (UCL=0.3717) were identified as those that more frequently used routines as the foundation of outcome development (see Table 5).

Discussion

*Are Family Routines, Priorities and Concerns Used as the Foundation of Outcome Development?*

As DEC recommended best practice (2004), and further literature suggests that outcomes be derived from reported family routines, priorities, and concerns, it is important to investigate these items to determine if recommended practice is actually implemented. Routines, as defined, are events or times of day that recur within the typical day of a family (McWilliam & Scott, 2001). Of the 234 unsatisfactory routines analyzed in this study, two types of routines - meals and play - represented almost half of the total routines reported in this study. Routines such as bedtime, community, personal hygiene, dressing, nap, morning wake-up, transitions, and toileting together represented the other half reported. It may be that families with small children have routines that are mostly consumed with mealtime and play, but other routines must be considered and discussed to ensure all the priorities and concerns are extracted from these routines.

Furthermore, each family has a unique set of routines that make up a typical day and, when developing the IFSP, it is important to determine what types of routines are
Table 5

*Analysis of Variance for Degree*

<table>
<thead>
<tr>
<th>Degree</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>UCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>4</td>
<td>1.00</td>
<td>0.00</td>
<td>0.72</td>
</tr>
<tr>
<td>Counseling</td>
<td>11</td>
<td>0.18</td>
<td>0.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Early Childhood</td>
<td>20</td>
<td>0.40</td>
<td>0.50</td>
<td>0.00</td>
</tr>
<tr>
<td>General Education</td>
<td>9</td>
<td>0.11</td>
<td>0.33</td>
<td>0.00</td>
</tr>
<tr>
<td>Non-related</td>
<td>25</td>
<td>0.56</td>
<td>0.51</td>
<td>0.00</td>
</tr>
<tr>
<td>Nursing</td>
<td>46</td>
<td>0.43</td>
<td>0.50</td>
<td>0.00</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>10</td>
<td>0.90</td>
<td>0.32</td>
<td>0.52</td>
</tr>
<tr>
<td>Social Work</td>
<td>41</td>
<td>0.71</td>
<td>0.46</td>
<td>0.18</td>
</tr>
<tr>
<td>Sociology</td>
<td>10</td>
<td>0.80</td>
<td>0.42</td>
<td>0.37</td>
</tr>
<tr>
<td>Special Education</td>
<td>11</td>
<td>0.27</td>
<td>0.47</td>
<td>0.00</td>
</tr>
<tr>
<td>Speech/Language Pathology</td>
<td>14</td>
<td>0.29</td>
<td>0.47</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*Note.* Asterisks indicate fields having the greatest impact.

not working so that outcomes can be addressed to work toward improving the routine.

Unsatisfactory routines were reported by parents as those in which they were less than “happy” or those that had comments reflecting a desire for improvement. From this point,
the unsatisfactory routine is translated by the service coordinator into a family priority and concern. Finally, the priority or concern is used to develop an outcome with strategies that address the goal. It would be expected that most routines that were rated as unsatisfactory would directly relate to priorities and concerns, and those priorities and concerns would directly relate to outcomes. Thus, there would be a high percentage of outcomes that would trace directly to unsatisfactory routines. Similar to a study by Boone et al. in 1998, this study revealed that half of those unsatisfactory routines led to written outcomes. It cannot be assumed that families wanted all of their routines, priorities and concerns addressed; however, the results prompt some discussion as to whether service coordinators are writing the IFSPs using routines as the foundation for the development of outcomes.

Although it is of concern that only half of the unsatisfactory routines were addressed in outcomes, this suggests more involvement than was evidenced in the national study by Bailey et al, (2004) that found only 1 in 5 caregivers was aware of the IFSP. Furthermore, there is evidence of an increase in reporting as the service coordinators move through the writing process. Unsatisfactory routines that led to priorities and concerns were reported 69% of the time, with those identified priorities and concerns then used in the development of outcomes 72% of the time. This could be due to the fact that the routines section is a new component of the Kentucky IFSP. Service coordinators have had experience using priorities and concerns to develop outcomes; however, they have only been using the routines section to develop priorities and concerns since the mandatory training. Therefore, it seems that a focus on extracting priorities and concerns from the unsatisfactory routines reported by families would greatly improve the percentage of outcomes that are directly related to a routine.
Does the type of routine have an effect on whether it is addressed in outcomes?

Another finding of significance is the strong correlation between the adaptive domain and routines. For the purposes of this study, adaptive behaviors and skills were defined as those that demonstrated age-appropriate skills across a range of environments and focus on self-help and self-care. Some examples of these are dressing/undressing, eating, toilet training, brushing teeth, washing hands, self-calming, and age-appropriate independent functioning in typical community settings. Many routine types had a strong correlation with this domain. This finding poses a question as to whether certain domains lend more opportunity for being addressed in outcomes. Some reasons for this could be that parents are more concerned with or have more knowledge about skills in the adaptive domain and therefore feel more comfortable communicating such skills through their priorities and concerns. Adaptive skills may be regarded as more important for functioning in daily routines and may even be tied to physical needs at the base of Maslow’s Hierarchy of Needs (1954). According to Maslow, physical needs must be met before any other needs or skills are met. Therefore, it would explain why priorities and concerns related to the adaptive domain take precedence over any other routines, priorities or concerns that may arise. Whatever the reasons, further investigation may provide service coordinators with important information about what is important to families and how to provide continued support in the adaptive domain and increase support in other domains.

To what extent are siblings used in outcomes and strategies?

In addition to the outcome development items, this study considered the extent that siblings were included in the outcomes and strategies. Sibling interactions are a very important part of family routines and the literature clearly supports their shared learning
experiences (Azmitia & Hesser, 1993). Therefore, the presence of siblings in the family, provide additional opportunities for learning if they are included in strategies to work toward enhancing the development of the child with a disability. Only those IFSPs that clearly mentioned siblings in the routines, priorities, or concerns were analyzed to determine the inclusion of siblings in outcomes. The results show that only 36% of the IFSPs included siblings in the outcomes. As family-centered philosophy has an emphasis on family and child strengths (Dunst et al., 1991), it only seems logical to focus on strengths of sibling interactions. Sibling interactions lend multiple opportunities for learning (Azmitia & Hesser, 1993; Fry, 1992; Widmer & Weiss, 2000) wherever these interactions may take place; these interactions support the mandated and recommended practice of intervention in natural environments.

Additionally, the outcomes sections frequently mention “family” as those that will be included in carrying out strategies, but it cannot be assumed that siblings were meant to be included in this broad term. Service coordinators must be explicit in their documentation. Families may intend to include siblings and other family members, but if it is not clearly articulated in the IFSP document, then it may not be understood or forgotten with time.

*Do service coordinator demographics affect IFSP writing?*

When considering the development of outcomes based on unsatisfactory routines, it is important to consider the service coordinators that are responsible for writing the IFSPs. Although level of degree and years of experience did not show any association, one factor of significance is the type of degree held by the service coordinator. Degrees in clinical psychology, occupational therapy, social work and sociology showed a strong association with writing outcomes that were based on unsatisfactory routines. It is noted
that those in the field of early childhood, education and special education were not as strongly associated with writing outcomes that are based on unsatisfactory routines. The expectation is that those with degrees in education and early childhood related degrees had a strong focus on pedagogy, or how young children learn, but there is not a focus on andragogy, or adult learning. Those with degrees in psychology, occupational therapy, social work and sociology may have a better understanding of how adults learn and this may provide a better foundation for developing outcomes from the routines, priorities and concerns. Service coordinators with an understanding of Knowles Adult Learning Theory (1984), Bronfenbrenner’s Ecological Systems Theory (1979), and Maslow’s Hierarchy of Needs (1954) may have more success in transferring the subtle communications of families into a routine that is then developed into an outcome. Outcomes that are based on routines, priorities and concerns are important to families and the Adult Learning Theory explains that adults will learn an intervention strategy when they perceive it as important. However, it is also necessary to understand how priorities and ecological influences impact what families may perceive as important. This evidence shows a need to continue supporting and elevating expectations in early intervention for required certification programs, continuing education programs and higher education opportunities that include current recommended practice in IFSP writing and also include the basic philosophical foundations of early intervention.

Limitations

One limitation to this study was that it was not possible to determine which service coordinators responded, nor was it possible to identify the child and family receiving services. Although this added a positive aspect to participant confidentiality, it did not allow opportunity to determine if particular populations selected to participate
more than others. In addition, accuracy in family report on routines may impact the integrity of the data. It is not possible to determine if families reported truthfully or the type of support or coaching that was provided during the IFSP development.

In addition, it is known that service coordinator relationships are important to successful early intervention (McWilliam et al., 1995); however, it could be possible that when collecting the routines, priorities and concerns from families, this relationship has not developed fully. The initial IFSP meeting is held at the beginning of the relationship and families may not feel comfortable with divulging their personal feelings, concerns, and personal family routines. The reasons could be many including fear of judgment, personality, or stress.

This study was also limited by investigating IFSPs from only one state. Samples of IFSPs included in this state were from only one model of service coordination as Kentucky uses a dedicated model of service delivery. Thus it may not be possible to generalize the findings of this study to those states that do not use a dedicated model of service coordination. The final limitation is that Kentucky’s IFSP has an additional routines page that was still relatively new during this study; different results may be obtained after the state’s new IFSP has been in place for a longer period of time.

Recommendations for Future Research

One suggestion for future research is to gain a better understanding of why certain disciplines used routines as the foundation of outcomes more frequently than others. It is clear that those in the field of education, special education and early childhood have a heavy focus on working with children; however, it is not clear if particular degree types have a stronger focus in courses that provide a better framework for working with adults. As the majority of services provided by the service coordinator require a capacity for
working with adults as key members of the family-centered team, this may impact IFSP writing. This type of research may guide the direction of future courses offered to those in the field of early intervention to include a more specific focus on adult learning. Research of this type may contribute to greater opportunities for family-centered philosophy in the provision of services.

Additionally, research that includes IFSPs from a variety of states, including those with different models for provision of service coordination and with different processes for using routines to develop outcomes, may further add to our understanding of IFSP writing. This information would provide not only a greater and more diverse sample of IFSPs, but would also provide additional information on model of service delivery and processes used and how each impacts the use of routines in outcome development.

Of the research that has been done, very little emphasis has been placed on the role of siblings in intervention. As sibling interaction consumes a large part of typical daily routines, it must be acknowledged as an integral component in discussions and research surrounding family centered philosophy. Therefore, future research should include this component when considering studies on IFSP writing, family involvement and intervention strategies.

Although there is not much evidence to support recommended practice when using family routines as the foundation for outcome development, this study provides information to increase opportunities for improvement. Continued support for inclusion of IFSP writing in programs of study and continuing education are important to ensure that routines based interviews are meaningfully conducted, priorities and concerns are clearly extracted and outcomes are based on those routines, priorities and concerns. Specifically, IFSP training should include an understanding of adult learning, family
empowerment and the importance of sibling interactions. As the role of service
coordination continues to evolve, it is crucial that the effectiveness of the IFSP as both a
written document and a process continues to improve to meet the needs of families and
children with disabilities.
Appendices
Appendix A
The following 8 items in bold, all caps, are indicators to be analyzed on the IFSP Routine Utilization Tool. After carefully reading the instructions and reviewing the examples, proceed with the examination of the IFSPs

**ROUTINE NUMBER**
Look at the Family and Childcare Routines page to determine the number of routines identified in the IFSP

*Family and Childcare Routines:*
Turn to the page in the IFSP that is labeled “Family and Childcare Routines”. Using the information provided in both the “Routine” column and the “What goes well and what doesn’t go well for your child and family?” Determine the number of routines being addressed. Identify each routine on an individual IFSP by assigning a number beginning with the number 1 and continuing in numeric order.

Examples “Family and Childcare Routines” page:

<table>
<thead>
<tr>
<th>Routine</th>
<th>What goes well and what doesn’t go well for your child and family?</th>
<th>How happy are you with how this goes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakes up</td>
<td>Goes well. She is pleasant and picks out clothes from choices by pointing. Would like her to be able to dress herself</td>
<td>☒ Very ☑ Somewhat ☐ Not at all Comment: Dressing is a concern.</td>
</tr>
<tr>
<td>Daycare</td>
<td>Nap does not go well and she is frustrated with potty training. During play time hitting friends is a problem.</td>
<td>☒ Very ☐ Somewhat ☐ Not at all Comment: Mom is pleased with the Daycare.</td>
</tr>
<tr>
<td>Dinner</td>
<td>She loves to eat her lunch but has difficulty feeding herself.</td>
<td>☐ Very ☑ Somewhat ☐ Not at all Comment:</td>
</tr>
<tr>
<td>Bath time</td>
<td>He enjoys his bath but would like for him to be able to sit by himself in the tub.</td>
<td>☐ Very ☐ Somewhat ☐ Not at all Comment:</td>
</tr>
<tr>
<td>Evening</td>
<td>He falls asleep in his bed and sleeps through the night</td>
<td>☒ Very ☐ Somewhat ☐ Not at all Comment:</td>
</tr>
</tbody>
</table>

Examples of numbering the Routines:
Wakes up = 1
Daycare = As daycare is a typical setting for children, it may be reported as a “routine”; however there is more than one routine addressed in the section.

Nap = 2
Potty Training = 3
Play time = 4
Dinner = 5
Bath Time = 6
Evening = 7

If there is clearly more than one priority or concern addressed, score the routine assigning each priority/concern separately.

ROUTINE TYPE
Look at the Family and Childcare Routines page to determine the type of routine.

Family and Childcare Routines:
Turn to the page in the IFSP that is labeled “Family and Childcare Routines”. Select a routine in the “Routine” column. Look at the column “What goes well and what doesn’t go well for your child and family?” and identify the routine type using the descriptive writing provided on the IFSP. Assign:

- **Morning/Wake-up** if the description includes waking or early morning routine specifying other types of routines. If a specific type of routine is addressed assign that routine.

- **Dressing** if there is mention of putting on or taking off clothes in the description.

- **Meal** if there is any mention of eating breakfast, lunch, dinner or snack. There may by more than one routine identified in each IFSP as this type of routine as there are multiple opportunities for meals during a typical daily routine.

- **Play** if the description includes playing with family members, peers, free time, watching television, taking a walk, outdoor activities or general free time that is not specific.

- **Nap** if the description includes resting, napping or the difficulties with attempting to get the child to sleep or if there is a description of lack of nap being a concern.

- **Personal Hygiene** if bathing, washing hands or face, brushing teeth, grooming, cutting hair or changing of a diaper is described.

- **Toileting** if potty training is description whether it is currently an issue or they wish to work on this skill.

- **Bedtime** if the evening bedtime routine (which may include reading a book), evening sleeping habits, trouble with getting the child to sleep during the evening
hours or dissatisfaction with the amount of overnight sleep is described. This routine type is not to be confused with nap routines which occur at different times than the family’s typical sleeping hours.

- **Transition** if the description specifies concerns with times when the routine is changing. (examples: Drop off at childcare, putting toys away)

- **Community** if the description includes activities outside of the home or childcare setting, such as churches, restaurants, parks, shopping, doctors/therapy visits or traveling in a vehicle.

Examples “Family and Childcare Routines” page:

<table>
<thead>
<tr>
<th>Routine</th>
<th>What goes well and what doesn’t go well for your child and family?</th>
<th>How happy are you with how this goes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakes up</td>
<td>Goes well. She is pleasant and picks out clothes from choices by pointing. Would like her to be able to dress herself</td>
<td>□ Very ☒ Somewhat □ Not at all</td>
</tr>
<tr>
<td></td>
<td>Comment: Dressing is a concern.</td>
<td></td>
</tr>
<tr>
<td>Daycare</td>
<td>Nap does not go well and she is frustrated with potty training. During play time hitting friends is a problem.</td>
<td>☒ Very □ Somewhat □ Not at all</td>
</tr>
<tr>
<td></td>
<td>Comment: Mom is pleased with the Daycare.</td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td>She loves to eat her lunch but has difficulty feeding herself.</td>
<td>□ Very ☒ Somewhat □ Not at all</td>
</tr>
<tr>
<td></td>
<td>Comment:</td>
<td></td>
</tr>
<tr>
<td>Bath time</td>
<td>He enjoys his bath but would like for him to be able to sit by himself in the tub.</td>
<td>□ Very ☒ Somewhat □ Not at all</td>
</tr>
<tr>
<td></td>
<td>Comment:</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td>He falls asleep in his bed and sleeps through the night</td>
<td>☒ Very □ Somewhat □ Not at all</td>
</tr>
<tr>
<td></td>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>

Examples of types of Routines:

<table>
<thead>
<tr>
<th>Routine</th>
<th>Routine number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>Wakes up = 1</td>
</tr>
<tr>
<td>Nap</td>
<td>Nap = 2</td>
</tr>
<tr>
<td>Toileting</td>
<td>Potty Training = 3</td>
</tr>
<tr>
<td>Play</td>
<td>Play time = 4</td>
</tr>
<tr>
<td>Meal</td>
<td>Dinner = 5</td>
</tr>
<tr>
<td>Personal hygiene</td>
<td>Bath Time = 6</td>
</tr>
<tr>
<td>Bedtime</td>
<td>Evening = 7</td>
</tr>
</tbody>
</table>

*Daycare = As daycare is a typical setting for children, it may be reported as a ‘routine’, however there is more than one routine addressed in the section.*

**UNSATISFACTORY ROUTINE (USR)**

Look at the Family and Childcare Routines page to determine if the routine is unsatisfactory.
**Family and Childcare Routines:**

Turn to the page in the IFSP that is labeled “Family and Childcare Routines”. Using the information provided in **both** the “What goes well and what doesn’t go well for your child and family?” column and the “How happy are you with how this goes?” column, determine if the routine is considered to be unsatisfactory. Select “yes” in the drop down box if the routine is unsatisfactory. If the routine is not unsatisfactory, select “no” in the drop down box. If “no” is selected then proceed directly to the sibling questions and do not answer the next three questions.

Examples:
Assign a “yes” if anything other than “very” is checked in the “How happy are you with how this goes” column.

<table>
<thead>
<tr>
<th>Routine</th>
<th>What goes well and what doesn’t go well for your child and family?</th>
<th>How happy are you with how this goes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakes up</td>
<td>Goes well. She is pleasant and picks out clothes from choices by pointing. Would like her to be able to dress herself</td>
<td>□ Very  ☒ Somewhat  □ Not at all Comment: Dressing is a concern</td>
</tr>
<tr>
<td>Lunch</td>
<td>She loves to eat her lunch but has difficulty feeding herself.</td>
<td>□ Very  ☐ Somewhat  ☒ Not at all Comment:</td>
</tr>
</tbody>
</table>

**OR**

Assign yes if there is any description of concern or dissatisfaction written in the “What goes well and what doesn’t go well for your child and family?” section or comment section.

<table>
<thead>
<tr>
<th>Routine</th>
<th>What goes well and what doesn’t go well for your child and family?</th>
<th>How happy are you with how this goes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Play time</td>
<td>He is very content. Would like for him to interact with peers more often</td>
<td>☒ Very  ☐ Somewhat  ☐ Not at all Comment:</td>
</tr>
<tr>
<td>Bath time</td>
<td>She loves her bath, but can not support herself in a sitting position for very long which can make it very difficult.</td>
<td>☒ Very  ☐ Somewhat  ☐ Not at all Comment:</td>
</tr>
</tbody>
</table>

If routine documented on IFSP is broken into multiple routines, more than one routine is assigned per row by rater. Rate each one separately using above directions.

**USR WITH A PRIORITY/CONCERN (PC)**
Look at the Family Identified Priorities and Concerns pages to determine if the USR has a corresponding Priority/Concern
**Family Identified Priorities and Concerns:**
Turn to the pages in the IFSP that are labeled “Family Identified Priorities and Concerns”. Using the information provided on both pages, determine if the USR has a corresponding priority or concern. Select “yes” in the drop down box if the USR has a corresponding priority or concern. If there is not a corresponding priority or concern, select “no” in the drop down box. If “no” is selected then proceed directly to the sibling questions and do not answer the next two questions.

If the routine is marked as unsatisfactory, but there is not a clear description explaining why a PC can not be identified and a “no” should be selected.

**PC WITH A CORRESPONDING OUTCOME**
Look at the Outcomes for Our Child and Family pages to determine if there is the PC that is derived from a USR has a corresponding outcome.

**Outcomes for Our Child and Family:**
Turn to the pages in the IFSP that are labeled “Outcomes for Our Child and Family”. Using the outcome statements and strategies, determine if there is an outcome that corresponds with the PC which was derived from the USR. Corresponding outcomes may include referrals that correspond with the PC. Select “yes” in the drop down box if the PC has a corresponding outcome. If there is not a corresponding outcome, select “no” in the drop down box. If “no” is selected then proceed directly to the sibling questions and do not answer the next questions.

**DOMAIN ADDRESSED**
Using the Routine, Priority/Concern, Outcome and Strategies, determine the primary Domain addressed. ONLY SELECT ONE.

**Family and Childcare Routines, Family Identified Priorities and Concerns, Outcomes for Our Child and Family:**
Information may be examined using all of the pages above. Using information specific to the USR, that corresponds to a PC, which then corresponds to an Outcome, identify the primary domain that is being addressed. After determining the domain from one of 5 domains (see examples below), check the appropriate box on the tool.

Examples include but are not limited to:

**Cognitive:** problem solving abilities, reasoning, acquisition of knowledge, understanding games, and directions, thinking and talking about objects and people that are not present.
**Motor:** Including both Large muscle skills; basic body movements such as lifting the head, rolling over, crawling, walking, climbing stairs; and small motor skills such as grasping, releasing and drawing.

**Social/Emotional:** peer/sibling interactions, engaging in play, using appropriate behaviors when interacting with others, temper tantrums.

**Adaptive:** Includes skills such as personal care skills such as dressing/undressing, eating/feeding, toileting, grooming (e.g., hand washing, face washing, brushing teeth). Appropriate functioning in community environments such as restaurants, neighborhoods, stores, doctor visits, church, recreational areas, and safety practices such as seatbelts and holding hands while crossing the road are indicative of adaptive behaviors. And finally, self-directed behaviors such as independent play/self occupation, demonstrating caution and self regulation such as sleeping adjusting/transitioning to new environments and situations.

**Communication:** Expressing wants and needs, interact verbally with others, gesturing, signing, and non-speech sounds such as laughing.

**The following sibling indicators are specific to the IFSP. Therefore the tool will retain this information as it progresses to the next routine.**

**SIBLING INCLUDED IN ROUTINE, PRIORITIES or CONCERNS**
Look at the Family and Childcare Routines page and the Family Identified Priorities and Concerns pages to determine if a sibling is included. This indicator is specific to each IFSP and not to individual routines or priorities. Therefore, it is only necessary to answer the question one time for each IFSP. Select “yes” in the drop down box if a sibling is mentioned in either section. If there is no mention of a sibling, select “no” in the drop down box. If “no” is selected, do not answer the last sibling question.

**SIBLING INCLUDED IN OUTCOMES**
Look at the Outcomes for Our Child and Family section and the corresponding strategies to determine if a sibling is included in the outcomes or strategies. This indicator is specific to each IFSP and not to individual outcomes. Therefore it is only necessary to answer the question one time for each IFSP. Select “yes” in the drop down box if a sibling is mentioned in this section. If there is no mention of a sibling, select “no” in the drop down box.

After completing the form for an entire routine, the tool will automatically save indicators that are specific to individual IFSPs. By selecting the “Add Routine” button, the tool will allow for the next routine to be examined. Upon completion of all routines in an IFSP, select the “Add IFSP” button.
SERVICE COORDINATOR QUESTIONNAIRE

1. Are you an ISC or a PSC?  [ ] ISC  [ ] PSC

2. On what date did you attend the IFSP training? (today’s date)___________

3. How long have you been a service coordinator? _____ years _____ months

4. How long have you been a service coordinator in Kentucky? ____ years ____ months

5. What college degrees do you hold? (eg., B.S. in Psychology; M.S. Social Work)

<table>
<thead>
<tr>
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<th>Field(s)</th>
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<tbody>
<tr>
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<td>B.S.</td>
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<td>Ed.D.</td>
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<tr>
<td>Ph.D.</td>
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<tr>
<td>Other</td>
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</table>

6. For the IFSP you turned in today, is the family at or below the poverty level?  [ ] yes  [ ] no  [ ] I don’t know

7. For the IFSP you turned in today, does the child have multiple/severe disabilities?  [ ] yes  [ ] no  [ ] I don’t know

8. On average, how many hours each week do you provide service coordination? _____

9. If you are a PSC, on average, how many families are on your caseload? ______

10. If you are an ISC, on average, how many new referrals do you receive each month?_____

11. Do you feel that IFSPs in which you have participated have been family-centered?  [ ] yes  [ ] no  [ ] I don’t know

   Comments:_____________________________________________________________________
   ______________________________________________________________________________

12. Do you feel that the new IFSP will facilitate a more family-centered process?  [ ] yes  [ ] no  [ ] I don’t know

   Comments:_____________________________________________________________________
   ______________________________________________________________________________
Appendix C
**First Steps**

**Individualized Family Service Plan**

**General Family Information**

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<th>Name</th>
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<td>Parent</td>
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<tr>
<td>Legal Guardian</td>
<td>Legal Guardian</td>
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<tr>
<td>Surrogate Parent</td>
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<th>Evening</th>
<th>Telephone: Day</th>
<th>Evening</th>
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<th>Best time to call:</th>
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**IFSP Team**

<table>
<thead>
<tr>
<th>Date and IFSP Type</th>
<th>Team Member</th>
<th>Role</th>
<th>Telephone</th>
<th>Agency Name</th>
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| Date: | | | |
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<tr>
<th>Initial</th>
<th>6-month Review</th>
<th>Annual</th>
<th>Transition</th>
<th>Amendment</th>
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<table>
<thead>
<tr>
<th>Plan Effective</th>
<th></th>
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<tbody>
<tr>
<td>From:</td>
<td>To:</td>
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</table>

<table>
<thead>
<tr>
<th>Amendment Rationale or Transition Type:</th>
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**Primary Service Coordinator Contact Information:**

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<th>Name</th>
<th>Mailing Address</th>
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<th>State</th>
<th>Zip</th>
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**Backup Service Coordinator Contact Information:**

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<th>Name</th>
<th>Mailing Address</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Telephone</th>
<th>Best time to call:</th>
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</table>
### Medical Information

**Medical Area**

**Vision**
- Has your child's vision been tested? □ no □ yes if yes, when and by which doctor?
- Do you have any concerns about your child's vision? □ no □ yes if yes, please explain:

**Hearing**
- Has your child's hearing been tested? □ no □ yes if yes, when and by which doctor?
- Do you have any concerns about your child's hearing? □ no □ yes if yes, please explain:

**General Health Status**
- Does your child have a pediatrician or other healthcare professional you see regularly? □ yes □ no If so, please give the name and telephone number:
  - Name: ___________________________ Telephone: ___________________________
- When was your child's last well check or visit? ___________________________
- Does your child have any specialists or other doctors you see regularly? □ yes □ no If so, please give the names and reason why your child sees him/her:
  - Name: ___________________________ Why: ___________________________
  - Name: ___________________________ Why: ___________________________
  - Name: ___________________________ Why: ___________________________
- Does your child have any medical concerns or diagnosis? □ no □ yes if yes, please specify:
- Was your child born early or prematurely? □ no □ yes if yes, how many weeks early? ___________________________
- What medications is your child taking and why? Include any side effects:

  - Were there any concerns about your child or child's mother prenatally or at birth?

**Nutrition**
- Are there any concerns about your child's eating, general nutrition, or growth? □ no □ yes if yes, please explain.

**Dental**
- Has your child seen a dentist? □ yes □ no If so, when and by which dentist?
- Do you have any concerns about your child's dental health? □ no □ yes if yes, please explain.

Is there anything about your child's health (special equipment, allergies, other mental or physical information) that the team should know about to better plan and provide services to your family?

---

Child's Name ___________________________ CBIS# ___________________________ Page B ______
<table>
<thead>
<tr>
<th>Developmental Area</th>
<th>Student does this well</th>
<th>Student is learning to do this or needs help with this</th>
<th>Who provided information?</th>
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</thead>
<tbody>
<tr>
<td>Understanding others and expressing myself</td>
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<tr>
<td><strong>Communication</strong></td>
<td></td>
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<tr>
<td>Playing, Thinking, and Exploring</td>
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<tr>
<td><strong>Cognitive</strong></td>
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<tr>
<td>Moving my body and using my hands</td>
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<tr>
<td><strong>Motor</strong></td>
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<tr>
<td>Emotions, feelings, and interacting with others</td>
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<tr>
<td><strong>Social-Emotional</strong></td>
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<tr>
<td>Eating, drinking, toileting, and doing things for myself</td>
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<tr>
<td><strong>Adaptive</strong></td>
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</table>

Child's Name ___________________________    CBIS# ___________________________    Page C ______
Family and Childcare Routines

By learning about what your child and family commonly does, we can get an idea of what goes well for you, what you find challenging, and how we might help. Routine is just another way of describing what you and your child tend to do throughout most days. So we can better understand each routine, we will talk about what you like about your child’s participation, what everyone else does during the routine, what type of help your child needs, and how happy you are with the routine. Some of the routines that families share include waking, getting ready to go out, meals, playtime, hanging out at home, childcare routines, shopping, chores, visiting others, bath time, bed/nap time, and car trips.

<table>
<thead>
<tr>
<th>Routine</th>
<th>What goes well and what doesn’t go well for your child and family?</th>
<th>How happy are you with how this goes?</th>
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<tr>
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<td>□ Very Comment: □ Somewhat □ Not at all</td>
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<td>□ Very Comment: □ Somewhat □ Not at all</td>
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<td>□ Very Comment: □ Somewhat □ Not at all</td>
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<td>□ Very Comment: □ Somewhat □ Not at all</td>
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<td>□ Very Comment: □ Somewhat □ Not at all</td>
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</table>

Who provided information about routines on this page?

Child’s Name ____________________________ CBIS# ____________________________ Page D
Family Identified Priorities and Concerns

Describe your concerns and what is important for your child and family:

________________________________________________________________________

________________________________________________________________________

Think about the discussion about your family and child and your daily routines to answer the following:

Describe what your child enjoys or works well for your child. Think about people, places, textures, foods, routines, activities:

________________________________________________________________________

________________________________________________________________________

Describe what your child does not enjoy or does not work well for your child. Think about people, places, textures, foods, routines, activities:

________________________________________________________________________

________________________________________________________________________

Describe what your family enjoys:

________________________________________________________________________

________________________________________________________________________

Describe what you find challenging or don’t enjoy:

________________________________________________________________________

________________________________________________________________________

Describe activities your family would like to do, but are not able to right now and why you are unable to do this:

________________________________________________________________________

________________________________________________________________________

Describe anything you would like to know more about. Some ideas are below:

________________________________________________________________________

________________________________________________________________________

☐ Meeting families with a child who has similar needs
☐ Finding or working with doctors or other specialists
☐ Coordinating my child’s medical care
☐ Coordinating or making appointments with agencies
☐ How services work or how they could work better for me
☐ My child’s delay or disability or diagnosis
☐ Planning or expectations for the future
☐ Money for costs of my child’s special needs
☐ Finding people who can help me in my home
☐ Ways to play with my child that may help development
☐ Recreation, ways to have fun as a family
☐ Child care
☐ Support groups
☐ Help with insurance
☐ Resources that may be available
☐ Finding adequate housing
☐ Transportation


Child’s Name ___________________________ CBIS# ________________________

Page E ______
# Outcomes for Our Child and Family

What we want to happen (Including how we will know we are successful):

Related to Priority # ___

<table>
<thead>
<tr>
<th>Ideas and Strategies (Address family strengths and resources first.)</th>
<th>People who will help and their roles</th>
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</thead>
</table>

Is assistive technology needed? □ yes □ no

<table>
<thead>
<tr>
<th>Family Review (Date and initial in appropriate column)</th>
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<tbody>
<tr>
<td>1 No Longer a Need</td>
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</table>

Is modification or revision to outcome or its associated services needed? □ yes □ no

Comments:

Child's Name __________________________ CBIS# __________________________

Page G ______
Child and Family Transition Plan

This plan addresses which of the following transitions? □ From hospital to home  □ Between communities  □ Service in new setting  □ Exit First Steps before 3rd birthday  □ Exit First Steps at 3rd birthday  □ Other transition
Is this the official transition conference? □ yes  □ no

What our priorities or concerns are related to this transition:

What we want to happen:

<table>
<thead>
<tr>
<th>Strategies/Activities (Include family involvement/exploration of options, lead agency discussion, child preparation, and agency preparation and/or involvement.)</th>
<th>Target Date</th>
<th>Date Completed</th>
<th>People/Aencies who will help and role</th>
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<th>Unsatisfied or Worse</th>
<th>Unchanged; Still a Need</th>
<th>Partially Met; Still a Need</th>
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Child's Name __________________________ CBIS# __________________________

Page H
### Summary of Services

<table>
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<th>Service</th>
<th>Who will do this?</th>
<th>How and where?</th>
<th>Who will pay?</th>
<th>How often and how long?</th>
<th>Begin and End Dates</th>
<th>Total Units</th>
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All of the services provided by First Steps must be provided in places where children without disabilities would participate unless outcomes cannot be achieved satisfactorily in these environments. These places include home, childcare, or other places in the community. Are all services to be provided in natural environments? □ yes □ no If no, please provide a rationale for each exception:

---

Child's Name _______________________________ CBIS# ___________________________
KEIS Form 10 - January 2005

### Team Approval

#### Parental Consent for Provision of Early Intervention Services and Approval of the Plan:
The following rights, procedural safeguards, and assurances have been explained to me, and I have received a written copy of each:
- [ ] Informed Consent
- [ ] Written Notice of Rights
- [ ] Confidentiality
- [ ] Access to Records
- [ ] Dispute Resolution
- [ ] Right to Refuse Services
- [ ] I have participated in developing this IFSP, and all services and activities have been fully explained to me. I give my informed consent to carry out the plan. I understand my consent is voluntary and I can change my mind and revoke my consent for any or all services and activities at any time.
- [ ] I give my informed consent for a copy of this IFSP in its entirety to be provided to all members of the IFSP team.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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#### Other Team Members' Approval of Plan:
We agree that the outcomes selected reflect family priorities and concerns and the strategies selected support those outcomes. We agree to carry out the plan in a manner that supports the family’s ability to help their child participate in and learn from their everyday routines and activities.

<table>
<thead>
<tr>
<th>Signature (or printed name if not in attendance)</th>
<th>Date</th>
<th>Approval Method</th>
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<tr>
<th>Others Present:</th>
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</table>

Child's Name: ___________ CBIS#: ___________
Assistive Technology

What assistive technology is needed? ____________________________________________

This assistive technology is related to which outcome(s)? ____________________________

How will the assistive technology help achieve the associated outcome(s)? __________

__________________________________________________________________________

Does the needed assistive technology exist in the family's natural environment? □ Yes □ No

Is the assistive technology needed something all children use? □ Yes □ No

Is there something in the child's natural environment that could be used or adapted to serve the same purpose? □ Yes □ No

How will the assistive technology be acquired? □ Borrowed □ Purchased* □ Other ________________________________

*If purchased, estimated Cost ________________________________

*Is Assessment needed? □ No □ Yes □ Why? ________________________________

Assessor: __________________ Date: __________

Will the equipment permanently belong to the family? □ Yes □ No If no, when must it be returned and to whom? ________________

Review

<table>
<thead>
<tr>
<th>AT is Being Used</th>
<th>AT is no longer needed</th>
<th>AT is helping with associated outcome(s)</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
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AT=Assistive Technology

Child's Name ______________________ CBIS# __________________ Appendix ________
<table>
<thead>
<tr>
<th>Routines from family and childcare routines</th>
<th>Child Outcomes from the Outcomes pages</th>
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References


http://www.puckett.org


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