

University of Nebraska - Lincoln

DigitalCommons@University of Nebraska - Lincoln

Publications of Center for Public Affairs Research
(UNO)

Public Policy Center, University of Nebraska

1989

Early Childhood Special Education in the Next Decade: The Impact of Public Law 99-457 in Nebraska

Deana Finkler

University of Nebraska at Omaha

Cordelia Robinson

University of Nebraska at Omaha

Follow this and additional works at: <http://digitalcommons.unl.edu/cpar>



Part of the [Public Affairs Commons](#)

Finkler, Deana and Robinson, Cordelia, "Early Childhood Special Education in the Next Decade: The Impact of Public Law 99-457 in Nebraska" (1989). *Publications of Center for Public Affairs Research (UNO)*. 10.
<http://digitalcommons.unl.edu/cpar/10>

This Article is brought to you for free and open access by the Public Policy Center, University of Nebraska at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Publications of Center for Public Affairs Research (UNO) by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

Early Childhood Special Education in the Next Decade: The Impact of Public Law 99-457 in Nebraska

6

Deana Finkler
Cordelia Robinson

Nebraska has served handicapped children from birth to age 21 through special education and other services since 1978. But in 1991 Public Law 99-457 will include federal funding for preschool services and incentive grants for infants and toddlers. Because Nebraska has already been serving these populations, it will not receive new funds under the new law. States that will be taking advantage of the incentive funds will be looking to Nebraska—and other states with experience in serving handicapped infants and preschoolers—for precedence. Although under P.L. 99-457 policy has been set at the federal level, key state policy considerations remain. These include choosing the size of the population to be served, how to best serve the entire family, fostering interagency case coordination, developing appropriate intervention personnel, and solving funding problems.

Nebraska has provided special education and related services to handicapped children from date of diagnosis, or birth, to five years of age through Nebraska Revised Statute 79-3315, passed by the State Legislature in 1978. It is one of four states to have done so since then. In the fall of 1991, Public Law 99-457, the amendment to and expansion of the federal Education for All Handicapped Children Act (P.L. 94-142), will be implemented. This law mandates rehabilitative services for all handicapped children from age 3 through 21 (Part B), whereas previously services for handicapped children began at age 5. The law also includes incentives to serve handicapped infants and toddlers and their families from birth (Part H).

In addition to children who qualify for services under existing rules, there is a population of children who are at risk for developmental problems and could benefit from services, but who do not currently qualify. These at-risk children experience biological and/or environmental difficulties that carry significant risk of developmental delay according to standard norms in the psychomotor, cognitive, or affective

domains. These risks include a lesser likelihood of completing school and decreased levels of productivity (Barnett 1988).

States can receive money for planning and developing a system of community-based early intervention services not only for handicapped infants and toddlers but also for children who are at risk for developmental problems. Part H of P.L. 99-457 defines handicapped infants and toddlers as individuals from birth through age 2 who are in need of early intervention services because they: (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, language and speech development, psychosocial development, or self-help skills; or (2) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. The term may also include, at a state's discretion, individuals (from birth to age 2) who are at risk of having substantial delays if early intervention services are not provided. Each state is to define what criteria will be used to designate children as at risk if the state chooses to serve them.

A Legislative History of P.L. 99-457

Systematic federal funding for early intervention programs for developmentally disabled children began in the late 1960s, when demonstration projects for children under 8 years of age were funded under the Handicapped Children Early Education Program (HCEEP). This discretionary government program continues to the present. Hundreds of projects funded over its 20-year history provide the base of experience upon which P.L. 99-457 was built, particularly in regard to services responsive to the needs of children and families, as perceived by the families. However, the HCEEP program was discretionary, so when the Education for All Handicapped Act was passed in 1975, the provisions did not apply to children under age 5. Shortly after the passage of that act, greater activity was observed in the area of early intervention.

Initiation and passage of P.L. 99-457 was based on the assumption that the type of early intervention services to be delivered should be beneficial to handicapped children and their families. Under the new law, an Individual Educational Program (IEP) is required for children age 3 and older. For infants and toddlers from birth through age 2, an Individual Family Service Plan (IFSP) is required, including assignment

of a case manager to facilitate the coordination of services. When the qualifying child is an infant or toddler, the amended law specifies that the family is to be included and the "strengths and needs of the family in relation to their child" are to be addressed in the IFSP. The IFSP is to be written by an interdisciplinary team including the parents or guardians.

The emphasis upon family involvement implies an expectation that benefits go beyond the direct benefits to children and their families, and out to the community as a whole. In addition, early intervention services are expected to be ultimately cost-effective. The argument is that by supporting and strengthening the family in accordance with their perceived needs, the state will better help families meet their children's needs, and costly out-of-home care may be avoided. Thus, both stronger families and decreased total costs will result.

The Nebraska Context

The Nebraska system of community offices of retardation led the way in the deinstitutionalization movement of the 1960s. Nebraska LB 403, passed in 1973 anticipated P.L. 94-142 by mandating public school responsibility for all handicapped students 5 to 18 years of age (and later to 21 years of age), despite the severity of handicapping conditions. In 1978, the Nebraska legislature passed the Special Education Act mandating public school responsibility for serving children with handicaps from the date of diagnosis to the traditional school age of 5 years.

In 1986 then-Governor Kerrey appointed the Nebraska Department of Education as the lead agency responsible for implementation of P.L. 99-457 in Nebraska. But this does not mean that the Nebraska Department of Education must itself deliver or pay for the services provided. In 1987 Governor Orr established, according to federal statutes, the Interagency Coordinating Council to provide leadership in implementation of P.L. 99-457 within the state of Nebraska. Thus the state is now well into a four-year preparatory period during which planning, revising statutes and regulations, training, coordinating, creating interagency agreements, and implementing mandates must occur.

Some of the factors that contribute to Nebraska's unique position in the implementation of P.L. 99-457 (Part H) are the legislative history and current mandate, the size and stability of the population, and the relative stability of personnel in the state government. These factors are particularly applicable to the coordination of services by several agen-

cies. In fact, one strength that contributes to Nebraska's opportunity to be on the cutting edge of family and child legislation is the degree to which middle management staff in state-level agencies know one another and have a history of working collaboratively on implementing policy where the actions of one agency affect the other.

The Nebraska Legislature passed the Family Policy Act in 1987. This legislation asserts the importance of a ". . . caring social unit, usually the family, to the development of children." It stipulates that when children and families require assistance from any component of state government that every reasonable effort shall be made to provide service by the least intrusive and least restrictive methods and as close as possible to the home community. While conceived independently of special education legislation and with much greater breadth in its implications, the Family Policy Act is entirely consistent with the spirit of P.L. 99-457 and can provide guidance regarding policy issues to be decided in implementing the expansion of P.L. 99-457, (Part H) in Nebraska.

Elements of a Statewide System

P.L. 99-457 stipulates that each state develop a system consisting of a comprehensive, coordinated, multidisciplinary program of early intervention services for all handicapped infants, toddlers, and their families. The components of this system are outlined below and the Nebraska effort in each is summarized.

The definition of the term "developmentally delayed" that will be used by the state in carrying out the program.

Current eligibility criteria specify significant disabilities or health problems (Rule 51). The Interagency Coordinating Council (ICC) Task Force is proposing that the state continue with the current definition of special education outlined in Rule 51.

Reasonable goals and timetables for making appropriate early intervention services available to all handicapped infants and toddlers in the State.

Through LB 889, child-focused early intervention has been available. Issues in the legislation yet to be addressed include case coordination and services to address family needs.

Performance of a timely, comprehensive and multidisciplinary evaluation of the functioning of handicapped infants and toddlers and family needs to appropriately assist in their development.

Child assessment capability is generally good in Nebraska, either through school diagnostic personnel or special services such as Barkley Center and Meyer Children's Rehabilitation Institute. Assessment of family needs is being addressed by the ICC Task Force on IFSP and case management.

Development of Individualized Family Service Plans and the provision for case management services.

Again, the ICC Task Force on IFSPs is developing recommendations in this area. It has published a child-focused and family-centered philosophy and a listing of case management functions.

A comprehensive child-find system and a system for referrals to service providers that includes timelines and provides for participation by primary referral sources.

If eligibility is left as is, then current child-find efforts would seem adequate. If eligibility is extended to include at-risk children, then child-find efforts will need to be addressed.

A public awareness program on early identification of handicapped infants and toddlers.

Again, if no change is made in the definition of handicapped, the level of awareness is generally good, with perhaps a need for some attention to nursing personnel and the medical specialties of family practice and obstetrics. Changes in eligibility would necessitate some additional personnel training.

A central directory that includes early intervention services, resources, and experts available in the state, as well as research and demonstration projects being conducted in the state.

An Information Referral Service is operated jointly by Education and Vocational Rehabilitation. This may need to be revised or updated with the inclusion of family services. Also, a system to operate across all agencies included in the ICC should be considered.

A comprehensive system of personnel development that includes training of public and private service providers, primary referral sources, and persons who will provide services after receiving such training.

The state has certification for early childhood special education, and colleges and universities have developed programs in this area. However, no systematic plan exists for any other disciplines involved in early intervention efforts. NDE has sponsored training activities for specific disciplines and the early childhood State Education Training Series (SETS). An HCEEP project, Getting Started Together, has provided inservice for two years. An ICC Task Force is working in this area.

A single line of authority in an agency designated by the Governor to carry out: (1) general administration, (2) identification and coordination of all available funding sources, (3) resolution of interagency disputes, and (4) entering into formal state agency agreements.

A task force has just begun working on these issues.

A policy pertaining to contracting or making other arrangements with local service providers.

Rule 51 addresses provisions for contracting. As family service needs are addressed, a greater use of contracting may occur.

Procedural safeguards with respect to early intervention programs.

Rule 51 addresses this component.

A system for compiling data regarding the early intervention programs (which may be based on a sampling of data).

Such data will need to be integrated into the central directory.

In 1988 the NICC identified four major issues that it wished to address and formed four task forces. These groups, each chaired by a council member, also have membership representation beyond the ICC itself to include persons who are key resource people in the development of policy. The issues which these task forces are addressing include: (1) definition of eligibility, (2) guidelines for Individual Family Service Plans (IFSPs) and case management, (3) interagency cooperation and agreements, and (4) personnel preparation.

Defining the Target Population

The legislative intent of Nebraska's Special Education Act in mandating services from the date of diagnosis is to provide service to the most severely handicapped infants and toddlers. Qualifications for eligibility in Nebraska Department of Education Rule 51 comprise a most conservative definition of developmental delay. If Nebraska continues with its present policy, which is an option under P.L. 99-457, it will serve only those children who meet these tight eligibility criteria (see box, page 106). Table 1 presents the numbers of children (birth through age 2) served in Nebraska from 1979 through 1988.

Many states are considering serving children who are identified as at risk. Estimates of at-risk children vary widely depending upon the definition. Three categories are prevalent in the literature: (1) established conditions, (2) biological risk, and (3) environmental risk (Tjosem 1976). Meisels points out that these categories are not mutually

Table 1 - Children Under 3 Served by Nebraska School Districts, 1979-1988.

Age Group	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Under 1	40	30	59	47	53	60	61	53	4	37
Age 1	78	101	119	125	144	147	152	133	136	149
Age 2	139	161	173	187	200	239	250	270	239	257
Total	257	292	351	359	397	446	463	456	416	443
Total births	26,199	27,335	27,164	26,954	26,254	26,099	25,540	24,425	23,813	24,000 (est)

Source: Nebraska Department of Education.

exclusive, but they are useful in developing a definition of the population to be served (1988). While in principle a definition can be developed independently of an estimate of the numbers of individuals who will be encompassed by such a definition, in practice the numerical implications will be considered as these numbers will provide the information necessary to make projections.

When P.L. 94-142 was passed, the proportion of school-age children projected by the United States Department of Education as eligible for service was 12 percent. The United States Department of Education, in its Ninth Annual Report (1987) to Congress on the Education of the Handicapped Act, reported a survey of prevalence rates of 3- and

5-year-olds served by 26 states as ranging from less than 1 percent to a high of more than 5 percent of the population. A recent national analysis of children below 5 years of age who were enrolled in services showed an overall prevalence rate of 2.4 percent (Meisels and Wasik, in press). Such figures can be difficult to interpret because each state may define eligibility differently. Based upon these reports, however, a consensus seems to be developing regarding a prevalence rate of about 2 percent

**Nebraska Criteria for Serving Children Birth to 21 Years
According to Nebraska Department of Education Rule 51, 1987**

1. **Hearing Impaired** - In order for a child to be verified as hearing impaired, a hearing loss must be documented that has been determined to or can be expected to produce significant delays that would: result in standardized test scores falling 1.3 standard deviations below the mean in one or more of the following areas: receptive language, expressive language, and speech production or cognition; or result in a social/behavioral handicap.
2. **Mentally Handicapped** - In order for a child below age five to be verified as mentally handicapped, the evaluation shall include the analysis and documentation of: at least a two (2.0) standard deviation deficit in intellectual functioning, with at least a 1.3 standard deviation deficit in adaptive behavior; or at least a two (2.0) standard deviation deficit in adaptive behavior, with at least a 1.3 standard deviation deficit in intellectual functioning; or a medical condition or syndrome which can be expected to produce such delay in later childhood.
3. **Orthopedically Impaired** - In order for a child to be verified as orthopedically impaired, the evaluation shall include the analysis and documentation of a signed, written report from a physician which describes the severe motor impairment and any medical implications which would describe: impaired motor functioning which is expected to significantly interfere with educational performance; the child's level of educational or developmental performance; and any muscular or neuromotor impairment or skeletal deformity that limits the ability to move about, maintain postures, manipulate materials required for learning, or perform activities of daily living.
4. **Other Health Impaired** - In order for a child to be verified as Other Health Impaired (excluding an autistic condition), the evaluation shall include the analysis and documentation of a signed, written report from a physician that describes: the current health status and gives any medical implications of the impairment; a chronic or acute health impairment which results in reduced efficiency in educational or developmental performance because of a temporary or chronic lack of strength, endurance or alertness; and the child's level of educational or developmental performance.
5. **Speech-Language Impaired** - In order for a child below age five to be verified as speech-language impaired in the area of language, the evaluation shall include the analysis and documentation of scores from comprehensive standardized language tests (which may include but not be limited to vocabulary tests) which shall be at least 2.0 standard deviations below the mean for chronological age (a standard score of 70 or below as compared with age peers).
6. **Visually Handicapped** - In order for a child to be verified as visually handicapped, he or she shall be verified in one of three categories: blind, legally blind, or partially sighted.

of birth to 3-year-old children being eligible as handicapped or at risk when a combined risk definition of biological and socio-cultural factors is used.

Advantages of Providing Early Intervention for At-Risk Children. Several advantages are gained by serving children in the at-risk category. This supposition is clearly stated in the following quotation from P.L. 99-457:

Congress finds an urgent and substantial need to enhance the development of handicapped infants and toddlers and minimize their potential for developmental delay; reduce the education costs to our society, including our schools; minimize the likelihood of institutionalization; and enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps.

Early intervention can help to minimize the impact of developmental delays in at-risk children, prevent secondary problems, or prevent the exacerbation of primary problems in children with known disabilities. To date, however, program evaluations on early intervention programs have not included information regarding such possible outcomes.

Reviews of literature in the area of early intervention have varied from concluding no benefits in terms of child developmental gains to modest positive effects for early intervention. However, one of the difficulties in examining comprehensive services in this area is the lack of consistency or meaning in outcome measures, particularly for children with significant disabilities. The lack of detailed reports is also a problem with regard to the population of children included in a sample, the lack of differentiation among outcomes within studies that served heterogeneous populations, and the lack of long-term follow-up.

An argument frequently made, but also lacking substantial data at present, is the potential cost savings of early intervention, which may alleviate the need for special education services during the traditional school years. More information is now available regarding the cost savings of early intervention programs. However, with the exception of the Perry Preschool Project data (Barnett 1988), little information is available regarding long-term follow-up of children who have received early intervention. (For information on the Perry Preschool Project, see Chapter 5, "Improving Life Chances of Children in Nebraska.")

The positive results of the Head Start Program show that providing services to preschoolers considered to be at risk does reap benefits, both economic and social, in later life.

Nebraska needs to specify an at-risk definition to include some combination of biological and/or environmental risk criteria, and it must extend early intervention services, including family support. While this decision may more than double the number of birth to age 3 children served (from approximately 400 children under age 3 per year to approximately 1,000), many of the primary components to mandate, implement, monitor, and evaluate program servers are represented in Nebraska under the existing entitlement and discretionary programs operated by agencies represented on the ICC.

Disadvantages of Serving At-Risk Children. Before a decision is made to mandate services to at-risk children, several potential disadvantages should be considered. The first issue is to determine what, if any, possible untoward effects may result in being labeled at-risk. The primary concern here is that such a label may stigmatize a child or set in motion a self-fulfilling prophecy, teaching a child that he or she has a lowered capacity to learn. A related concern is whether families might become stigmatized. A third issue concerns the reliability of assessments in accurately identifying children in need at less than two years of age when ecological traits are recognized as critical in determining who is at risk. McCall has repeatedly pointed out the lack of predictive power of infant assessment tools (1982).

Although it will be a difficult task, Nebraska educators, child care professionals, parents, and policy makers have demonstrated that they are willing to take steps to define the term *at risk* and provide services in order to strengthen the developmental opportunities for all citizens.

The Individual Family Service Plan. Perhaps the provision of P.L. 99-457 (Part H) that generates the most discussion is the mandate of Individualized Family Service Plans for children under age 3. According to Section 677 (d), an IFSP must be developed for infants or toddlers and their families.

The IFSP is a written document containing the following elements:

- (1) A statement of the child's present levels of physical, cognitive, language, speech, and psycho-social development, as well as self-help skills, based on acceptable objective criteria.

- (2) A statement of the family's strengths and needs relative to enhancing the development of the family's handicapped infant or toddler.
- (3) A statement of the major outcomes expected to be achieved for the infant and toddler and the family; the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made, and whether modifications or revisions of the outcomes of services are necessary.
- (4) A statement of specific intervention services necessary to meet the unique needs of the infant or toddler and family, including the frequency, intensity, and method of delivering services.
- (5) The projected dates for initiation of services and the anticipated duration of such services.
- (6) The name of the case manager who will be responsible for implementation of the plan and coordination with other agencies and persons.
- (7) The steps to be taken in supporting the transition of the handicapped toddler to services provided under Part B of P.L. 99-457, to the extent such services are considered appropriate.

Some of the above provisions are similar to those of traditional early intervention service plans, such as in the Individualized Education Program (IEP) specified in P.L. 94-142 and currently used in Nebraska for handicapped children, from birth to age 21. Provisions related to identifying family strengths and needs and outcomes are new requirements.

It is obvious from the IFSP requirements that a number of issues will need to be resolved, such as who is the family, and what range of services will be available. The state has a responsibility in the resolution of these issues. A suggested response to questions such as these comes from "Recommended Practices for the Individual Family Service Plan" (Turnbull et al. 1989). This is a document prepared by the Office of Special Education Programs by the Association for the Care of Children's Health (ACCH), under contract with the National Early Childhood Technical Assistance System (NEC-TAS) at the University of North Carolina.

The answer to the question of who makes up the family potentially affects how well the child and family are served as well as the breadth of services to be considered in an IFSP. The reality of contemporary society is that the traditional nuclear family no longer represents the majority of households. The extended family of relatives, neighbors and friends may be reasonably considered an integral part of the family support system for any family. Persons such as aunts, boyfriends, babysitters, foster grandparents, and child care practitioners may well be primary child caretakers and/or central to long-term family support. Any definition of family support needs to be flexible enough to include such persons when identified as family by the parent and/or guardian. To do otherwise would be to disempower families by denying their own senses of self and imposing a stranger's definition.

The ACCH report suggests that P.L. 99-457 does not mandate "family assessment"; it simply directs gathering information about family strengths and needs relevant to their children's development, urges that the families themselves should determine what aspects of their family lives are relevant to their children's development, and suggests that only those strengths and needs should be identified. Similarly, the report recommends that families determine their own levels of involvement, which can vary over time, and that goals for the children and families should be determined collaboratively. This perspective is concordant with the Nebraska Family Policy Act and has the advantage of limiting rather than expanding the range of issues to be considered at any one time.

Interagency Cooperation. P.L. 99-457 mandates the use of resources from a number of different federally funded programs to provide services to infants and toddlers and their families. The expectation implicit in the legislation is that states will develop interagency agreements to enable various agencies to work together to coordinate resources in the most cost-effective manner in order to meet child and family needs.

Experience in working with the families of children from birth through age 2 who currently qualify for services under the categories identified by Rule 51 has taught that the fabric of the service system has holes in it. Few people are aware of the full range of services available to children and families, the many different funding sources that exist, and the different qualifying conditions and coverages. If family-centered services are to be coordinated, a central registry is needed. Per-

haps an on-line computer listing needs to be developed, which can be readily kept up to date and easily cross-indexed for points of service entry. A variety of such systems currently exists (Yajnik, Mayfield and Wuori 1987; Yajnik and Wiles 1988). Also needed is a way of qualifying families for services across existing agencies without their being required to make separate, physical applications at each agency. Case managers are needed who have skills in brokering services across agencies where responsibility for service delivery or financial support is unclear.

An ombudsman or brokering board should be empowered to negotiate solutions across funding sources/agencies upon request from a family, case manager, or agency. This board should be authorized at the state and federal levels so that families are not advised to move to another county or school district in order to qualify for services. The state of Florida is moving toward delivery of integrated services by providing case coordination services through specially trained nurses located in each county. Initial reports from this program suggest that it is cost-effective and that families like it (Reiss, Lefton, and Freedman 1989).

In Nebraska the number of children currently qualifying for services under Rule 51 is sufficiently small and stable so that restructuring does not seem a worthwhile effort. However, should Nebraska decide to serve at-risk children, the numbers of children and families requiring services will increase. The range of services required by such children and their families might be quite limited or handled most readily by school-based parent training programs, since schools are one of the most accessible and "normal" or non-stigmatizing community service agencies. Such training programs do not currently exist for families of at-risk children.

Preparation of Personnel. If Nebraska stays with its current definition of eligibility under the Special Education Act, then the personnel pool necessary for direct intervention with handicapped infants and toddlers appears to be adequate. School districts are not reporting acute difficulty in obtaining qualified personnel for this age group. But if eligibility requirements are changed, personnel needs will change as well.

In 1981, certification criteria for early childhood special education were developed and accepted by the Nebraska Council on Teacher Education (NCTE). While the certification criteria addressed future

personnel needs, an immediate need arose for personnel as the mandate for services began in the fall of 1979. A clause was placed in Rule 51 to enable schools to hire personnel already working with handicapped infants, toddlers and preschoolers, despite the fact that few were certified teachers. This grandfather clause enabled a relatively smooth transition from the Office of Retardation programs—which had been the primary providers of services to infants and preschoolers—to public school-funded programs for children with verified handicapping conditions.

Traditional agency programs do not handle well those children who are medically fragile or who have unusual family situations. For example, in a single-parent family here in Nebraska, one of a set of twins qualifies for special education and for respite care paid for by Medicaid. The other twin does not qualify and must be taken out to day care when the mother goes to her low-paying job, while a registered nurse comes in to care for the handicapped twin. A better solution would be to have a trained respite care worker take care of both children in the home. This person would not be as expensive as a nurse and would be able to handle the target child's medical and developmental needs as well as take care of the other twin. Unfortunately, no programs are available that tailor respite care training to management of specific medical conditions, and no insurance coverage is readily available to pay for such persons could they be found.

Nebraska teacher preparation programs have been providing some course work in early childhood special education since 1979, when the Nebraska Department of Education Special Education Office, sponsored a series of three courses (one on infants, two on preschoolers) through the State Education Training Series (SETS). Over the past 10 years these courses have been offered at the University of Nebraska at both the Lincoln and Omaha campuses, and for professional growth credits through a number of local school districts, educational service units, and agencies such as Head Start throughout the state. Participants in these course offerings have included parents and representatives from various disciplines interested in children and family needs and services.

In addition to the SETS training, from 1985 to 1988 the Department of Special Education at the University of Nebraska-Lincoln offered 15 hours of graduate credit courses with a specialization in infants to a

multidisciplinary group, most of them already serving in infant intervention roles.

The content of these offerings includes a heavy emphasis on skills needed in working with parents as well as direct instruction of children. The SETS courses do not, however, have a specific component on case coordination. The infant specialization series had one course directed toward working with parents and families. The primary additional training issues needed to be addressed to fully implement P.L. 99-457 are the areas of case coordination and elements of an IFSP, particularly identification of family needs and intervention strategies directed toward meeting those needs. Consideration should be given to incorporating case coordination into the training program of professionals in education, human services, social welfare, nursing, and associated disciplines so that this service may be provided by the team members whose disciplines are most relevant to the needs of the individual child (Finkler, Jackson, and Robinson 1989).

Funding P.L. 99-457 (Part H)

Population stability probably will continue in Nebraska, and the growth in numbers of handicapped infants, toddlers, and preschool children will be slow. Under the current qualifying definitions of Rule 51, approximately 1,600 handicapped children below five years of age enroll in special education each year in Nebraska. The below-age-three group includes approximately 400 children and is quite stable in size.

By legislative choice, all handicapped preschool programs in Nebraska are primarily funded with federal dollars, and all special education programs for children five and older are funded with state and local dollars. According to the Special Education Act, the preschool funding formula now provides 90 percent reimbursement to local school districts. Federal funds for planning and programs associated with P.L. 99-457 may not be used to supplant financial commitments or services that would have been paid for from other public or private sources. In addition, the state may not reduce medical or other assistance or alter eligibility to the detriment of handicapped children under Title V (Maternal and Child Health Act) or XIX (Medicaid). The range of costs for educational programs varies, of course, according to the type of program and services required.

Four new types of expenditure allocations are associated with P.L. 99-457: the costs of case management for children from birth through

age two; a broader array of services to families; a consideration of services to at-risk children; and personnel training, family training, and counseling. New programs, such as delivery of services in child care settings, may be needed because of the large proportion of families with children under three years of age where both parents (or the custodial parent in single-parent families) work outside the home. Integrated preschool experiences using existing community and private facilities may be desirable for the three- to five-year-old child. Integrated or mainstream settings are desirable because they represent the least restrictive educational environment and should be chosen if suitable for the child's developmental needs.

Case management costs also vary depending on the purpose and complexity of case management services. Numerous health insurance companies have instituted case management procedures for medically fragile children in an effort to achieve cost containment. Case management costs in Nebraska for a wide range of health, school and family services for severely involved medically fragile handicapped children ages birth to two were estimated by Project Continuity, an HCEEP federal demonstration project at the University of Nebraska Medical Center, Meyer Children's Rehabilitation Institute (MCRI). The MCRI researchers found that case coordination services offered by social service, education, and nursing professionals averaged about \$350 per child per month for personnel costs, ranging from one to 44 hours of case management time (Finkler 1988). If overhead increases that figure by 50 percent, the costs might average \$525 per child per month. Due to the highly specialized nature of services provided to children below five years of age and their families, projecting average costs is very difficult. The MCRI project focused on advocacy of child needs and brokering solutions to service problems as necessary, so its estimates may be higher than those of other approaches.

With early assignment of case coordinators, families of qualifying infants and toddlers may be referred as soon as possible to a broader array of services such as respite care, homemaker services, visiting nurses, family counseling, and pilot parents. Focusing on family needs will raise issues regarding the adequacy of financial resources and need for family support. The emphasis will be to coordinate resources rather than to increase resources.

Barnett, Escobar and Ravsten (in press) found that a program to teach parents to help their language-handicapped preschoolers in

ordinary activities at home produced greater gains in language development than did a five-day-per-week, center-based program. This one-semester parent program was reported to cost only about \$700 per child. This is much less than the figure of \$4,000 to 6,000 usually cited for providing language services to preschool handicapped children.

Finally, changes in eligibility could either increase or decrease costs. A recent review by Barnett described the cost-benefit analysis of the Perry Preschool Program, in which services to mildly handicapped, disadvantaged children were provided at a cost of \$6,200 per year plus transportation, and the benefits of such programs obviated costs up to \$20,000 over the elementary school years (1988). Barnett also cites a study suggesting that children could be served in mainstream settings at lower than average cost (1988). Itinerant specialists working with children in regular day care centers and kindergartens found gains in language abilities and later reductions in special education placements. The cost was less than \$500 annually per child (Weiss 1981).

Obviously, program costs can vary greatly, and their total social benefits as well as immediate cost should be considered in choosing among them. Three strategies may be used to pay for the additional costs, assuming that parents are in the home, interested in services, and willing to pay for them. The first one moves costs to the parents, who are given training to, for example, facilitate language development. Such cost-shifts to families may be justified, particularly for at-risk children where program costs are low, the shifted costs to families are low, and the benefit expected is great.

A second strategy is to seek financing from other sources. Funds for case coordination may be permissible for some children from Medicaid, from the Maternal-Child Health Care program, and from private insurance companies. Similarly, funding may be spread among federal, state, and private agencies to provide aid that facilitates needed services, such as a funding agreement to provide insurance for private respite care workers.

The third strategy would be to change programs to either less costly or more costly but more beneficial formats. Integrated preschools are one possibility, using existing programs. Alternatively, schools might offer both integrated preschool and day care programs, the latter funded by parents, which would cover part of the overhead costs for the school-based program and use existing physical facilities. Certainly, combinations of all three strategies are possible.

Recommendations

Nebraska should consider expanding its definition of eligibility for infants and toddlers to include children who are at risk for developmental problems. Further, certification should be broadened to include persons with nursing, social services, human development, and early childhood education backgrounds so that these persons could provide direct intervention services.

At-risk children are usually children with whom other agencies are already involved in some element of service provision, as most at-risk children come from families who meet poverty level guidelines. Specifically, many of these children may qualify for programs for low-income children through the Department of Social Services and Department of Health. The personnel involved in those programs are, of course, nursing and social work personnel. Some states have employed strategies such as providing some specialized course work at the associate degree level for personnel working in child care programs. Other states have included licensed practical nurses or home-maker personnel as a potential cadre of people who could be appropriate personnel if they had some additional child development information and training.

Another issue with respect to personnel that needs to be addressed is the level of expertise of the service provider for children who possess medically complex conditions. The numbers of such children are small, but their health care and developmental needs are very complex. Services addressing these health care and developmental needs should be coordinated with one another. Nurses, while prepared to meet the needs of such children, are generally precluded from serving in a primary developmental intervention role by current education certification standards.

In summary, several policy-related issues exist in regard to current use reallocation, training, and preparation of personnel interested in early intervention programs. The issues raised bridge interagency planning and regulating procedures. University and college preparation programs and state agency officials and departments must address the issues of case coordination and family needs. Needs for information in this area can probably be addressed through inservice training programs. *Getting Started Together* (Jackson, Hays and Robinson In press) provides a federally funded model of inservice training located at the University of Nebraska Medical Center.

References

- Barnett, W.S. 1988. "The Economics of Preschool Special Education Under Public Law 99-457." *Topics in Early Childhood Special Education* (8).
- Barnett, W.S., C.M. Escobar, and M. Ravsten. In Press. "Parent and Clinic Early Intervention for Children with Language Handicaps: A Cost-Effectiveness Analysis." *Journal of the Division of Early Childhood*.
- Finkler, D. 1988. *Case Management*. Paper presented to American Evaluation Association. Boston.
- Finkler, D., B. Jackson, and C. Robinson. 1989. "Case Coordination." Paper presented at Fourth Annual National Symposium on Information Technology as a Resource to Health and Disability Professionals. Charleston, SC.
- Garwood, S. 1987. "Political, Economic, and Practical Issues Affecting the Development of Universal Early Intervention for Handicapped Infants." *Topics in Early Childhood Special Education* (8).
- Jackson, B. J., B. J. Hays, and C. Robinson. In press. "Multiple Delivery Methods for an Interdisciplinary Audience: Assessing Effectiveness." *Journal of Continuing Education in the Health Professions*.
- Johnson, B., M. McGonigel, R. Kaufmann (Eds.). 1989. "Guidelines and Recommended Practices for the Individualized Family Service Plan." National Early Childhood Technical Assistance System, Association for the Care of Children's Health. Washington, DC: ACCH.
- McCall, R. 1982. "The Process of Early Mental Development: Implications for Prediction and Intervention." In N.J. Anastasiow, W.K. Frankenburg, and A.W. Fandal (Eds.), *Identifying the Developmentally Delayed Child*. Baltimore: University Park Press.
- Meisels, S.J. 1988. "Developmental Screening in Early Childhood: The Interaction of Research and Social Policy." In L. Breslow, J.E. Fielding, and L.B. Lave (Eds.), *Annual Review of Public Health* 9.
- Meisels, S.J., and B.A. Wasik. In press. "Who Should Be Served? Identifying Children in Need of Early Intervention." In S.J. Meisels and J.P. Shonkoff (Eds.), *Handbook of Early Intervention*. New York: Cambridge University Press.
- Nebraska Department of Education. 1986. *Preliminary Report: Staff Survey of Early Childhood Special Education Service Providers*. (May).
- Reiss, J., A. Lefton, C. Gray, and S. Freedman. 1989. "MCH-NET: Maternal and Child Health Network." Paper presented at Fourth Annual Symposium on Information Technology as a Resource to Health and Disability Professionals. Charleston, SC.
- Tjossem, T.D. (Ed.). 1976. *Intervention Strategies for High Risk Infants and Young Children*. Baltimore: University Park Press.
- U.S. Department of Education. 1987. *Ninth Annual Report to Congress on the Implementation of the Education of the Handicapped Act*. Washington, DC: U.S. Government Printing Office.
- Weiss, R. 1981. "INREAL Intervention for Language Handicapped and Bilingual Children." *Journal of the Division for Early Childhood* (4).
- Yajnik, G. G., and D. C. Wiles. 1988. "The Logical Choice: Linking People with Services." *Proceedings from the National Symposium on Information Technology*. Columbia, SC: University Printing Department.

Yajnik, G.G., K.L. Mayfield, and D.F. Wuori. 1987. "A Model Computerized Information System for Chronologically Ill and Disabled Children." *Proceedings from the AAMSI Congress*. Washington, DC: American Association for Medical Systems and Information.