A QUALITATIVE STUDY OF THE CREATION AND IMPLEMENTATION OF COMPREHENSIVE SCHOOL-BASED MULTIDISCIPLINARY COMMUNITY SERVICES

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CHAPTER ONE

INTRODUCTION

Importance of Program

Over the past two decades, the United States Congress has enacted a wealth of legislation on behalf of children with disabilities and their families, and the United States Supreme Court has affirmed the right of all children with disabilities to a free and appropriate public education in the least restrictive environment (Data Research, Inc., 1994). This evolution in federal policy has often been based on exemplary, leading practice in states. This policy has moved us from a paradigm where a child with a disability was seen as sick, deviant, or devalued, and needed to be "fixed" by special people in special places, to today's paradigm which values a child with a disability as a human being, a citizen with capabilities, competencies, capacities, and contributions. The child with disabilities is now seen as part of a family and an included member of a community, supported through an array of generic and specialized services (Ashbaugh, 1981; Ashbaugh & Bergman, 1991).

This federal policy culminated in the enactment of P.L. 101-336, The Americans With Disabilities Act (ADA) 1990, a landmark civil rights legislation calling for an end to discriminatory practices against any person with a disability. The development of this

legislation, shown in Table 1, provided for increased funding and access to services in support of the legislative aims (Brown & Ringma, 1989; Dwyer, & Spas, 1991; McLoughlin & Christensen, 1980). These programs represent a wealth of potential resources for children with disabilities and their families. However, the consumers' ability to take advantage of these programs is limited by their lack of knowledge of how to access available programs, agency policies and practices that confound their efforts to make use of program resources, and the lack of time needed to negotiate their way through the agency systems governing the distribution of these resources.

Table 1

Federal Legislation Concerning Individuals with Disabilities and Their Families.

Year	**Legislation**	**Service or Program**
1965	Title XIX of the Social Security Act	Medical assistance (Medicaid), rehabilitation or other services to help families and individuals in independence and self-care
1973	Rehabilitation Act of 1973, §504 (PL 93-112)	Provides basic civil rights protection against discrimination in federal programs
1974	Family Education Rights and Privacy Act (FERPA (PL 93-380)	The 'Buckley Amendment' gives parents and students over 18 the right to examine, have explained and question the correctness of students' personal files
1975	Education for Handicapped Children Act (EHA)	Special education and related services for children age 5-21 years
1983	Amendments to EHA (PL 98-199)	Expanded incentives for early intervention and transition programs

1983	Rehabilitation Act Amendments (PL 99-506)	Authorized transition projects from school to work for youth with disabilities
1984	The Vocational Education Act (Carl D. Perkins Act) (PL 98-524)	Requires vocational education services be provided to students with disabilities
1986	Amendments to EHA (PL 99-457)	Special education and related services for children age birth through five years of age
1986	Rehabilitation Act Amendments (PL 99-506)	Provided programs for supported employment of individuals with disabilities
1988	The Technology-Related Assistance for Individuals with Disabilities Act (PL 100-407)	Provides for any item, piece of equipment or product system to increase, maintain, or improve the functional capabilities of individuals with disabilities
1988	Amendments to Social Security Act	Eliminated the prohibited use of Medicaid funds for services on an Individualized Family Service Plan (IFSP) or IEP
1989	Omnibus Budget Reconciliation Act (OBRA)	Makes EPSDT services available whenever a child is suspected of having a condition that requires assessment, diagnosis and treatment
1990	Americans with Disabilities Act (PL 101-336)	Persons with disabilities will not be denied an opportunity to participate in programs or activities
1990	Carl D. Perkins Vocational and Applied Technology Education Act (PL 101-392)	Intended to develop academic and occupational skills in all segments of the population including individuals with disabilities
1990	Amendments to EHA, now Individuals with Disabilities Education Act (IDEA) (PL 101-476)	Provides for transition services and assistive technology
1990	Developmental Disabilities Assistance and Bill of Rights Act (PL 101-496)	To provide family support service to maintain the family unit and reunite family members who have been placed out of the home

Sources: National Information Center for Children and Youth with Disabilities, 1991; Ahearn, 1993

First, understanding these programs and determining how to access resources and build service capacity is a problem (McLoughlin, Edge, Petrosko & Strenecky, 1981). Making sense of these programs and figuring out how to access resources and build service capacity through them becomes even more difficult at the community, service agency, and consumer levels. In many service agencies, programs are run through a maze of state, local, and private organizations. Each of these organizations has its own special interests and each is protective of its domain, including traditionally favored constituents and funding sources. Most service agencies have a difficult time accomplishing intra-agency let alone inter-agency agendas (DePaena & Hayden, 1990).

Secondly, agency policies hamper the effectiveness of programs (Agosta & Bradley, 1985; Schalock, 1985). Generally speaking, society is structured for typical families not families with children who have disabilities. Access to a number of individual entitlement programs (e.g., Medicaid) is effectively restricted by funding limits, eligibility criteria, restrictive provider and service requirements, and by the stigma of what some perceive to be "welfare" funds. The frequency, scope, and duration of covered services are limited (Butler & Friesen, 1988; Kane & Leuci, 1988; Michigan State Board of Education, 1991; Pollard, 1990b; Treet & Hutinger, 1981). Limited funding often results in payment rates that are set below what is usual and customary. The strict medical model for reimbursement or payment for services is based on the maintenance or restoration of normalcy of function. This goal does not take into account the child who cannot be made "normal." Also, burdensome accountability

requirements are imposed on providers, thereby discouraging providers from participating in many of these programs. The low payment rates and strict accounting practices tend to discourage providers from participating in many of these programs (Gettings, 1991; Hemp, 1992). Local education agencies, early intervention agencies, and rehabilitation agencies are typically understaffed. Few have the resources to hire staff for resource development. The result is a lack of providers, either independent or agency supported. Among the providers who participate, strict eligibility criteria serve to limit the frequency, scope, and duration of services. Information is often not readily available on how to access these programs. The development of standard procedures to expedite eligibility and payment processes are often not consistent within agencies. Restrictive requirements may include limited certification and licensing standards that reduce the number of qualified providers available to participate (Pollard, 1990a).

Finally, the ability to tap the resources available through these programs is limited by the amount of time, expectations, and resources families have to negotiate their way through the agency systems governing the distribution of these resources (Upshur, 1991). The time family members can afford to spend on these programs is limited (Marshall et al., 1990). Family expectations influence their ability to utilize agency services. The "end of the rope" comes at different times and in different forms for different families. Not all families benefit equally from typically available services (Upshur, 1991). Frequently the professionals dominate and give directions to families. Professionals need to develop better ways of collaborating with parents (Upshur, 1991).

Inter-agency collaboration is often required to obtain the multiple agency approval needed to reach these funds. With limited staff and resources, local education agencies, early intervention agencies, and rehabilitation agencies have a difficult time accomplishing the needed inter-agency collaboration. The time family members can afford to mine these programs is even more limited. Many families find that the agencies that are set up to alleviate some of their problems actually add to the difficulties that they experience (Bernheimer, Young, & Winton, 1983).

The agency policies and practices that limit access to programs and resources are unfortunate for the many children and families deserving of the support intended by Congress. These agency policies and practices are misguided since programs can be implemented in ways that will allow more individuals and families to be served with the same or fewer resources and the availability of less costly, more effective service arrangement. The model of comprehensive school-based multidisciplinary services allows for informed choice. This model has been shown to be an effective way to limit costs as families tend to choose the most cost effective and needed services.

It is the seeming inability of children with disabilities and their families to take advantage of these many programs that prompted the United States Departments of Education, and Health and Human Services to undertake a joint demonstration project. The aim of this joint project is to demonstrate that by providing the financial wherewithal for agencies and families to spend time needed to secure these resources, and by providing families and service agencies with the technical assistance needed to

understand how best to access them, locally-centered, state-supported collaboratives will be able to marshal additional federal, state, local and private resources in support of family- and community-centered services and supports for children, youth and young adults with disabilities.

Services provided in a Comprehensive, School-based, Multidisciplinary, Community Service Model include the use of case management and a team approach to determine specific needs on an individual basis. Specific services may include mental health services, health services, occupational therapy, physical therapy, nursing care and monitoring, speech therapy, special education and related services, social work, parent training, and/or psychological services. Programs implemented in this Comprehensive, School-based, Multidisciplinary, Community Services Model will allow more individuals and families to be served with the same or fewer resources. This is accomplished by reducing duplication, increasing cost sharing and decreasing barriers that will allow for services to be provided on school-site that were previously provided only at other community agencies. This will result in the provision of more effective services at a reduced cost (deLeone, 1987; Minnesota Disability Law Center, 1991).

Problem Statement

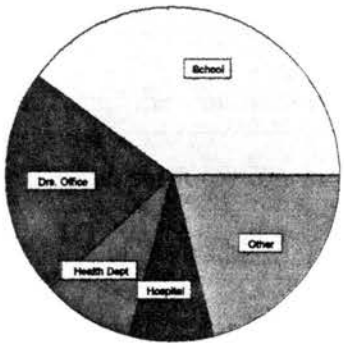
Would the Comprehensive, School-based, Multidisciplinary, Community Services Model provide the needed services in a cost-effective manner? Many children

and youth with disabilities are not receiving the services that are needed to deal with their problems. In many states, including Oklahoma, a full range of services for all families does not exist. This continuum of services may include residential 24-hour care, day treatment/partial hospitalization services, transitional services to the home and/or community of residence, outpatient services, or other services required to effectively deal with specific problems (Bernheimer et al., 1983; Oklahoma Commission on Children and Youth [OCCY], 1992).

Much of Oklahoma is rural with sparse resources, resulting in a shortage of service providers in some areas (OCCY, 1992). Many available positions for related service providers are often left vacant. This results in a lack of qualified personnel to provide services for children with special needs (Oklahoma State Department of Human Services, 1990).

Figure 1

Location of Service Delivery



As shown in Figure 1, 40% of the services for children and youth are provided at local schools. The distance between service delivery sites (annual travel is 143 miles statewide and 220.5 miles for the Southeast region of Oklahoma) and lack of adequate transportation systems (15% of the parents statewide and 20.1% of the parents in the Southeast region of Oklahoma stated that transportation was not available and accessible) exacerbate the problems families face when attempting to access services. When transportation is available, more than 65% of the parents pay part or all of their own transportation (OCCY, 1992). Combined with a lack of coordination between the services that are available, the effectiveness of those services that are provided is eroded.

In many states, including Oklahoma, there is no comprehensive plan for coordinated interagency service delivery to children and youth with disabilities. A continuum of care does not exist. Families become frustrated after referral from one agency to another, without appropriate interventions being initiated (Turnbull & Turnbull, 1990). Often, gaps in services persist because of the complexity of determining agency responsibility. The result is that many children and youth with disabilities do not receive the services that are needed to deal with their problems. Would the Comprehensive, School-based, Multidisciplinary, Community Services Model for coordinated services between the available service providers provide the needed services in a cost-effective manner?

Purpose

The need exists for interagency coordination and collaboration in developing service plan provision for children, youth, and young adults with disabilities and their families (Melaville & Blank, 1991; United States Department of Health and Human Services, 1992; William T. Grant Foundation, 1988). This purpose of this thesis is to investigate the creation and implementation of the Comprehensive, School-based, Multidisciplinary, Community Services Model. This information will be used to determine the effectiveness of the Model in providing services at a reduced cost.

Documentation is necessary for generalization, in the event that other schools/communities wish to implement similar services for children with disabilities. Generalization or at least an approximation of this Comprehensive, School-based, Multidisciplinary, Community Services Model should be possible. The Comprehensive, School-based, Multidisciplinary, Community Services Model will be the basis for a program, to be known as COSMOS (*CO*mprehensive, *S*chool-based *M*odel *O*f *S*ervice).

It is the seeming inability of children with disabilities and their families to take advantage of potential services that prompted the development of this program. Locally-centered, state-supported collaboratives have marshaled additional federal, state, local and private resources in support of family- and community-centered services and supports for children, youth and young adults with disabilities. The aim of this program is to develop

a procedure for providing guidelines for agencies and families to secure the finances and resources needed to provide services to individuals with disabilities.

First, the COSMOS Program will provide families and individuals with the knowledge and technical assistance to allow access to needed resources. Second, the COSMOS Program will assist community service agencies in the development of flexible policies and practices. As a result families and individuals should be able to access available services. Third, the COSMOS Program will provide families and individuals with knowledge on how to secure the finances needed to use existing program resources effectively. The ultimate goal of the COSMOS Program is to empower children with disabilities and their families to access available programs, (McAlester Public Schools, 1992; O'Brien, 1989; Robin, et al., 1988; Weatherly, 1985).

Conceptual Assumptions

A central assumption is that interagency collaboration is an effective and cost saving technique. This results in information sharing between agencies and families. Funding resources can be directly applied to individuals with disabilities and their families (Ashbaugh & Bergman, 1991; Minnesota Disability Law Center, 1991).

Although each agency acts as an individual entity, they are under the direct or indirect control of central government leadership that has increased interagency coordination through memorandums of understanding, interagency agreements, and

legislative action, such as the *Children's Budget*. Interagency coordination for services to children and youth has been mandated by law (OCCY, 1992).

All states must coordinate services by state agencies participating in a central commission that includes agency heads or designees for the purposes of insuring more comprehensive services for children and youth. In the state of Oklahoma, interagency coordination is accomplished through the Oklahoma Commission on Children and Youth (OCCY). The Governor of the state of Oklahoma heads the OCCY, which was created in 1982. The mission of the OCCY is to provide coordination for all agencies, private and public, to coordinate their activities.

With the prospect of resources being restricted even more, there is even a greater need for interagency coordination to sculpt the maximum services with the resources available (Ashbaugh & Bergman, 1991). The Oklahoma Commission on Children and Youth (OCCY) can provide the vital linkage and empowerment to develop and improve the services to children and youth in Oklahoma. The OCCY commissioners meet monthly to consider proposals and agency budgets, hear staff reports, make appointments to councils and committees, approve grants, and make recommendations to the state organizations for developing or improving services (OCCY, 1992).

In Table 2, the members are the Directors or designees of the Departments of Health, Education, Mental Health and Substance Abuse Services, and Human Services. There are other members who are representatives of the Juvenile Justice Oversight and Advisory Committee of the Supreme Court, a statewide association of youth serving

agencies, the Oklahoma Bar Association, administrator or designee of the Juvenile Justice Unit of the Department of Human Services, Metropolitan Juvenile Bureaus, statewide Court Appointed Special Advocates, the Oklahoma Planning and Coordinating Council for Services to Children and Youth, the District Attorney's Council, and appointees of the Governor, Speaker of the House, and Senate Pro-Tempore. Thus, it is assumed that basis for interagency coordination for the development of the COSMOS Program would require participation of the OCCY (OCCY, 1992; Oklahoma State Department of Education, 1993).

Table 2

Membership of the Oklahoma Commission on Children and Youth

Agencies Represented on the Oklahoma Commission on Children and Youth	
Department of Health	Department of Education
Department of Mental Health	Department of Human Services (DHS)
Oklahoma Supreme Court	Oklahoma Bar Association
Governor of Oklahoma	Oklahoma House of Representative
Oklahoma Senate	Metropolitan Juvenile Bureau
Juvenile Justice Unit of DHS	Juvenile Justice Committee of Supreme Ct.
Substance Abuse Services of DHS	State Assoc. of Youth Service Agencies
Council for Services to Children & Youth	District Attorney's Council

Rationale

The COSMOS Program based on the Comprehensive, School-based, Multidisciplinary, Community Services Model will be investigated to determine if the COSMOS Program can make resources available and result in policies that reduce the barriers preventing children with disabilities and their families from accessing services. Family resources and expectations may be enhanced by increasing the knowledge of how to access available services and funding sources. Family support should be a guiding philosophy.

Families should receive the support necessary to maintain their children at home. Family support services must be based on the principle of "*whatever it takes.*" In short, family support services should be flexible, individualized, and designed to meet the diverse needs of families. Family supports should maximize the family's control over the services and supports they receive. Family support services must be based on the assumption that families, rather than states and agencies, are in the best position to determine their needs (Darling, 1991).

Family support services should encourage the integration of children with disabilities into the community. These services should be designed to maximize the integration and participation in community life for children with disabilities (O'Brien, 1989).

All children, regardless of their disability, belong with families and need enduring

relationships with adults. When states or agencies become involved with families, permanency planning should be a guiding philosophy. As a philosophy, permanency planning endorses children's rights to a nurturing home and consistent relationships with adults. As a guide to state and agency practice, permanency planning requires family support. This family support is achieved by increasing their knowledge of how to access funding sources and available services. Interagency collaboration makes resources available and results in policies that reduce the barriers that prevent families from accessing services. This study will investigate if the COSMOS Program is flexible, individualized, and designed to meet families' diverse needs and encourage the inclusion of children with disabilities into the community (Ashbaugh & Bergman, 1991; Darling, 1991; Melaville & Blank, 1991).

Working Hypothesis

While people conducting qualitative research may develop a focus as they collect data, they do not approach the research with specific hypotheses to test. Data is collected through sustained contact with the subjects participating in the project including flexibly structured, in-depth interviews of those subjects. An open-ended approach allows the subjects to answer from their own frame of reference rather than from a frame of reference structured by prearranged questions.

The research questions for this qualitative study were: 1) Does a comprehensive,

school-based multidisciplinary community program for services facilitate interagency cooperation and/or participation to provide appropriate services to children and youth with the cost of on-site services being shared among agencies, not shouldered only by the school? 2) Does the program increase families' access to available services?

Definition of Terms

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or one's being regarded as having such an impairment (Data Research, Inc., 1994).

Inclusion is a method of integration where special education and related services are provided in the regular educational environment to the maximum extent appropriate. To achieve this, school and community resources should be combined and integrated (Pardue-Vaughn, 1996).

Related services have been defined by the Oklahoma State Department of Education (1993) as:

> Transportation and such developmental, corrective, and other support services as are required to assist a child with a disability to benefit from special education, and includes speech pathology and audiology, psychological services, physical

> and occupational therapy, assistive technology, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes (p. 85).

Interagency cooperation utilizes interpersonal skills, communication, problem solving, critical thinking, a strategic planning to strengthen community relationships to provide necessary services to students and families (Thompson & Harris, 1995).

Multidisciplinary Community services involve total community collaboration between schools, non-profit organizations, businesses, and individuals to provide service (OCCY, 1991).

School-Based or School-Linked programs provide for comprehensive health and related services delivered by an interdisciplinary team typically including: doctors, nurses, counselors, audiologists, speech/language pathologists, occupational and physical therapists, school psychologists, licensed psychologists, and other health care professionals. These services are provided in the school or on the school grounds (Fox, Wicks, & Lipson, 1992; Oklahoma State Department of Human Services, 1995).

Family Services Coordinator is an individual who can facilitate a collaborative change process at the state and community level to develop a system of comprehensive, community-based, family-centered, consumer-driven, flexible, individualized, preventive, culturally competent, fiscally responsible, and integrated services; across the public and private health, human services, education, housing, employment, public

safety, judicial, transportation and other sectors; and that is held accountable for improving outcomes for children and families. The family services coordinator is responsible for helping collaborative groups design and implement a process that enables them to think, plan and act strategically to create a new system of support and service delivery for children and families (McAlester Public Schools, 1992).

Scope and Delimitations

Services can be made more accessible to children and adolescents. Planning and operating effective, school-based services remains a difficult, multifaceted task, and many issues of design and implementation have not been thoroughly studied. There is limited research information available on schools, especially those with less than five thousand students, located in rural settings. The proposed development of the COSMOS Program (*CO*mprehensive, *S*chool-based *M*odel *O*f *S*ervice) based on the Comprehensive, School-based, Multidsiciplinary, Community Services Model is the first one of its kind in the United States to include children from birth through the age of 21.

A primary difficulty facing school systems is a stable source of funds. Funding problems have resulted in financial limitations, which schools seek to remedy through a continual search for alternative funding, including grants. Even with Medicaid reimbursement, the rates are low and there are limits on who can provide services for

reimbursement, and the bureaucratic impediments can delay services. Often, a strict medical model for reimbursement does not meet the '*best practice*' criteria for implementing integrated services.

A second concern is confidentiality. Single-point entry is where one agency obtains information from a family or individual that would be shared with other agencies for accessing personal data for the purpose of obtaining services from multiple agencies. This is a potential breech of confidentiality as personal and sensitive information may be made available to a wide range of service providers who may not otherwise have access to this information. Uniform eligibility criteria among agencies can reduce duplication of services and fill demonstrated gaps in services (Stark County Family Council, 1993).

A third concern involves training programs for staff members or others involved in the delivery of services. A change in policies and practices would require training for the individuals involved in providing the services needed by individuals with disabilities and their families. This need for additional training is demonstrated by the lack of mental health day treatment. Mental health day treatment for children and youth was not available within a one hundred-mile radius of McAlester, Oklahoma (McAlester Public Schools, 1992). The development and provision of mental health treatment require additional training for school staff, other professionals, and/or families involved in accessing these services. Training is available at a minimal cost. Training programs for staff are available through the Oklahoma State Department of Education. Agencies also need time to recruit and/or train existing staff.

Time is the final factor that can limit the development of comprehensive school-based multidisciplinary community services. Services that involve school or family on a significant level were severely limited. Community's agencies working together with outside private agencies can bring more services to the community. Active participation in planning and coordinating boards at local and state level for the Oklahoma Commission on Children and Youth and the Oklahoma Special Services Council can facilitate interagency coordination. For this to be successful, key participants must be allowed the time to actively participate.

While the COSMOS Program attempts to deal with many of the problems inherent in the development of comprehensive school-based multidisciplinary community services, much remains to be accomplished. Increased parent participation and activism, an integral part of the future, will require vigilant nurturing and support. (Hutchins & McPherson, 1991).

Outline of Remainder of Program

The remainder of the program provides a historical review of the development and effects of comprehensive school-based community services. As a qualitative study, the COSMOS Program was investigated with a naturalistic approach. The naturalistic approach views those being studied as informants who "teach" the evaluator. The dominant perspective is that of the informant. The number of subjects is limited to those individuals

involved in the development of the program. Purposeful sampling is utilized because the particular subjects facilitate the development of the project. The subjects provided information utilizing unstructured interview techniques to determine if the COSMOS Program would provide the needed services to individuals with disabilities and their families in a cost-effective manner.

Revisions and projected needs for technical assistance are discussed. For the development of other programs utilizing this model factors are discussed to promote the generalization of the model to additional sites.

CHAPTER TWO

REVIEW OF THE LITERATURE

Historical Review

In the 1890's school-based health programs were initiated in response to the large numbers of immigrant children who arrived in the United States suffering from infectious diseases (e.g., tuberculosis). By 1920, school health nursing services had started in New York City. These early interventions were denounced as 'socialized medicine' by the American Medical Association during the 1920's (Gullota, 1995; Tyack, 1992). It was not until the 1930's that schools began to promote standardized health screenings and first aid services, with referrals to physicians for additional care. During the 1940's this model of service began to change as urban schools increased their nursing staffs to provide daily and follow-up care for students (Garfinkel, 1993; Tyack 1992).

The national agenda for children with special needs is still in the process of evolution. Interagency links and collaboration began gaining support in the 1960's. From 1970 when the first school-based health clinic was founded in Dallas, Texas, to thirty-one centers in 1984, the number of school-based health centers has expanded to its present number of about five hundred centers nationwide (Gullota, 1995).

Significance of Comprehensive, Culturally Sensitive, School-Based Community Services

Most of the integrated service programs target at-risk youth; these include children of migrant workers, children in single-parent families, limited-English-speaking youth, pregnant minors, children in single-parent families, children who live in poverty, and abused or homeless children (Center for the Study and Teaching of At-Risk Students, 1992, Olenick & McCroskey, 1992). Interagency collaboration brought about a distinct move toward home and community-based services for children and youth. The evolved approach is multi- agency, multidisciplinary, and coordinated (Melaville & Blank, 1991; Weatherly et al., 1985). During the 1980's this agenda was advanced by congressional action and by joint activities of the U.S. Public Health Service and the private sector. A clear trend in this evolution is the development of community-based systems, based on the belief that 'best practices' involve a comprehensive approach centered on the child, the family, and the community (Hutchins & McPherson, 1991; O'Brien, 1989; Pollard, 1990b; Robin et al., 1988).

Several arguments exist as to why these services should be based in the school. First and foremost, this is the place where most of the children and youth are and many schools have already developed programs beyond the basic academic skills, such as guidance programs, nutrition programs and school nurse services. Second, most students feel more comfortable in the school setting rather than in a health care facility. Third, outside medical care often conflicts with educational or extra curricular activities.

Finally, many children and youth lack the resources or medical insurance necessary for outside services (Gans, Blyth, Elster, & Gaveras, 1990; Perrin, Guyer, & Lawrence, 1992; Zuniga-Hill, 1995).

Rationale for Comprehensive School-Based Community Services

Comprehensive, school-based, community services have been supported by evidence that indicate the: (1) growing number of children and youth with unmet needs; (2) connections among needs, problems, and conditions formerly perceived as separate; and (3) increasing number of health care professionals whose health and well-being are being eroded by working conditions and responsibilities. The two basic models which are developing include the *school-linked model*, where connections are made between health and social service organizations and the *school-based model* where health and social services are provided on school sites. In many situations the two models are combined in school-linked comprehensive services (Lawson, 1995).

Schools alone are not able to provide the necessary nor required services. The community services are not addressing the needs of children and families adequately. Some students and their families receive overlapping services, while others are fragmented or have gaps (Zuniga-Hill, 1995). Integrated services involve the delivery of education, health, and social services for both children and families. This integration is more than a merger of systems. It is collaboration; ". . . a partnership in which a number of service agencies develop and work toward a common set of goals." (Larson, Gomby,

Shiono, Lewit, & Behrman, 1992, p.7). The two most common models for providing integrated services involve school- or community-based models. The proponents of school-based models maintain that: (a) there is a historical precedence for providing services in schools, (b) schools are most likely to be in touch with children in need of services, and (c) schools are the dominant institution in rural communities (Larson et al., 1992; Lutfiyya, 1993). There are some concerns about a school-based model, as Chaskin and Richman (1992) caution that schools are not neutral sites and that many families may associate schools with failure and trouble.

The community-based model provides for a convenient, single point of entry. Community-based programs have an advantage in that they are family-focused, prevention-oriented, community-centered, and responsive to local needs (Abdal-Haqq, 1993).

Historically, cooperation among agencies at local, state, or federal governments is not encouraging. Negotiation of interagency agreements and understandings will play a significant role in state agency cooperative service provision (Gallagher et al.,1988). Faced with a new paradigm, interagency links and collaboration have gained supports since the 1960's. Currently national and state support for comprehensive school-based community services is evident (Melaville, Blank, & Asayesh, 1993; Zuniga-Hill, 1995).

The Surgeon General's Report: *Children With Special Health Care Needs* (United States Public Health Service, 1987) outlines action steps to improve access to care and quality of life for children with special needs and their families. The first step was to pledge a national commitment to all children with special health care needs and their

families. Additional steps included encouragement of community-based service systems, adequate preparations of providers of care, of development of coalitions to improve the delivery of services, to establish guidelines to control costs of services, and to continue research and the dissemination of information.

In 1994, the Surgeon General supported the implementation of high quality, integrated services at the federal, state, and local levels. This was intended to provide effective and efficient services for children, youth, and families. The Surgeon General stated that this should be accomplished by helping existing services improve the quality by working together (McLellan, 1994). There is a distinct move toward home and community-based services for children with special needs. The model that is evolving is a Comprehensive, School-based, Multidisciplinary, Community Services approach (Hutchins & McPherson, 1991; Melaville & Blank, 1991; O'Brien, 1989; Pollard, 1990; Robin et al., 1988; Weatherly et al., 1985).

Increased parent participation and activism, are clearly an integral part of integrated services for children with special needs. "Parents have to be recognized as the special educators, the true experts on their children; and professional people . . . teachers, pediatricians, psychologists, and others have to learn to be consultants" (Hobbs, 1985, p. 497). Service providers must look at the importance of the family context and the need for a variety of levels and types of family involvement activities and learn to view each family situation as unique. Preconceived ideas of families and their needs must be rethought and efforts begun to stop offering only what is available or what is considered acceptable and to provide families and individuals what is needed. "There is

no fixed recipe or formula regarding what will work in all situations with all families. No two families are alike, and what has worked in the past with one family will not necessarily work in the future with another" (Benson & Turnbull, 1985. p. 149).

Table 3

Factors Encouraging Comprehensive School-based Community Services

I.	Difficulties of teachers working with homelessness, AIDS, family dysfunction, drug abuse, or adolescent pregnancy.
II.	Lack of awareness of how and/or where to obtain services combined with sense of isolation.
III.	Fear for job security as number of referrals to outside agencies increase.
IV.	Controversial programs such as pregnancy prevention or psychological counseling.

Comprehensive school-based community services attempt to combine both the school-based and community-based models. This is accomplished by providing a place for services that are most likely to be in touch with children in need of services and taking advantage of the idea that schools are the dominant institutions in rural communities. Comprehensive school-based community services draw upon the community-based programs concept of family-focus, prevention-orientation, and responsiveness to local needs.

There are several factors that encourage schools to work more closely with community agencies. First, few teachers are comfortable dealing with students' emotional difficulties, particularly those difficulties that involve homelessness, AIDS,

family dysfunction, drug abuse or adolescent pregnancy. Second, while many school personnel develop informal relationships with community agencies, they are unaware of the how or where to obtain services and there is a sense of isolation. Third, school social service staff fear for job security if they refer too many children and youth to outside agencies. Fourth, because many of the programs (e.g., pregnancy prevention, psychological counseling) are often controversial, school staffs are concerned about parental and community support (Farrar & Hampel, 1987).

To deal with some of these problems, the comprehensive school-based community services model attempts to establish connections between schools and community agencies through: (a) case management; (b) programmatic integration, where the school and community agency join to develop a range of services, (c) co-location, whereby nurses, social workers and other professionals are brought into the school; and, (d) a community coordinating council (Ascher, 1990; McAlester Public Schools, 1992).

Difficulty Establishing Comprehensive School-Based Community Services

Coping with diversity is an inherent difficulty when developing policy. There is a wide range of family differences in socioeconomic status, marital status, cultural background, family values, geographical locations, attitudes, interests, and diversity in disabling conditions. Flexibility is of essence in the face of such diversity. Additional diversity in the range of professionals participating is likely to present a challenge in implementation of case management, interagency coordination and individualized

service plans. Each of these professions carries its special skills, traditions and history. For legislation and to be successful, there must be substantial cooperation among professionals for effective multidisciplinary service delivery (Gallagher et al., 1988). Unfortunately they often carry a record of indifferent cooperation with other fields (Darling, 1991).

Coordination of various disciplines can be achieved using a multidisciplinary, interdisciplinary or transdisciplinary team approach. An integrated programming team consists of professionals who are involved in some form of ongoing service delivery for students and their families (Campbell, 1987). Factors that may limit integrated services include poor preservice preparation for teamwork, stressful role changes and related logistical problems (Rainforth & York, 1987).

Thus, the difficulties encountered in developing comprehensive school-based community services involve inadequate inter professional cooperation, and poor in-service preparation and training. Individuals and groups who wish to plan and implement service integration face major challenges, as the process of integration often entails fundamental changes to the ways agencies conduct business (Bruner, 1993).

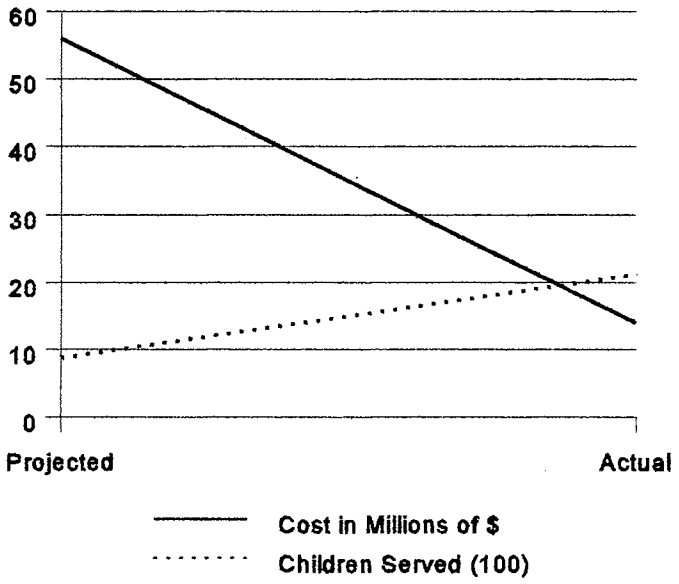
Effects of Comprehensive School-Based Community Services

Traditionally, physical and occupational therapy and speech pathology, have been practiced in medical settings using diagnostic-prescriptive models as the basis for

designing remedial intervention programs. The traditional practice of therapists providing isolated services in separate rooms has not met the needs of persons with severe disabilities (Rainforth & York, 1987). Coordination of various disciplines is achieved using a multidisciplinary, interdisciplinary or transdisciplinary team approach.

Figure 2

Number of Children Served and Cost of a Comprehensive, School-based Multidisciplinary, Community Services Program in 1990.



Programs based on a Comprehensive, School-based, Multidisciplinary, Community Services Model can be cost efficient and are typically seen as more functional than isolated pull out therapy. As shown in Figure 2, in Minnesota, a comprehensive, multidisciplinary community program resulted in a 240% increase in the number of children served with only a 20% increase in spending over a ten year period

(Minnesota Disability Law Center, 1991).

Advocates of comprehensive school-based community services suggest that improvement of services for children and youth should include resources for coordination, top-level commitment from key officials, concentrating on issues of mutual relevance, clearly defining responsibilities, setting realistic time frames, and providing training to end professional and institutional isolation (Levy & Copple, 1990). Successful programs are generally comprehensive and provide an easy point of entry to services. In addition successful programs move beyond crisis and early intervention to the development of skills and provision of preventive services. These programs cross professional and bureaucratic boundaries to provide non-traditional services. Staff training and skills are developed to build trust and respect. A facilitator, who is from the local community, is used to coordinate services. Both teachers and parents are in the communication loop. The child is dealt with as a family member and the family is treated as part of the community. Finally, accountability is built in for meaningful measures (Ascher, 1990).

Demonstration projects have indicated that comprehensive school-based community services have the potential to be effective service delivery model. In 1974, Stark County Ohio began developing collaboration in the form of Parent/Child Education Centers. Additional services have been added until the Family Council was identified as a pilot project for the state. As part of the Family Council, the Creative Community Options (CCO) include the child and family, teachers, Department of Human Services workers, Mental Health workers, and Mental Retardation/Developmental Disabilities

staff. This project emphasized a single point of entry with multiple systems case management under the direction of a lead case manager. It is a public/private partnership that sought to increase service capacity by working together.

The purpose of the CCO is to develop a wide range of service options including treatment, education, recreation, and living arrangements. These services are written into a plan for the child. During the development of the Stark county comprehensive, school-based community services the number of residential treatment placements for seriously emotionally disturbed students has decreased from 144 in 1980 to 15 in 1993 (Stark County Family Council Manual, 1993).

The Iowa Plan, a network approach to providing home care services for children with disabilities and chronic diseases who require medical technology services, is seen as a means for cost-effective service provision. Its success pivots on interagency cooperation and coordination of services (Hulme, 1985).

Medicaid resources, particularly the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component, can provide medical examinations and prescribed treatments for children and youth (see Appendix A for all the services children and youth are eligible for as part of Medicaid assistance). Since the 1989 Omnibus Budget Reconciliation Act (OBRA) allowed school districts to access these services, the number of schools utilizing Medicaid has increased. In 1993 thirty-seven states reported school billing, with six states reporting school billing among 90% or more of the schools (Ahearn, 1993).

A pilot study in Virginia, the Community Linkage Information Program (CLIP),

identifies services used and needed by schools, as well as, opportunities for joint intervention. CLIP attempts to eliminate barriers to information regarding available services. A one year field test indicated that CLIP produces positive effects and the program is currently expanding successful linkages between the schools and service agencies (Baylor & Snowden, 1995).

In Wisconsin, Madison Metropolitan School District has entered into an integrated and coordinated project for children birth through five years of age. This will be accomplished by identifying available funding sources, establishing a partnership between families and community entities, implementing an effective communication and dissemination system, developing an effective technical assistance plan, and implementing a coordinated community-based service plan for preschool children with disabilities in natural environments (Ashbaugh & Bergman, 1994).

Other agencies developing comprehensive, school-based community services include the Regional Services and Education Center in Milford, NH, which is developing strategies for the development and financing of supports and services for children with disabilities from birth to six years of age. The Children's Development Center in Rockford, IL, is developing an improved collaborative system for identifying medical and developmental needs of young children using EPSDT. The Virginia Institute for Developmental Disabilities focuses on children birth through three years of age. The project will focus on financing services and supports for infants and toddlers with disabilities.

Shared services where schools promote academic cooperation through

cooperatives, collaboration or other pairings have been successful. More than thirty states provide for some type of shared service with successful examples for rural schools noted in South Dakota, Connecticut, California, Alaska, Iowa, Minnesota and the Appalachian areas (Hanuske, 1983).

Higher education is becoming involved in the development of comprehensive school-based community services. Inter-professional training programs to facilitate health and human services training into teacher education programs are being developed at Ohio State University, Jackson State University (Mississippi), University of Louisville (Kentucky), University of New Mexico, and the University of Washington (Abdal-Haqq, 1993).

A survey by Pollard & Rood (1990) indicated that school-linked services showed some evidence of success. These services addressed critical needs of families such as: (1) health care that is appropriate and affordable; (2) social services to promote self-sufficiency; and (3) schools that are flexible and student centered. Respondents to the survey wrote that they wanted schools that ". . . provides [students] motivation to finish their education with hope for the future and the knowledge that what they learn will be useful." (P. 17).They pointed out that, while school-linked services are promising, the effectiveness of such services has not been sufficiently evaluated. They recommend that the effectiveness of comprehensive, school-based community services provided by city or county agencies continue to be evaluated.

Summary

The national agenda for children with special needs is evolving. Interagency links and collaboration have gained national support over the last thirty years. The model that is evolving is multi-agency, with an emphasis on family-centered, multi-cultural, community-based services in which children with disabilities are seen as inclusive members in all aspects of their community. Coping with diversity is an inherent difficulty when developing policy. Comprehensive school-based community services can be cost efficient and are typically seen as more functional than isolated pull out therapy. The development of such programs can result in an increase of appropriate comprehensive services for children and youth.

It is notable that research is sparse in the area of comprehensive school-based community services. This may be attributed to the fact that school-based health clinics have only been in existence for twenty-two years. During this time various programs have developed school-based community services for specific needs such as students who are seriously emotionally disturbed or require medical technology services. The comprehensive systems that are being developed provide for children birth through six years of age. Higher education systems are beginning to develop training programs to facilitate comprehensive school-based community services. The current program, *COSMOS*, is being developed to provide comprehensive services to students birth through twenty-one years of age.

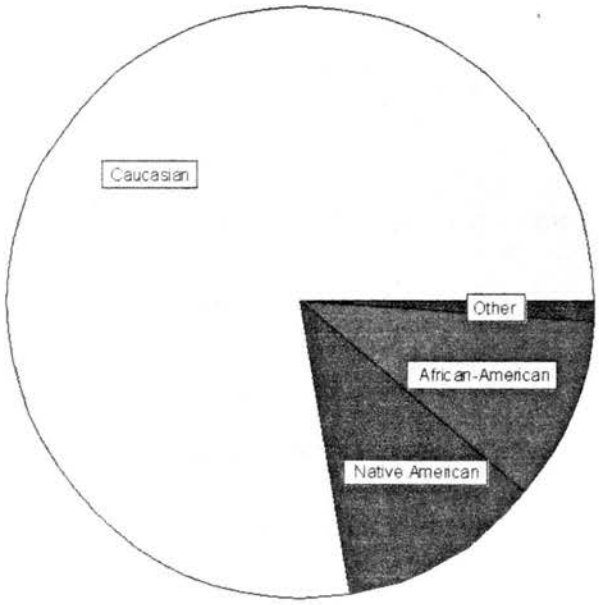
CHAPTER THREE

DEVELOPMENT OF PROGRAM

The purpose of this paper is to describe a program model that may be duplicated across the state of Oklahoma which increases coordination between agencies in the provision of family-centered, culturally-sensitive, community-based services to children and youth with disabilities. McAlester Public Schools is an independent school district in rural southeastern Oklahoma, directed by a Board of Education elected by the residents of the community. In the 1994-95 school year, the district had an enrollment of 2,989 students, Prekindergarten to 12th grade. As shown in figure 3, Native Americans made up about 11% of the school population, 10% were African-American and 1% encompassed other minorities, with the remaining 78% being Caucasian. There were 450 identified children with disabilities birth to 21 years of age served by 23 certified special education staff and 10 support personnel. The district professional staff numbered 221. The Regional Education Service Center XV, a branch of the Oklahoma State Department of Education, is utilized for psycho-educational evaluation and consultative services. Pittsburg County Regional Guidance Center, a division of public health services, provides child guidance, psychological, and consultative services for the district. High school students have the option of attending the Kiamichi Area Vocational Technical School as a part of their secondary curriculum.

Figure 3

Racial/Ethnic Make-up of School District



Subjects

Subjects

The schools involved were in the McAlester Public Schools. These included the Early Childhood Center, which serves four to six year olds; six elementary schools, transitional first grade to sixth grade; one middle school, seventh and eighth grades; one alternative middle school program, seventh to ninth grade; one mid-high school, ninth and tenth grades; one senior high, grades eleven and twelve; and one alternative high

school, grades nine through twelve. The area is also served by Headstart for children three to five years of age, two private day-care homes, one private day-care center, home based services (on an as needed basis), and education services for children four years old to grade twelve at a private day treatment facility. Services for children birth through three years of age are provided by the Early Intervention Unit based at the Department of Health.

The five subjects who were monitored are the core staff that developed the concept and implemented the project (see Appendix B). Purposeful sampling was utilized because the particular subjects were directly involved in the development of the project and were able to give first hand details of the process, pitfalls, and successes.

After the services were in place eligible students were identified. Although the students were indirect recipients of services from the project and not subjects for study, data was collected to determine the number of students served. Those students included students with disabilities under the Individuals with Disabilities Education Act (IDEA) or other students who may have a disability or are at-risk as shown in Table 4. (Oklahoma State Department of Education, 1993).

Community

Participating agencies, in addition to the McAlester Public Schools and the Oklahoma State Department of Education, include: the United States Department of Education, the United States Department of Health, the United Cerebral Palsy

Association, the Human Services Research Institute, a newly developed Pittsburg County Advisory Committee, the Region XI Advisory Board of the Interagency Coordinating Council for Special Services to Children and Youth, OCCY's District IV Planning and Coordinating Board for Pittsburg and Latimer counties, other Regional Boards, the statewide Special Services Council for Children and Youth with Disabilities, the Puterbaugh Foundation, the McAlester Regional Health Center, the Public Service Company of Oklahoma, the State of Oklahoma Department of Human Services, the Pittsburg County Health Department, Sooner Start (Oklahoma Early Intervention Program), the Carl Albert Community Mental Health Center, the Kiamichi Area Vocational-Technical School District No. 17, the Oklahoma Independent Living Center, the McAlester United Way, Inc., the Pittsburg County Chapter of the American Red Cross, and the Boys Club of McAlester.

Table 4

Participants in the COSMOS Program in 1992

Participants	N
COSMOS Staff (Subjects)	5
IDEA Students	403
At-Risk Students	58
Agencies	11
School Personnel	26
Mental Health Staff	1
Families	360-370

Development of Program

A foundation for interagency collaborative delivery of special services exists within southeastern Oklahoma, due to established communication networks and a prevailing attitude that teamwork and local people can solve common problems. The school staff has been trained to conduct groups in cooperative problem solving. Collaborative planning and cooperative processing, components of a site-based management program of the Oklahoma Project Leadership in Educational Administration Development, have received emphasis throughout the system.

During the initial phase an assessment was made to determine if a need for school-based services existed. This may be accomplished by conducting either a needs survey or the utilization of an existing survey from other organizations such as the Oklahoma Commission on Children and Youth (OCCY), the Office of Handicapped Concerns, or from the United States Department of Education or Health and Human Services. In our case we utilized the needs survey information that our region collected for OCCY.

The identification of existing services was an essential part of the program. This was necessary to avoid duplication of services, reduce the costs associated with the provision of services, and fill gaps due to lack of service providers. This identification process addressed specific areas for the provision of related services, listed in Table 5.

Table 5

Related Services/ Providers

Audiology	Psychological Services
Counseling Services	Recreation
Early Identification and Assessment of Disabilities in Children	Rehabilitation Counseling Services
Medical Services	School Health Services
Occupational Therapy	Social Work Services in Schools
Parent Counseling and Training	Speech Pathology
Physical Therapy	Transportation

Administrative support is essential for the development of a comprehensive and effective program. Initially, the administration of the local educational agency (LEA) must recognize the need for services and that this model will provide the most effective services at a minimum of cost to the school district. The administrative support of state and federal officials/agency heads is integral to the development of a comprehensive system of services, which may require altering policies and procedures for the agencies involved in the program.

As shown in Figure 4, a primary goal was to utilize collaborative planning for the development of interagency agreements and payment systems for services to children and youth with disabilities.

Figure 4

Primary Goals for Program Development

I. Project Coordinator
Primary Goals

Collaborative Planning	Parent Involvement	Service Site
• Advisory Committee • Comprehensive Data Base • Written Interagency Agreements	• Advisory Committee • IEP Team Participation	• Local School • Contractual Basis • Cooperative Policies

II. Staff Development
Primary Goals

In-Service	On-Site Personnel	Parent Involvement
• In-house Staff • Outside Expertise	• Reassignment • Retraining	• Advisory Committee • IEP Team Participation

III. Medicaid
Primary Goals

EPSDT	Related Services	Medical Services
• Mobile Unit • On-Site Service Provision	• Transportation • IEP Team Participation	• Screenings • Psychiatric Care • Medical Treatment

Three activities were required of the project coordinator to accomplish this goal. First, the project coordinator formed an advisory committee, including parents of infants, toddlers, children, and youth with disabilities, minority members, professionals in the field of special education, early intervention and related services. The advisory committee was formed to increase the participation of parents and community members. Secondly, a comprehensive data base was developed by the project coordinator in consultation with agency representatives, to include all identified service providers. This comprehensive data base was developed to increase the knowledge of present policies and procedures of all available service providers in Pittsburg County. Finally, written interagency agreements and payment systems for key service providers were developed by the project coordinator with key agency representatives to decrease gaps in service provision. Cooperative agreements with local health department and other service providers increased collaboration among providers by providing uniform service criteria by modifying existing regulations and policies. The establishment of a regional interagency coordinating council enhanced the cooperation and collaboration among providers.

Scheduled monthly meetings of the regional interagency coordinating council were held with the purpose of cooperating to develop better service provision for children and youth in our region through system changes. These meetings involved representatives from several of the public and private agencies that provide services for children and families in our area. Initially, the group included McAlester Public Schools, the Professional Development Center, Carl Albert Mental Health Services - Children's

Services, The Department of Human Services - Child Welfare and Juvenile Services Unit (court related services), Oaks Rehabilitation Center - Prevention Outreach, Regional Guidance Center - Counseling and Child Abuse Prevention, Early Intervention Unit - Sooner Start, McAlester Regional Health Center, local pediatricians, Oklahoma Independent Living Center, local churches, Oklahoma State University Extension Services, and United Way.

As specific needs and gaps in services were identified representatives from other agencies were invited to participate in the ongoing meetings. These included Vocational Rehabilitation Services, Vocational - Technical Education, Shadow Mountain Psychiatric Hospital, Oakcrest Psychiatric Hospital, Green Country Mental Health Services, local psychiatrists, the District Attorney's office, local judges, legislators, the police department, the sheriff's department, Developmental Disabilities Service Division of DHS, the Emergency Youth Shelter and the Juvenile Detention Center, local banks, La Casa, Indian Health Services, University Affiliated Program of Oklahoma, local community members and parents. The meetings were open meetings and any other interested parties were encouraged to attend.

Another primary goal involved parent participation. If family-centered, culturally sensitive, community-based and cost-effective services to children and youth with disabilities are to be increased, then parent participation in the planning process for comprehensive service delivery is important. Advisory groups met at regular intervals throughout the first three years of the program. This helped provide for the development of a service coordination model that elevates parent participation in planning and

increases collaboration among providers to ensure appropriate comprehensive services, expanding service options and funding sources. The parents' participation in their children's Individual Education Plan (IEP) team meetings allowed the parents to become an integral part of the service delivery model. Through participation by parent representatives on the advisory committee and the opportunity for all parents to attend their children's IEP team meetings, parents were able to act as advocates for children and youth with disabilities and determine the actual service delivery available for their individual children.

Parent awareness workshops were planned and conducted to inform and educate parents and families within Pittsburg County about the availability of services, multiple funding sources, the written interagency agreements and parent interviews process in addition to other relevant information they, as primary care providers need to insure and expedite the proper delivery of services for their children.

The next goal was to decide where services would be provided to insure comprehensiveness of appropriate services. Services were provided on-site at the local school, through existing agencies (e.g., Vocational-Rehabilitation), on a contractual basis from service providers (OT, PT, speech), or through cooperative policies involving physicians/pediatricians. Service provision was determined on an individual basis by a multidisciplinary team that included parents, a special education teacher, a regular education teacher, a school administrator, any other professional that provides necessary services, and often the students themselves. After the services were in place, eligible students were identified. These students included students with disabilities under P.L.

101-476 (IDEA-B) or students who may qualify for other services (Medicaid, Supplemental Security Insurance, or the Oklahoma Department of Human Services).

At the local level staff development involving training and information was implemented. This was accomplished by bringing in people from other agencies to inform teachers and other professionals about eligibility criteria. Existing personnel were identified and utilized. This was done through the use of on-site personnel, reassignment, or retraining.

Obtaining a Medicaid provider number was the next step in the development of the comprehensive service program. This was accomplished by contract with the State Department of Human Services for provision and reimbursement of specific services. Technical assistance at this stage was essential in obtaining a Medicaid number and establishing billing procedures to begin accessing funds.

Early Periodic Screening Diagnosis and Treatment (EPSDT) was provided by agreement with the health department and other providers that completed these screenings, which included a mobile unit, and on-site service providers. EPSDT was used as part of the basis for a student's Individual Education Plan particularly related services for eligible children, once the school was a Medicaid Provider. School personnel coordinated with family, school, service providers, providing transportation and assistance with completion of forms, etc. as necessary. As a result, access to services and screenings were enhanced for children with disabilities and their families.

To increase the number of Medicaid eligible children and youth receiving services in McAlester School District, the project staff worked out a system with DHS to better

identify students needing EPSDT services. The county DHS office identified high risk students who were not receiving Medicaid but who might have been eligible. Contacts were than made through the project to let parents know about resources and services that were available.

A transition program can be implemented to provide for the needs of children and youth as they leave the school system and begin to function in the community. These areas include independent living, community membership, vocational needs, post-secondary education, and basic life skills. The utilization of technology to enhance provision of these services can be provided through technical assistance and assistive technology.

The implementation of the services begins with the referral process. Once a student had been identified, case management was invaluable in the provision of integrated related services. Staffings or "cluster meetings", which are individual meetings involving all providers, parents or others with an interest in the identified student, resolved issues in the early stages before they became problems.

Evaluation of the program can be formative to determine the effectiveness of the services provided in reducing or eliminating negative effects of presenting problems. Formative evaluation can provide feedback for adjustment and modification of services. Summative evaluations may involve the parents' perceptions, providers' perceptions, school's perceptions and the number of students receiving services compared the number receiving services prior to the implementation of the program.

Follow-up of the project would provide valuable information regarding long-term

parent satisfaction, provider satisfaction, and school satisfaction. This can be accomplished through interviews with participants and questionnaires.

The program description outline can be used by schools as a guide to developing comprehensive, school-based, multidisciplinary community services to meet the needs of the children and youth in the school and community in a cost-effective manner.

Design

Guba and Lincoln (1981) recommended a qualitative approach involving a naturalistic and participant oriented evaluation procedure. They suggested that naturalistic and participant-oriented evaluation procedures would be appropriate for understanding the complexities of educational activity, particularly when there is concern for the consumer. Rather than the traditional internal and external validity, this qualitative study was concerned with the credibility of the findings and the applicability in other contexts.

By taking a naturalistic approach to evaluation, the evaluator studied an educational activity *in situ,* or as it occurs naturally, without constraining, manipulating, or controlling it. Naturalistic inquiry casts the evaluator in the role of a learner, and those being studied in the role of informants who "teach" the evaluator. The dominant perspective was that of the informant, because the evaluators learn their perspectives, learn the concepts they use to describe their world, use their definitions of these concepts, learn the "folk theory" explanations, and translate their world so the evaluator and others can understand it.

The advantages of this qualitative approach include an understanding of the complexities of educational activity, which is useful in examining innovations or changes about which little is known. The qualitative approach also allows for increased flexibility and attention to contextual variables that reflects a genuine understanding of the inner workings and intricacies of educational programs. Some difficulties with naturalistic and participant oriented evaluation procedures are that the procedures are nondirective and there may be a tendency to be influenced by atypical information. Atypical information might include an undue focus on a personality conflict with a specific service provider, or due to preconceived notions of a consumer refusing to participate (Worthen & Sanders, 1987).

The use of naturalistic and participant-oriented approaches to evaluate new educational programs has been well documented (Hérbert, 1986; Patton, 1980; Sanders & Sonnad, 1982; Wolf & Tymitz, 1977). The design is flexible. Design decisions were made throughout the study, at the end as well as the beginning. Because there was a specific problem that was the focus of the research the procedure of analytic induction was employed. Analytic induction is where data are collected and analyzed to develop a descriptive model that encompasses the processes in the development of a working model for service provision.

Evaluation of Program

For program evaluation the core staff focused on and monitered activities which

targeted needs of families with children and/or youth with disabilities, emphasizing input from families and collaboration with service provider agencies for the purpose of increasing the quantity and quality of appropriate services which are culturally sensitive and community based. Expanding the range of funding sources for provision of services by schools was emphasized. The school system personnel were change agents in affecting fundamental modifications in the system of service delivery in the state of Oklahoma.

Procedure

Support and Collaboration

Support and collaboration with other agencies must begin at the national level. The Human Services Research Institute and the United Cerebral Palsy Association provided expertise in overcoming the deficits in knowledge concerning legal issues in accessing funds through alternative sources; i.e., third party payments, habilitation and psychological services provided at the school site by outside agencies, and health clinics at school.

Support from the directors/heads of agencies or their representatives at the state level was elicited from the Oklahoma Commission on Children and Youth, Department of Mental Health, Department of Human Services including Developmental Disabilities Services, Vocational Rehabilitation Services, and Medical Services for Children With Special Health Care Needs, State Department of Education, University Affiliated

Programs, and the Public Health Department.

Program Activities

1. Hire a project coordinator: The coordinator acts as a liaison between the various agencies. The coordinator also provides a communication link between the service agencies, the families and the school.
2. Hire project staff (secretary). The project staff is responsible for maintaining all necessary records, conducting all necessary correspondence, filing necessary materials, and performing other duties assigned by the project coordinator.
3. Form the advisory committee, which consists of nine members. The ethnic/racial representation of the committee mirrors the ethnic/racial make-up of the community. The advisory committee consists of three parents of children or youth with disabilities, three professionals in the field of special education, one early intervention specialist, one transition specialist, one related service provider and the project coordinator as an ex officio member.
4. The project coordinator meets monthly with the ICC special services council. This is to advise the council of the progress and implementation of the project and to seek advice about breaking down potential barriers or problems, and to keep the council informed of the overall status of the project.
5. The project coordinator compiled a data base of the present policies and procedures for services from the various agencies (Table 6). This includes types of

service provided, criteria for individuals to receive service, method of reimbursement to the agency, and other pertinent information.

6. The Project Coordinator developed written interagency agreements and payment systems with assistance of the advisory committee and the ICC special services council. The interagency agreements will provide for the delivery of service as needed and avoid the duplication of services. The payment systems provide for the reimbursement for services from multiple funding sources.

7. In-service materials were prepared for both practitioners and parents. The in-service materials provide information on service availability and multiple sources of funding accessibility. The materials can also be used for dissemination of information to third parties.

8. The materials and information developed during the project were made available to other Regional Boards during the first year of the project.

9. In-service was conducted for the practitioners and service providers from the participating agencies. The in-service included information on the written interagency agreements, the format for provision of services, availability of multiple sources of funding, and the format for the parent interviews.

10. A conference was conducted for parents and families within the Southeast quadrant of Oklahoma. The in-service included up-dated information on the written interagency agreements, the increased availability of services, availability of multiple sources of funding, and information that may be called upon to provide to insure the proper delivery of services.

11. The interagency service delivery was documented by service category, number of families served, amount of interagency service deliveries, and service providers.
12. The project was continually up-dated during the second year of operation. Revisions included the addition of services that were essential to the parents and families, expansion of needed services, inclusion of parent information required to provide appropriate service, or other information/services as needed.

The identification of existing services was an essential part of the program. This was necessary to avoid duplication of services, reduce the costs associated with the provision of services, and fill gaps due to lack of service providers.

Administrative support was essential for the development of a comprehensive and effective program. At the local level staff development involving training and information was implemented.

Community Support

To ensure the success of the program, community support was elicited. Advisory groups involved parents, concerned community members, school officials, and agency representatives. This provided for the development of a service coordination model that elevates parent participation in planning and increases collaboration among providers to ensure appropriate comprehensive services that expand service options and funding sources.

Table 6

Agencies Involved in the COSMOS Program

1. Oklahoma Department of Health
    a. Regional Guidance Center
    b. Sooner Start Early Intervention Unit
2. The Department of Human Services
    a. Developmental Disabilities Services
    b. Vocational Rehabilitation
    c. Juvenile Services Unit
    d. Child Welfare
    e. Medicaid
3. The Department of Mental Health
    a. Family Builders
    b. Therapeutic Nursery
4. KIBOIS Community Action
    a. Head Start
    b. Area Transit System
5. Five County Cooperative
6. Scottish Rite Childhood Center for Language Disorders
7. Pittsburg County Youth Shelter
8. Indian Health Services
9. Oklahomans for Independent Living
10. McAlester Regional Health Center
11. McAlester Clinic
12. Oaks Rehabilitative Services
13. OSU Extension Center
14. Juvenile Detention Center
15. Eastern Oklahoma Health Education Center
16. Oklahoma Office of Handicapped Concerns
17. University Affiliated Programs - East Central University
18. United Cerebral Palsy Association
19. United States Department of Education
20. Oklahoma State Department of Education
21. United States Public Health Service
22. OCCY District IV
23. Region XI Advisory Board of the Interagency Coordinating Council
24. Carl Albert Mental Health Services
25. Shadow Mountain Psychiatric Hospital
26. Oak Crest Psychiatric Hospital
27. Green Country Mental Health
28. La Casa
29. Puterbaugh Foundation
30. Kiamichi Area Vocational-Technical School District No. 17
31. McAlester United Way
32. Boys Club of McAlester
33. Pittsburg County Red Cross

Services were mainly provided on-site at the local school, through existing agencies (e.g., Department of Rehabilitation Services, etc., from transition part of the Individualized Education Plan), on a contractual basis from service providers (occupational therapy, physical therapy, speech therapy, etc.), or through cooperative policies involving physicians/pediatricians.

To define the collaborative approach utilized in this project required looking at the context within which we functioned. The support of the Oklahoma Interagency Coordinating Council for Special Services to Children and Youth for the project is a critical element in understanding how a small local school district in southeastern Oklahoma could be involved in a systems change effort of this scope.

The term inter-agency collaboration was recognized that it needs to occur at every organizational level. Success at one level facilitates collaboration at other levels. In our case, the state set the stage with the Special Services Council. The Special Services council was established by the Oklahoma legislature in 1990 to develop an interagency state plan for comprehensive service delivery designed to enhance the capacity of families to meet the need of their children. Participating cooperatively in these activities are local schools, parents, the State Department of Education, Vocational and Technical Education, Human Services, Health, Mental Health and Substance Abuse Services and other public and private agencies. Reporting to the Special Services Council are eleven regional boards organized with representation from local parents and agencies. At each meeting, parent concerns are a separate and distinct topic of discussion.

Within this framework the concept of coordinated, comprehensive service delivery was emphasized. The missing piece was a local initiative to develop and implement a model for integration of services that shifts the emphasis away from the school or service agency and toward the child or family to be served. The work plan for our project utilized a bottom-up approach to collaboration, starting with a local school. However, the linkage with the state level Special Services Council creates a flow of two-way communication that affected not only grass roots services delivery but also state policies.

The key indicator of project effectiveness is the impact families have on the direction of service delivery and resource acquisition, not just the traditional counting of numbers of children served or contact hours. Qualitative analysis aimed at determining whether the collaboration was effective at improving communication and breaking down bureaucratic barriers. Are services for children more effective? Are more resources available and being directed toward frontline services?

The goals of our project centered around elevating family involvement in planning for services, opening up new options for services that are family-friendly in the areas of health and transition and accessing revenue sources that will be directed toward school-based services.

Obtaining a Medicaid provider number was the next step in the development of a comprehensive service program (see Appendix C). The successes we have experienced at the local level with establishing school-based health clinics and the school becoming a provider of Medicaid services are contributing to increased efforts at the state level to change Oklahoma's Medicaid plan and opening up avenues for increased services and

funding through Medicaid for schools across the state (see Appendix H).

The work of collaboration is done by individual people, not agencies. It is important to recognize the stages of concern that people hold when change through collaboration is initiated. There may be such a thing as instant collaboration producing instant gratification, but change that was meaningful and lasting, required careful planning combined with thoughtful involvement of people over a period of time. The pitfall of assuming that gathering information will automatically translate into desired action immediately is misleading. Facts and data cannot be absorbed, digested and turned into the kind of knowledge needed without mental and emotional readiness on the part of team members. There needs to be time, collaboratively, to assess what has been learned, in terms of information about what each agency can contribute to the process and how it all fits together.

In McAlester, it took several months to begin to assimilate the information about Oklahoma's Department of Human Services Medical Services division and EPSDT requirements, as well as our Department of Public Health policies and procedures that pertained to health screenings for our students. We are still learning in these areas, as the people from those agencies learn about educational organization demands. Understanding each other's organizational philosophies, missions, and boundaries is needed in order to see other agencies as part of the solution rather than as a part of the problem.

Analysis of Data

Analysis methods for qualitative data involve continuous data analysis (Bogdan & Biklen, 1982). Participant observations throughout the project development were the primary form of documentation and description or recipe of the process. Unstructured Interviews with primary participants followed implementation of the program to develop understanding of how to reduce or eliminate negative effects of presenting problems (see Appendix D). This formative evaluation provided feedback for work plan revisions and projected needs for technical assistance (McAlester Public Schools, 1992).

While much of the data was collected during fieldwork as the program was in progress, Patton (1980) and Bogdan & Biklen (1982) suggest that a final report should be prepared. This report would: examine rival explanations; review exceptions; compare multiple perspectives; examine the quality of the data; and consider reactions to the reported data by members of the project. These summative evaluations include information on the service providers who are cooperating in the comprehensive, school-based multidisciplinary community program and the students receiving services. This was accomplished through interviews.

Summary

The purpose of this study was to determine the effectiveness of a program model for comprehensive, school-based, multidisciplinary, community services. Purposeful

sampling was utilized to determine the effectiveness of the program. Were the services for children with disabilities more effective? Were more of the resources being directed toward primary services rather than administrative or support services? The assessment of the program's effectiveness was qualitative and naturalistic to allow for a greater understanding of the complexities of the program from a consumer's perspective and to provide feedback for adjustments or modifications if necessary.

The Program Development and Procedures sections provided for the generalization and application of this model to other sites. These sections allow for the development of additional programs through a step-by-step procedure. This allowed for the creation of additional programs with greater efficiency by avoiding some of the pitfalls inherent in the development of new and innovative programs.

CHAPTER FOUR

ANALYSIS AND EVALUATION

Outcome of Study

The study was designed to be qualitative. Using this approach, a naturalistic and participant oriented evaluation procedure was used. The dominant perspective is that of the informant. It is the informant who provides information as to the credibility of the findings and applicability in other contexts. In this approach traditional internal and external validity are not the primary focus, nor are there traditional analysis methods for the data. Rather unstructured interviews with the primary participants were utilized to provide for a summative evaluation concerning the research questions: 1) Does a comprehensive school-based multidisciplinary community program for services facilitate interagency cooperation and/or participation to provide services to children and youth with the cost of on-site services being shared among agencies, not shouldered only by the school? 2) Does the program increase families access to available services?

In addition to the interviews, data was collected regarding the service delivery. These numbers are included in Table 7.

Table 7

Service Delivery Resulting from the COSMOS Program

Type of Service	**FY 1992**	**FY 1996**
Students Served Under IDEA	403	493
Students Served as At-Risk	58	100
Advisory Committee Meetings (Parent)	00	20
Parent University Training	00	04
Parent Awareness Workshops/Conferences	00	05
Mental Health Services: Teachers	01	04
Mental Health Workers	00	06
Interagency Collaboration Meetings	00	80
Interagency Agreements	02	08
Agencies Involved with Schools	11	33
EPSDT	00	245
Related Service Providers (SLP, PT, OT)	00	07
School-based Clinic - Certified Sites	00	06
Physician Referrals	00	28
School Personnel - Special Services: Certified Teachers	17	21.5
School Personnel - Special Services: Professional Staff	05	08.5
School Personnel - Special Services: Support Staff	07	12.5

From January 1992 to December 1995, 80 scheduled interagency meetings were held with attendance that ranged from 13 to 37 with an average of 19 participants per meeting. These figures do not include subcommittee meetings.

After the Pittsburg County DHS office identified eligible children, who were not receiving Medicaid, then contacts were then made to let parents know about the available services. DHS staff helped identify fifty-two children for the health clinics over a three month period from December 1992 to February 1993. These children accessed services that they were eligible for but might not have received otherwise. Sixty-two children received EPSDT services during the 1992-1993 school year. During the 1993-1994 school year sixty-eight children were served through the school-based clinics, at four certified school sites. Two other school clinic sites were certified in the 1994-1995 school year, one hundred and fifteen children received initial or follow up EPSDT services. Two hundred and forty-five children received coordinated, comprehensive services through EPSDT referrals that they might not have received otherwise. Child count numbers of children receiving special education services have increased from 400 on June 1, 1992, to 499 on December 1, 1996.

Additional services that were needed in the community and school were achieved through the use of private facilities such as psychiatric services in a day treatment center located outside the school in the community. This increased the acquisition of services that were otherwise unavailable due to distance and other accessibility issues. An example of increased collaboration among service providers to ensure that more comprehensive and appropriate services are available is the collaborated effort between

Green Country Mental Health Services and McAlester Schools to implement a middle school program which targeted at-risk adolescents. This was done to provide the students with intensive counseling, expressive therapies and education at the school site. The program began July 11, 1994. The summer program for the at-risk adolescents was successful and a 1994-1995 school year program ensued with an enrollment of twenty students. This school-based day treatment program accessed Medicaid funds. Even though Medicaid funding was utilized children were not denied attendance if they were not Medicaid eligible. The program does seek maintenance of 70% Medicaid reimbursement, but has received payment of less than 70%. One teacher and three mental health workers provided on-site education/therapeutic services to the targeted seventh and eighth graders with an emphasis on "adventure-based learning experiences" such as rock-climbing, hiking, camping, multi-cultural activities, and field trips to museums, and other points of interest.

Due to the success of the alternative education services, during the summer of 1994 and the 1994-1995 school year, the program was continued into the 1995-1996 school year. In January 1996 the program was extended to serve children from the sixth to the twelfth grade. Plans are in action to include fourth and fifth grade students during the 1996-1997 school year. Future plans for alternative education services will include students from the second to the twelfth grade.

An example of direct service collaboration among providers or use of cluster meetings to get needed services is the case of an 8-year-old boy who suffered a traumatic brain injury. His chance of recovery was good, but he needed services throughout the

summer as well as the school year. His team of medical doctors and rehabilitation specialists out of Dallas, Texas, met with the McAlester Oklahoma team which included a special education teacher, physical therapist, occupational therapist, speech pathologist, DHS social worker, family services coordinator, and special services director. The interstate meeting was held via a telephone conference call. As a result the student received extended school year services including academic instruction and speech therapy for one and one half hours daily. The physical therapist and social worker made weekly home visits to provide physical therapy, and to work with mom on parenting and other issues related to family needs. When the parents had difficulty understanding the behavior changes due to the brain injury, the team called in the psychologist to explain matters and to help develop a behavior management plan that went across environments. All services were paid for through Medicaid, except the one hour of academic instruction daily and the consultation of the psychologist.

Another example of multiple agencies formulating one plan of service for a child is the case where a local pediatrician, school nurse, a dietitian from the regional hospital, school food services staff, regional guidance staff, school administrator, special education and regular class teacher, a school counselor, a school volunteer, the family services coordinator and the parent met. They developed a plan for a student with anorexia, a growth hormone deficiency and clinical depression.

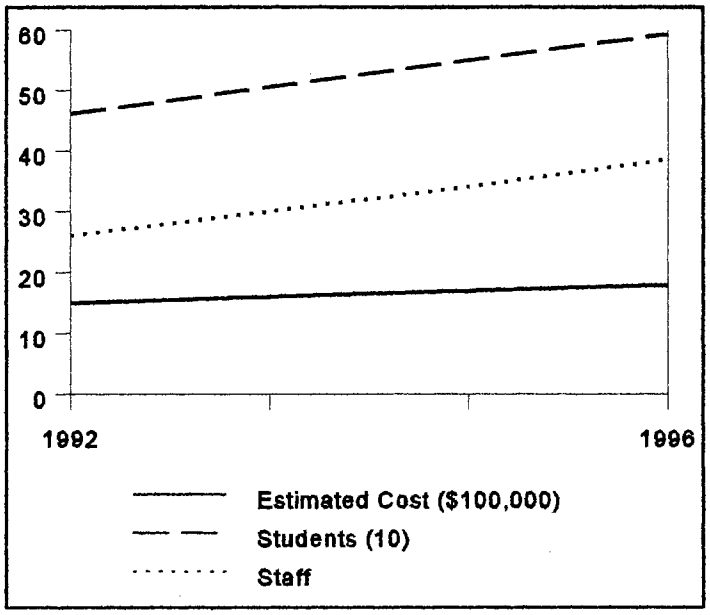
An example of retraining was sending high school teachers and paraprofessionals to training provided by the State Department of Education so they could provide appropriate job coach services to students in the district. After the training was

completed, a contractual agreement was made with vocational rehabilitation services to pay a portion of a high school teacher's salary in order to free her up to coordinate school to work activities. Other essential personnel (e.g., service providers, coordinators) may be employed or used on a contractual basis.

The Director of Special Services estimates that the cost increase for the four-year period is approximately 20%. Figure 5 shows a 28.6% increase in number of students served and a 48% increase in the number of additional school staff.

Figure 5

Number of Children Served and Cost of a Comprehensive, School-based Multidisciplinary, Community Services Program in 1996.



With regard to the second research question, 'Does the program increase

families' access to available services?', the following information is provided. The first parent conference was held June 23, 1993. The targeted training was arranged to: (1) raise awareness of the history and present status of policy and, service delivery for people with disabilities; (2) expand the vision of potential effects of the use of technology on lives of people with disabilities; (3) increase the knowledge base of potential resources for the acquisition or use of assistive technology for families and providers; and (4) gaining an understanding of the value of integrating therapeutic services into the educational setting, rather than relying solely on clinical model services. The conference was sponsored by O.I.L., East Central University - University Affiliated Programs, McAlester Public Schools, and United Cerebral Palsy Association. There were approximately 90 consumers and providers that attended. Participants expressed overall appreciation and satisfaction with an increase of awareness. The conference was free of cost for families, with reimbursement for travel to and from the conference and child care during the conference.

University Affiliated Program, through East Central University, joined with McAlester Public Schools in accessing technical assistance through United Cerebral Palsy Association for a regional conference for parents, educators and other service providers which focused on inclusion, on September 30, and October 1, 1993. The program was arranged by Allan Bergman who coordinated arrangements with all presenters. We utilized IDEA-discretionary funds to underwrite part of the costs. The conference was well attended by special educators, other service providers and parents, with a total registration of 110 people. The lack of participation of regular education

personnel was disappointing. Evaluative feedback showed a very positive response from participants.

In February 1994, a parent's perspective conference was held in McAlester, Oklahoma. The one day conference was planned by a parent representative with support from the project staff, Region XI Special Services advisory board, and OASIS. There were 53 registered participants. Presentations included eligibility and general information provision by representatives from service agencies such as DHS - DDSD, Office of Handicapped Concerns, Vocational Rehabilitation, McAlester Schools, the Health Department, Social Security, and others. In addition, information was provided concerning parents' rights in education, a sibling panel and a parent panel provided opportunities for individual concerns, and stress reduction techniques were provided. Feedback was favorable, except for complaints about the five-dollar charge for a sack lunch. Further needs were identified through the evaluation process. Specific requests were made for more training about Attention Deficit Hyperactive Disorder, and written materials about the different agencies. Families were reimbursed for travel and child care.

In response to the evaluation, project staff presented information on Attention Deficit Disorders to a parent support group at Oklahoma Independent Living Resource Center, later in the school year. Topics included were etiology of the disorder, behavior management, medication, working with the schools for development of a comprehensive plan, and parents rights under IDEA and 504. Eleven parents attended the meeting. Information was also provided about the organization Children and Adults with Attention

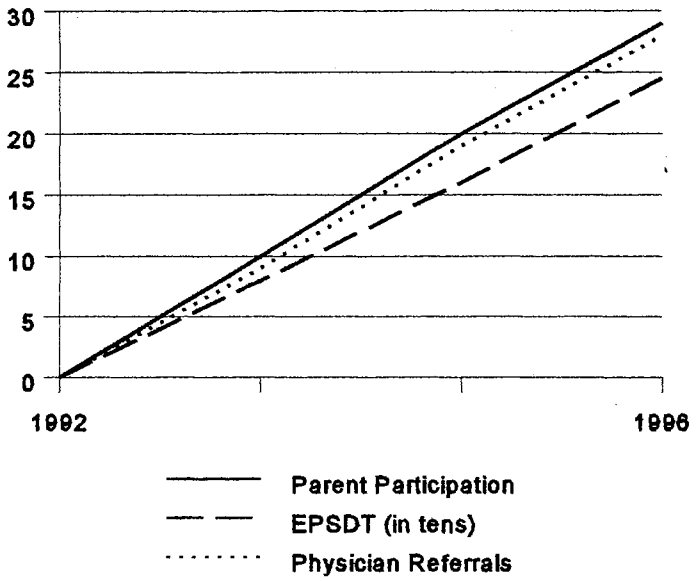
Deficit Disorder (C.H.A.D.D.). To date the parent group continues with variable attendance.

A "Master Key to Services for Parents" manual was developed for parents that included information about McAlester School's Community Life Skills program, materials relating to service coordination, school-based health clinics, Medicaid, Supplemental Security Insurance, futures planning, a list of referral agencies with contact persons and phone numbers, and a list of resources and materials available at the McAlester Schools Family Resource Center and lending library. The "Master Key to Services for Parents" manual provides dividers in a three-ring binder so parents can maintain service material in one folder. It includes sections for evaluations, medical information, Individual Education Plans and other special education forms.

A Parent University has been implemented for four consecutive years from 1993 to 1996. The day long, Saturday workshops were held once a year. They addressed areas identified by parents through a needs assessment surveying all parents in the McAlester School district. Several topics were in response to input of families of children with disabilities. Speakers were generally local service providers from outside the school, the school psychologist, the family services coordinator, the director of special services, and nationally known speakers provided by agencies other than the school system. The effectiveness of the program in response to the second research question, 'Does the program increase families access to available services?', is shown by Figure 6.

Figure 6

Increase in Parent Training and Access to Services.

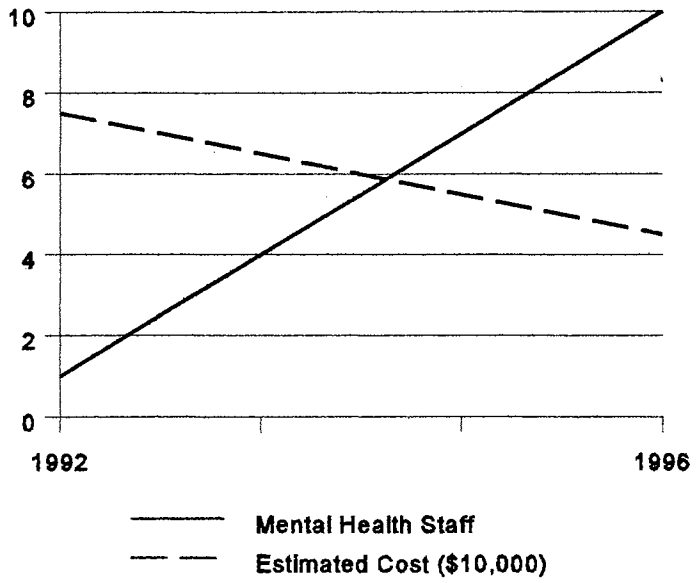


Over the four-year period attendance at the Parent University numbered in excess of 350 parents. Similarly, attendance at the Parent Awareness Workshops numbered in excess of 350 parents. Including the Advisory Committee Meetings, more than 10,000 hours of parental participation resulted from the COSMOS program. Family access to services is shown by the increase in EPSDT services and physician referrals from zero in 1992 to 245 and twenty-eight respectively in 1996.

Another indicator of the ability of parents to access services would involve out-of-district placements. As shown in Figure 7, the services available increased 10 times while the costs of placement decreased 40%.

Figure 7

Out-of-District Services Available and Cost



The following is a summary of the subjects' (participant's) evaluation of the program:

1. How did comprehensive, school-based multidisciplinary services facilitate interagency cooperation and/or participation?

A framework for the process of collaboration was developed by attending monthly interagency meetings. This created a more frequent level of communication between the various agencies involved, which allowed for give and take of information

that increased the quality and level of planning. A broader view of possibilities was gained by the participants. Effective contracts and agreements were developed on a formal and informal basis with the Department of Human Services, the Pittsburg County Health Department, the Department of Rehabilitation Services, Oklahomans for Independent Living (OIL), and other organizations that were needed. Support was given at the state and federal levels for the administration of major agencies, which facilitated cooperation at the local level. After the framework was in place, cluster meetings took place. At the cluster meetings mutual goals were set for individual students. Specific agencies took the responsibility for providing specific services. With this comprehensive planning, there was less duplication of services and some of the service gaps were filled. Interagency cooperation and participation were achieved.

2. Describe the services for children and youth provided or paid for by an agency outside of the local school district.

The Health Department provided staff, equipment and supplies for conducting the EPSDT physicals for children. These services were provided at the school-based clinic and at the Health Department. The Regional Guidance Center provided staff for group and individual therapy to be administered at the school site which was over and above the services they typically provided. In addition to the usual counseling, diagnosis, and referral done by the guidance center staff, a process was put in place for interagency staffing of joint clients. The Department of Human Services (DHS) helped the school

identify children and youth eligible for Medicaid services, as a result the school could receive payment from Medicaid for related services provided at school. Social work services were provided by DHS. Physical therapy, occupational therapy, speech/ language therapy and related evaluations have been increased due to partial payment by Medicaid. The DHS - Rehabilitative Services provided funding to help support a transition specialist on the school staff. They also provided funding for school activities, such as job skills class, on the job training, job sampling, and other career exploration activities. They also provided a job training fund for students who were paid for part of their work. The staff at OIL provided job coaching and job placement services for high school students with disabilities. Local businesses provided job training sites for students. The local businesses also provided technical assistance for determining the necessary job related skills. The Juvenile Services Unit also provided home based counseling services, placement through the court, and routine coordination with the school for children with behavior problems. Private mental health facilities provided services for students at the alternative school. These services are available for all alternative education students at no cost to the school nor the family. Day treatment is provided through another private facility, which reimburses the school for educational services provided by school staff on their site.

3. Did the comprehensive, school-based mutidisciplinary services provide for an increase in services to children and youth?

The consensus is that services have increased due to the comprehensive, school-based multidisciplinary services. The previous amount of services that were provided increased in some cases and services were added that were not previously available. Some of these services included increased health services, targeted case management, technical assistance for teachers and families, a family resource center and library for families, and increased psychological services which include day treatment. The collaborative planning helped decrease gaps in the continuum of services and reduced duplication of services. There is still a significant problem in obtaining physical and an occupational therapist to provide services for students.

4. Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.

Because of the coordinated effort, the other agencies are taking responsibility for picking up the bill and providing some of the services needed by individual students. Medicaid reimbursement and reduced school cost for out-of-district placement for psychological services have resulted in decreased school costs. Since these monies are not spent on school cost for out-of-district placement for psychological services, an increase of other services or service providers is possible. Service provision is more of a community effort and costs are shared.

Obtaining a Medicaid provider number for the school was difficult and was a source of frustration dealing at the state level. There was additional difficulty and

considerable lag time in determining service provider eligibility and services that were reimbursable. There was concern about the school's inability to bill for the school psychologist's services, even with federal approval, state level agreement, and the state Attorney General's decision. As the coordinator suggests, "This is unfortunate because there is a cap on Medicaid and if we don't spend it we will never get it back."

5. Did the comprehensive, school-based multidisciplinary program increase the families', children, and youth's ability to access available services?

All of the respondents reported that the families' ability to access services was increased. This was done through education, technical assistance, increased service providers in the community, services available at the school site, meetings with multiple agencies present rather than several meetings at different locations, and the provision of transportation to necessary meetings. One respondent believed that in some cases the barriers were not decreased as much as they could have been. She stated, "If we had it to do over again we would have made the project much smaller."

6. How does the family receiving comprehensive, school-based mutidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?

There is a general consensus among respondents that the parents overwhelmingly

perceived the program as effective. The parents were cooperative and seemed to appreciate the united effort to provide services for their children. The parents usually expressed satisfaction with the quality of services. There have not been any formal complaints about the service plans nor implementation. Three of the five respondents indicated that there was only one parent who felt that the program did not make a difference for her child. The parent was not specific about any complaints and remains a positive, cooperative team member.

7. What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?

Interagency collaboration and the ensuing agreements for the shared responsibility of service provision and cost sharing were seen as contributing to the increase in services for children and youth with disabilities. The cluster meetings, a multiple agency team approach, were seen as a primary factor in the increase of services for children and youth with disabilities. When the planning process involved multiple agencies and families, gaps in the continuum of services were identified.

Bureaucratic roadblocks at the state level were identified as factors that had the potential for decreasing services to children and youth with disabilities. As a result of this delay at the state level, an inordinate amount of time was spent by the school staff in trying to become a Medicaid provider. The delay cost the entire state by decreasing potential federal dollars that were intended for service provision within the state. It was

suggested that administration at the federal level could have circumvented this problem by providing more direction to the state level agency heads. This may have resulted in a more timely completion of this portion of the project. The time spent negotiating this entanglement may have been more productive through the increase of service provisions and alternative funding sources.

8. Of the services that have been provided, which would you say have been the most important?

Three specific services were seen as important overall. First, there was an increase in psychological services including day treatment in the community and on the school site. Secondly, the cluster meetings that utilized the interagency approach were seen as providing a broader base of options for service planning. Third, the EPSDT physicals were also seen as an important service, not just for the increase in health services, but for an increase in coordinated services and appropriate referrals.

9. How would you rate the overall effectiveness of the comprehensive, school-based community service program?

The general impression of the respondents is that a good, solid foundation has been developed for service provision. A process for service provision through interagency cooperation has been established and implemented. More options are

available and accessible for students and their families. Costs and responsibilities were shared among agencies. There was a general concern that the process for becoming a Medicaid provider took too much time, due to bureaucratic entanglement. There was some disappointment that everything that was planned at the outset had not been accomplished. These two factors diminished the overall rating given to the project. The overall ratings fell within a range of 75 to 85 percent for the program. All respondents felt that the accomplishments that were made were worthwhile and positive. They indicated that the project has been worth the effort. Negative impacts of the program were not directly identified. The respondents did feel as though they were change agents, a critical mass.

10. What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?

The resounding response was, "Do it." Start by laying ground work with a strong multiple/interagency group. Involve people who can commit an agency to the task. Start out small and build from there. Individuals who attempt a similar program must understand that the collaborative process takes time, but much can be accomplished. Time must be budgeted and staff given the freedom to do what is required.

Administrative support must be in place. Change is required at all levels of the organization. Risks must be taken and a plan of action developed for long term goals, short term objectives, and a time line for completion. Specific individuals from various

agencies who will be responsible for specific objectives need to be identified. In Oklahoma, some barriers have been removed at the state level. In addition schools need to begin and complete the process for becoming a Medicaid provider. Additional technical assistance may be sought through the OCCY. As an old proverb states, "It takes a community to raise a child."

Summary of the Results

The answers to the research questions indicated that the program was successful in achieving its goals. First, the comprehensive school-based multidisciplinary community program developed services that facilitated interagency cooperation and/or participation. As a result services to children and youth were provided with the cost of on-site services being shared among agencies, not shouldered only by the school. Secondly, the program increased families access to available services through this coordinated interagency cooperation. Overall, the comprehensive school-based multidisciplinary community program was successful in achieving its goals.

While a variety of obstacles appeared in our path, the general feeling was that things went smoothly in the project. We are disappointed in the amount of time it took to implement the electronic billing capability and Medicaid eligibility determination through a computer linkup with the Department of Human Services (DHS). Efforts to expedite matters were met with a series of delays (primarily due to bureaucratic impediments) from DHS. Our billing for Medicaid reimbursement was delayed due to

slow response for technical answers from DHS and sometimes from some providers to supply the necessary documentation on a timely basis. We have worked through these issues and we believe we are on solid footing at this point. It was due to persistence that these components are in place.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Problem Statement

The need exists for interagency coordination and collaboration in developing service plan provision for children, youth, and young adults with disabilities and their families. This program outlines a service coordination model intended to increase and improve available services, facilitate community support and parent participation, and reduce stress involved in service delivery model that is cost-effective. Would the Comprehensive, School-based, Multidisciplinary, Community Services Model provide the needed services for children and youth with disabilities in a cost-effective manner? Many children and youth with disabilities are not receiving the services that are needed to deal with their problems. A full range of services does not exist in rural Oklahoma. This continuum should include the services required to effectively deal with specific problems (Bernheimer etal., 1983; OCCY, 1992).

Subjects

Using purposeful sampling the subjects were the individuals involved in the

development of the program (see Appendix B). The students were not subjects. Rather, they were recipients of services from the program. However, data was collected regarding the number of students served and types of services provided. Information was gathered on family training opportunities and participation. School information included number of staff and out-of-district services.

Procedures

The program outlined is based upon a model developed by McAlester Oklahoma Public Schools in conjunction with the United States Department of Education and the Department of Health and Human Services (Ashbaugh & Bergman, 1991; McAlester Public Schools, 1992).

The program activities were designed to increase interagency collaboration and community support for the program. The collaborative approach required looking at the context within which the program facilitators functioned. The support the program received from the Oklahoma Interagency Coordinating Council for Special Services to Children and Youth was a critical element in understanding how a small local school district in southeastern Oklahoma could be involved in a systems change effort of this scope.

The term inter-agency collaboration was used to recognize the needs that occur at every organizational level. Success at one level facilitates collaboration at other levels. The Special Services Council set the stage for this interagency collaboration.

The work of collaboration was accomplished by individuals, not agencies. It is important to recognize the stages of concern that individuals have when change through collaboration in initiated. Change that was meaningful and lasting, required careful planning combined with the thoughtful involvement of people over a period of time. To ensure the success of the program community support was elicited. Advisory groups involved parents, concerned community members, school officials, and agency representatives.

The project staff has been involved in developing and implementing a Service Coordination model which elevates parent participation in planning and increases collaboration among providers to ensure comprehensiveness of appropriate services, and expanding service options and funding sources. The service coordination model was developed in a manner that parents were included in the planning stages of service delivery and involved all appropriate parties in planning so that all of the services were aimed toward the desired outcomes. 'Cluster meetings' and brainstorming sessions for service options, have been initiated. Through this process, agency participants and parents resolved issues at early stages, before they became problems. Still, some parents continued to have difficulty believing that their input was important or was being taken into account. Building the foundation for collaboration takes time, but we have found that this model can be utilized in our community with other agencies and by parents themselves taking the initiative to call the meetings. Creative and innovative means of providing services have resulted from this level of cooperation, with families finding easier access to existing service options in the community.

The Program Development and Procedures section provides for the generalization and application of this model to other sites. This implementation may allow for the development of additional programs through a step-by-step procedure. This allows for the creation of additional programs with greater efficiency by avoiding some of the pitfalls inherent in the development of new and innovative programs.

Evaluation Procedures

The analysis methods for qualitative data involve continuous data analysis (Bogdan & Biklen, 1982). Data was gathered on the number of students served, additional services provided, family participation, and interagency participation. Observations throughout the project development were the primary form for the documentation and description of the process or a recipe for success. For the evaluation procedures of this program, a final interview with the primary participants was conducted. The unstructured interviews (see Appendix E) with the primary participants following implementation of the program were intended to develop an understanding of how to reduce or eliminate negative effects of presenting problems. This formative evaluation provided feedback for work plan revisions and projected needs for technical assistance (McAlester Public Schools, 1992).

Conclusions

Findings

The COSMOS Program resulted in an increase in the number of students served, the addition of new services (EPSDT), increased family and community participation, and an increase in available staff. This was accomplished with a minimal cost increase overall and a decrease in the cost of out-of-district placements. Overall, the benefits of the COSMOS Program were greater than the increase in cost.

The interviews with the primary participants provided support for the effectiveness of the program. There were some difficulties that were encountered. Even after the support of the Director of Medicaid Services (Department of Human Services) was in place, the efforts of the school were unduly delayed by the person designated to assist the process at the state level. Applications for a Medicaid Provider number were submitted by the school system. These applications were denied without communication as to what additional information was required nor how to correctly complete the forms. The process that should have been completed within six months or less became a two-year process. To complete the process, the program team had to elicit the help of OCCY, the designated person's supervisors at DHS, and regional executives from Texas. Some components of billable services took more than three years to complete. This underscores the need for interagency collaboration. Currently DHS is providing information (see Appendix H) to assist schools in obtaining a Medicaid provider number so that schools may be reimbursed for services.

Additional findings that may negatively impact service provisions continue to be a shortage of community services and providers. There continues to be a significant shortage of physical and occupational therapists and the cost of these services may be prohibitive. Project staff are exploring ways to remedy this shortage.

In future collaborative efforts, it is important that the communication link needs to be stronger between project staff and UAP. Clear understanding of the focus of the conference and sponsorship of the activity was not evident in the advertising brochures that were produced and mailed by UAP.

Conclusions

The answer to the first research question, "Does a comprehensive school-based multidisciplinary community program for services facilitate interagency cooperation and/or participation to provide services to children and youth with the cost of on-site services being shared among agencies, not shouldered only by the school?"; is that the program did accomplish these objectives. The program did facilitate an increase in the provision of services through interagency cooperation and the cost was shared among agencies.

The second research question, "Does the program increase families' access to available services?"; was also answered positively. The program did lead to an increase in the families' ability to access available services. Creative and innovative means of providing services have resulted from this level of cooperation. These include

interagency collaboration to provide and pay for Medicaid and Health Clinic services at the school, cluster meetings involving multiple agencies to devise a single plan for individual students, parent training and involvement, and alternative education programs.

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. They live under one roof or many. A family can be as temporary as a few weeks or as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members, we nurture, protect, and influence each other. A family is a culture onto itself, with different values and unique ways of realizing its dreams; together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations. Families have found easier access to existing service options in the community as a result of the comprehensive school-based multidisciplinary services program.

Recommendations

The program description outline can be used by schools as an effective guide to developing comprehensive, school-based, multidisciplinary community services to meet the needs of the children and youth in the school and community in a cost-effective manner. The model comprehensive school-based multidisciplinary services is relatively new and innovative. There is little, if any, research available on various aspects of such a

model. Additional research should be encouraged to provide information regarding the potential of this model for services. Future research into this area may identify shortcuts to the provision of services as well as pitfalls to avoid.

There are several recommendations that may apply to most attempts to provide a comprehensive school-based multidisciplinary services program. First, there is a distinct need to formalize changes in state policy concerning *who* can be a service provider and access Medicaid reimbursement.

Second, confidentiality and sharing information must be addressed. The need for uniform eligibility criteria further the possibility for one point entry. Families have to answer the same questions over and over again, even within agencies. Agencies have to use staff to collect the same information other agencies already have. Most agencies obtain and compile information regarding organizational and service requirements for Medicaid and other service agencies. The duplicity of services provided and information that families must submit should be decreased.

Third, the pitfall of assuming that gathering information will automatically translate into desired action is misleading. Facts and data cannot be absorbed, digested and turned into the kind of knowledge needed without mental and emotional readiness on the part of team members. There needs to be time to collaboratively assess what has been learned in terms of information about what each agency can contribute to the process and how it all fits together.

Fourth, permanency planning should be a guiding philosophy since all children, regardless of disability, belong with families. This requires family support,

encouragement of a family's relationship with the child, family reunification for children placed out of home, and the pursuit of adoption for children when family reunification is not possible. Family support services should be flexible to provide the supports necessary to maintain their children at home. These services should foster the integration and participation in community life for children with disabilities (O'Brien, 1989).

Fifth, beyond the acquisition of knowledge is the need for the motivation to act effectively on what we know. Again, this requires individual work and team processing to plan effectively. Since collaboration is done by people, it is important to be able to determine and draw on the strengths of individuals within organizations for the accomplishment of goals. The talents and skills of people are more important than the formal job position held. It takes time to develop this type of knowledge base, but it is critical for success to choose the key players carefully.

Sixth, the program team identified the value of starting with a small program to allow for manageability, rather than attempting a massive change effort all at once. Building success with a smaller project provides a foundation on which to add components and more participants as time goes on. Since entrenched habits and practices are the targets for change, it may be wise to begin with a focus and then expand from there. Let us keep in mind that a better working relationship among agencies is a means, not an end in itself. What we need are improved services for children.

Seventh, consider other agencies. Another important point is that the strategy

which is most effective in a particular community may not apply in the next: the set of agencies involved or how they connect will differ from community to community. Mention must be made that collaboration is a process whose outcomes may not be predictable, because a single party cannot have information at the beginning to see what shape the jointly determined activities will take.

Overall, the development of comprehensive school-based multidisciplinary community services is ongoing and a continual refining process. In a collaborative context, members of other agencies can bring new ideas for consideration, which, if implemented will take schools much further down the road of coordinated, comprehensive service delivery than was anticipated at the beginning. The input of families and community members is essential to the development of effective services, which may be utilized. Comprehensive school-based multidisciplinary community service is an innovative approach that holds the potential for the improvement of services to children and youth with disabilities and their families.

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APPENDIXES

APPENDIX A

TREATMENT SERVICES FEDERALLY APPROVED FOR MEDICAID ASSISTANCE

- Vision care including eyeglasses
- Hearing including hearing aids
- Dental care
- Podiatrist services
- Optometrist services
- Chiropractor services
- Physician services
- Medical and remedial care (i.e., psychologists, social workers, audiologist)
- Home health services
- Private duty nursing services
- Clinical services furnished under physician direction
- Nursing facility services
- Inpatient hospital care
- Outpatient hospital care
- Personal care services
- Transportation
- Case management
- Hospice care
- Preventative services
- Rural health clinic services
- Family Planning services
- Laboratory and x-ray services
- Emergency hospital services
- Rehabilitation services
- Intermediate care facilities
- Intermediate care facilities for the mentally retarded
- Inpatient psychiatric services
- Christian Science nurses/sanatoria
- Physical therapy and related services
- Occupational therapy
- Speech and language care for hearing or developmentally related disorders
- Prescribed drugs, dentures, and protheses
- Nurse midwife services (where authorized)
- Respirator care
- Certified pediatric and family nurse practitioner (where authorized)
- Community supported living arrangements for persons with developmental disabilities
- Other diagnostic, screening, preventative, and medical or remedial services provided in a facility, a home, or other setting, recommended by a physician or other licensed practioner

Source: Orloff, T., Rivera, L., & Rosenbaum, S. (1992) cited in Ahearn (1993)

APPENDIX B

JOB DESCRIPTION OF SUBJECTS

1. The *Coordinator* has a wide range of work experience from social worker, child abuse prevention specialist, psychological assistant, rehabilitative and job placement specialist. She holds a Master's degree in Community Counseling from OSU. She has an excellent working relationship with many of the key agency representatives. It is her task to develop agreements with agencies/service providers, collect data and maintain on-going documentation of progress.

2. *Director of Special Services*, serves as project director. She is responsible for maintaining on going administrative supports, overseeing the project, state and local interagency coordination, and the task of obtaining a Medicaid provider number for the school system.

3. *School Psychologist/ Special Education Program Specialist*, involved in training of staff and parents, working with families, utilizing case management techniques, referrals, and interventions for children, youth and families, participant in interagency coordination and planning.

4. *School Nurse* actively involved in the development and implementation of on site health clinics, working with families to access Early Periodic Screening Diagnosis and Treatment (EPSDT) either at school or at the Department of Health.

5. A *Special Education Teacher* certified in several areas was involved in the daily implementation of the program. This involved providing information to parents and other professionals, scheduling appointments and meetings, and following up on the services to ensure that the services were received and to avoid duplication of services.

APPENDIX C

MCALESTER PUBLIC SCHOOLS GUIDE FOR DEVELOPMENT OF MEDICAID SERVICES

1. Asssess local resources for provision of Medicaid reimbursable services.

2. Through ongoing consultation and training, become familiar with state Medicaid plan, and policies and procedures that govern access to SSI funds.

3. Through collaboration, form local partnerships for delivery of EPSDT services; e. g., health department, private physicians, regional hospital, local medical clinic, and medical supply companies.

4. Identify needed services not presently accessed by Medicaid eligible families and determine projected number to be served.

5. Develop and implement a program of information dissemination to parents and providers regarding EPSDT and related services.

6. Enter into contractual agreeement with state medical services division to become Medicaid provider.

7. Establish procedures for documentation of services and billing for reimbursement.

8. Begin process for certification of school sites as EPSDT clinics through public health department.

9. Initiate parent contacts through home visits and teacher referrals to explain services, begin intake process, and refer to school nurse for preliminary screenings. (Height, weight, hearing, vision).

10. Conduct preliminary staffings with medical team to plan comprehensive evaluation.

11. Conduct school clinics and follow up on referrals resulting from screening process.

12. Assist parents with application process for SSI eligibility.

13. Upon provision of related special education services provided in response to screening referrals, submit appropriate billing.

14. Budget Medicaid reimbursement revenue for comprehensive service provision.

APPENDIX D

EPSDT AND HEALTH RELATED SERVICES

1. Review Screening results of all students
2. Referrral for EPSDT Screen
3. Parental contact of students referred for screening to:
    a) Obtain informed consent to conduct current EPSDT screen, or
    b) obtain parental permission for release of information from private/public provider
4. Conduct EPSDT screen
5. Records generated and maintained
6. Diagnosis - service delivery team
7. Treatment
8. Reimbursement claimed

APPENDIX E

INTERVIEW QUESTIONS

1. How did comprehensive, school-based mutidisciplinary services facilitate interagency cooperation and/or participation?

2. Describe the services for children and youth provided or paid for by an agency outside of the local school district.

3. Did the comprehensive, school-based mutidisciplinary services provide for an increase in services to children and youth?

4. Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.

5. Did the comprehensive, school-based multidisciplinary program increase the families', children and youth's ability to access available services?

6. How does the family receiving comprehensive, school-based mutidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?

7. What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?

8. Of the services that have been provided, which would you say have been the most important?

9. How would you rate the overall effectiveness of the comprehensive, school-based community service program?

10. What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?

APPENDIX F

WRITTEN AGREEMENTS

I, _____ , hereby authorize or direct Laqueta D. Vaughn, or associates or assistants of her choosing, to perform the following procedure:

1. Each participant will be asked ten (10) interview questions (Appendix E, attached)
2. The participant will answer each of the ten (10) interview questions. The time involved will be approximately 30-45 minutes for each participant.
3. Each participant's responses will be identified by position (e.g., teacher) and referred to in the text by position. All identifying information will be destroyed at the completion of the project.
4. Any discomfort or risk is minimal.
5. The possible benefits to the participant may involve a better understanding of the services available to student with disabilities. By evaluating these services, society as a whole may benefit as individuals with disabilities are able to achieve more of their potential.

This procedure is conducted as part of a thesis entitled *A Qualitative Study of the Creation and Implementation of Comprehensive School-Based Multidisciplinary Community Services*.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may contact Dr. Paul Warden, at (405) 744-6036. I may also contact University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; telephone: (405) 744-5700.

Signed _____

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 04-22-96 IRB#: ED-96-117

Proposal Title: A QUALITATIVE STUDY OF THE CREATION AND IMPLEMENTATION OF COMPREHENSIVE SCHOOL-BASED MULTIDISCIPLINARY COMMUNITY SERVICES

Principal Investigator(s): Paul Warden, Laqueta Vaughn

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
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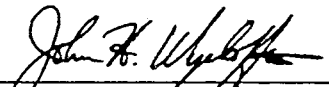
Signature:  Date: April 30, 1996

Chair of Institutional Review Board

APPENDIX G

INTERVIEW DATA

Coordinator

1. *How did comprehensive, school-based mutidisciplinary services facilitate interagency cooperation and/or participation?*

If it is run the way it truly is supposed to be run all the team players would be there. It expanded the number of agencies involved. The cooperative agreements made with the Department of Human Services and Department of Health helped facilitate interagency collaboration for school based services.

2. *Describe the services for children and youth provided or paid for by an agency outside of the local school district.*

EPSDT physical, Children were underserved. We were only at 8% in Oklahoma for children having physicals when needed. The DHS had a goal of increasing EPSDT by 80%. We had the health clinics at the school. Referrals were made back to the school for related services. The guidance center provides services in the school such as therapy groups at school instead of the Health Department. The agencies feel a lot more comfortable coming to the schools since we have monthly District IV and Region XI board meetings. JSU comes to cluster meeting for the development of service plans. And they are now willing to set in on any meeting. Family Focus- Eastern Oklahoma Youth Services has been working real close with the school.

3. *Did the comprehensive, school-based mutidisciplinary services provide for an increase in services to children and youth?*

My only experience with schools has been with the grant so comparison is difficult. But I believe there is more of an awareness of the agencies for referral. There is more networking and a more comprehensive referral service and that we do work more closely together . We try to help families become eligible and to actually access those services available.

4. *Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.*

We have increased salaries to attract higher level people. We hired another half time speech person. Psychological services have increased. We have had a lot of lag time at the state level. Even when they have agreed that this is what we need to do they still have not let us access funds for some services. Even with agreements made, policies changed, the person(s) controlling funds have not made it possible for us to bill for psychological services. I think there is just some reluctance to open doors. This is unfortunate because there is a cap on Medicaid and if we don't spend it we will never get it back. I don't know, maybe they are worried about matching funds, but the school matches 30% and the feds 70% the state would not be out any money. So 70% of funds

that the school would normally have to furnish could come from the federal dollars. This would increase federal funds coming into the state.

5. *Did the comprehensive, school-based multidisciplinary program increase the families', children and youth's ability to access available services?*

In some cases I think a lot, in some cases I don't think as much as it could. If we had it to do over again we would have made the project much smaller. Hopefully, the families have increased their ability if for no other reason because we opened an avenue for them. We do help them to access SSI, DDSD, gate keepers, and social workers at DHS. Other agencies help by making more appropriate referrals.

6. *How does the family receiving comprehensive, school-based mutidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?*

I can think of several that it really worked the way it needed to. The first one the parent does not have a lot of resources and even though she was not as involved as some, but she was helpful and cooperated in the process. Another family, the parent really felt the support of the school. When she needed parenting skills she received training. When she didn't understand the behavior a neuropsychologist explained it to her. Even when they needed fans in the summer. The school nurse followed the child and make home

visits. The parent definitely felt as though it was positive. So far only one parent felt as though we did not increase services to meet her child's needs. We worked intensively with the family and other organizations to provide services, but she did not think that the grant make a difference for her child. We did use the telecommunication set up to help obtain necessary evaluations to get a myoelectric arm and hand for her child and we provided a video camera for mom to video tape behavior at home for documentation for the doctor. We worked on behavior management with the family but they were not used. We are not clear as to why she was not positive about the services.

7. *What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?*

The biggest plus is the team approach that increases the services for children. I don't see kids falling through the crack. Any problem/concern that is presented about a child is addressed by a whole team. The family is not an island. The factor that decreases services continue to be provided to all children brought to our attention.

8. *Of the services that have been provided, which would you say have been the most important?*

I think the "cluster" meetings. The team approach is one of the most valuable factor at this time.

9. *How would you rate the overall effectiveness of the comprehensive, school-based community service program?*

Laying the ground work it rated on a one to ten, I'd say a seven. It's not as organized as I'd like. But the seed is planted and everyone is working together. For awareness laying ground work and effectiveness a 7 out of 10.

10. *What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?*

Laying ground work with strong multi/interagency group. The school should be real visible in the community. Being able to take risks, become a Medicaid provider. Get out of your mold. Don't think that it's something you can do yourself. It takes a whole community to raise a child. Start out small and build. You must come out of your nitch and work with multiple agencies and be more family oriented. The more people you bring into a child's life the more doors are opened for the child and family.

Director of Special Services

1. *How did comprehensive, school-based multidisciplinary services facilitate interagency cooperation and/or participation?*

It created a more frequent level of communication between the varied agencies involved. Which allowed for a give and take of information that increased the quality level of planning than there was. Then, for each individual student, because planning came from a variety of perspectives and also allowed for more ideas and more solutions for problems to be thrown into the pot, so to speak. Because there were people from various agencies brought together over one student or one families's needs, and, it did it because there was one agency and someone responsible to try to figure out who needed to be brought together from the various agencies so that what I just talked about could happen. Someone was responsible for inviting, for researching, for getting the word out that you know there needed to be a team approach, a multidisciplinary interagency team approach, to provide the types of programming and services that the student and family needed. In our case it was the family services coordinator. You knew basically who was responsible for seeing that it happened. It didn't mean that she was the only person doing that. She helped train people to understand that this is what we are trying to do. Then she facilitated cluster meetings and so on to get this going. There were formal agreements developed between the McAlester Public Schools and theDepartment of Human Services and , the Pittsburg County Health Departmen,t and the Department of Rehabilitation Services. There were informal agreements between Oklahomans for Independent Living and other organizations that were needed. These agreements spelled out who was going to do what and how the interaction of cooperation were going to occur so that a more comprehensive program could be provided for each student. This helped to insure that there was less duplication of services and then some of the service gaps could be filled.

2. *Describe the services for children and youth provided or paid for by an agency outside of the local school district.*

Okay, there are several agencies here we could talk about. I guess we could start with the local Health Department. They provided staff, equipment and supplies for doing the EPSDT screenings for children. We either referred and got them to the Health Department or they were completed in our school based health clinic. They provided the staff to come and actually do the EPSDTs. That allowed for referrals, appropriate referrals, to be made for services. As a part of that process the Department of Human Services helped to identify eligible, Medicaid eligible, children and youth. They worked directly with our staff to see that either eligibility requirements were met or that the family was assisted through a cooperative effort. DHS and MPS staff worked together to identify these families, to get them eligible if they weren't, or to help refer them on to other places if eligibility wasn't possible. Then, the Health Department, in addition to the school based health clinic, conducted EPSDT screens at their facility. They also work closely to provide counseling and other support services for our students. Either through school-based services like group therapy that were established, or for individual and group counseling that was on their site. Which might not be all that different from what has been formerly done except there was more of it. That came about as result of closer interaction brought about through the cooperative agreement and also because a weekly process was put in place for staffing of joint clients. A client that the Health Department and the school both served and so the school staff and Health Department

staff met weekly to staff the students. The staffing created more appropriate, better quality services and better programming for these kids. It created a stronger communication link between the two agencies and the between the families. Another thing that I could talk about would be the Department of Rehabilitative services. As a part of this initiative they provided funding to help support a transition specialist on our staff. They helped provide the funding for school activities, which included job skills class, on the job training, and job sampling with other career exploration activities. This led to the development of a contract with them for on the job training fund for students to actually be paid for some of the work they would be doing. Part of the contract was an employment committee that involved school staff and rehabilitation services staff, OIL staff , local business men/women, and votech staff and so on. The purpose of this group and regular meeting was to identify more possible work training sites for the students and to get a flow of information going back and forth between business and education as to what are the gaps in skills that students have that the education part needs to address. Also what are the things we can learn form the business world as how to help these students with for instance , help develop a resume, job interviewing, all those things that deal with employment options for students.

3. *Did the comprehensive, school-based multidisciplinary services provide for an increase in services to children and youth?*

I guess I answered a part of that in the second question. There is a natural flow to these questions and I am excited about the project and get carried away. Services have

increased due to the comprehensive, school-based multidisciplinary services. The amount of services that were previously provided, and we added services that we did not have before liked targeted case management, technical assistance and a family resource center and library for families, psychological services which include day treatment.

4. *Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.*

Before we began the project students often received a lower level of services, say, for counseling than was needed or to a greater level of residential treatment than was needed. We developed an agreement with a private hospital to bring a facility for day treatment to McAlester. With the day treatment parents can access community based partial hospitalization services with ongoing educational services that are provided by the school. We also included a half day mental health program to our alternative school at no cost to the school district. We were able to save more than $30,000.00 just for out of district placement for psychological services. That combined with reimbursement from Medicaid could pay for about two additional staff members or other increases in related services. Like I said because the agreement with rehab paid for wages of students in training and one half of a teachers salary we were able to free up more time for transitional services. I'm sure I haven't covered everything but you get the idea

5. *Did the comprehensive, school-based multidisciplinary program increase the*

families', children and youth's ability to access available services?

EPSDT is a way of increasing access to services . Parents gained information for accessing health and medical services for their children as a result of this (program). Based on family report, school based clinics increased parent knowledge and provided for increased interaction between health care providers, family and school. We have been able to increase PT/OT and speech services to a level greater than ever before, since P.L. 94-142. The services the family resource coordinator provides, I guess you could describe some of it as case management, at a level that the school was not able to do before. Social work type of services are also included. Because of increased awareness on the part of families and providers the accessibility for services has increased. An example would be that a private orthotist comes to the school to fit children for braces and orthotics that the family would have had to travel to Oklahoma City or Tulsa to access.

6. *How does the family receiving comprehensive, school-based multidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?*

Feedback from parents indicated that we did not have a single negative response or any negative feedback about the EPSDT screens at the school clinic and so in that area I could be almost safe in saying 100% of them felt this was a very effective way of

meeting their needs and they liked it. As far as the various things we've done through this project, I'm not sure that many of the families have a comparison to make because these were the only type of services they have received. We have run into some negativity. Some of our families hold the belief that a medical model of PT/OT /Speech therapy is the best/only way for these services to be provided. So education for these families was necessary. Many families have come to appreciate the educational model of integrated therapy and have seen the value of this method. I could not say that all families would agree and some hold out that the pull out, direct hands on, range of motion was the only way that therapy should be delivered. We probably have a small number that would say that.

I think that many families have been impressed when they come to a "cluster" meeting and there are individuals representing the various agencies to focus on their child and their needs. Problem solving by everyone impresses the parents and it gives them confidence that everyone is working to help their child. They appreciate it. I'm not sure we've done a real public relations job to say this was before and this is now. I'm not sure there is a real clear line between before and now because we were headed in that direction. Between 75-90% of families involved directly are positive about their children's programs.

7. *What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?*

The outstanding factor that I see is the frequent communication and a mechanism where by which individuals from various agencies are brought together to problem solve, for the family. These are the cluster meetings that I've talked about before. Any individual that has an interest in the child can call for a team meeting where the problem is stated, problem solving is done, and a plan is written out with who is going to be responsible for what action. This may sound like an IEP and it can be used as part of the IEP but it is not limited to that population.

Another thing is becoming a Medicaid provider. The advisory board that helped start this (OCCY District IV and ICC Region XI) is the monthly mechanism in which we work together to give more general problem solving and interagency collaboration. That grass roots meeting which brings together representatives form different agencies with an agenda, is the starting point. Through those meetings we have a voice that goes back to council and on to the legislative level to assist in; changes in state policy and laws and funding, so on. They take a great big deal of credit for this process. I must say the process is slow with some bureaucratic entanglement. I must say any decrease of services is due to bureaucratic entanglement as well as decreases in federal dollars. In a way that does force us to be more cooperative with each other. The biggest problem was the federal level of administration of this project did not provide enough direction to the state level agency heads to make the level of changes that this project was intended to make. Because I don't think that it is realistic to think that you can take regular local people that are not part of the mainstream of bureaucracy particularly in DHS. You can't expect them to have the knowledge base to make the changes in these organizations as

quickly as they needed to be made. It called for more involvement from the state level people in the federal level of training. The local people had great training at the federal level. But when we came back to the state and were presented with state level policies and procedures that were very difficult to change. This prevented us from accessing some of the federal funds that were intended. There was a lot of frustration because there was not a willingness on part of the state. I should say on part of particular individual(s) that was particularly in the Medicaid process. They were not open to change. We did make some inroads there but it took years, inching along with intensive work. We did finally get permission for schools to become Medicaid providers. We were able to add a few provider categories that were not there previously, speech therapy, PT and OT assistants. It was very difficult to get that. We are still not totally out of the woods on reimbursement for psychological service provision. Even through we've been cleared at the federal level and the State Attorney General level we still have resistance at the Health Care Authority (previously DHS) state office for us to access Medicaid dollars for school psychologist services. We have personnel who have at least equal or a higher level of training than persons that can provide these services for the private sector and other agencies have, that provide psychological services and collect Medicaid dollars. So there continues to be many areas that we have not been able to access funds, such as, administrative case management, in Oklahoma. The Rehab part of Medicaid should be available, they were intended to be used by the federal laws. Children and their families could receive and benefit from these services. State and Federal funds could be used as intended but they are not. We could provide more preventative services. Those are some

of the barriers to services and we can say we've won some battles but the war has not been won.

8. *Of the services that have been provided, which would you say have been the most important?*

I believe more students are involved. We did not have it before and so many students are benefiting from it. That is day treatment and the other psychological services we are able to access because of it. There are still bugs to be worked out and problems to address. We are able to get students more intensive help locally. At the same time it enables us to remove disruptive students that disrupted other students learning and get them the help that they need. So they can be addressed in the community and not have to go out of town. When the students are served in day treatment in the community the school is not out the cost for educational services. I know the first year day treatment was in place our district's cost for education services out of district was cut in half from close to $70,000.00 to in the 30,000.00's. So those funds were able to be funneled into other services.

9. *How would you rate the overall effectiveness of the comprehensive, school-based community service program?*

It is hard and I cannot be totally objective. I can say this, when I look at where

we were before the project and what is going on now I see that improvement has been make and I'm very proud of what has been accomplished. I think it will continue to grow and develop. I think it is impossible to truly measure how much has been accomplished. On the other hand I need to say the program is not anywhere near where we set out for it to be. We were not able to accomplish everything we had intended to accomplish in part due to the barriers I discussed earlier and also because I don't think a group getting together to plan something of this nature can possibly know all the factors going into it. So I don't think it is bad that it turned out differently than we originally planned. I think that it would be expected. Because there is no way you could have the vision when you are bringing together all the different agencies. You can't know all the problems and positives that will happen as your going along. We operated serendipitous because opportunities presented themselves that we could not have been aware of. Many, we took advantage of opportunities and on the other hand we were not able to accomplish much of what we thought we would be able to do. Such as, with technology. We had hoped to link up with telecommunication, etc., do more evaluation, therapy services, etc. We have been able to some rehab evaluations over distance with telephone/television hookups. We do not have the technology to do the consultative services we had hoped to. We still have a way to go. If I had to put a number on it, I give it a B- or a C+. I'm saying that in terms of where we expected. In the basis or foundation it set for change I give it an A+. In how far we went from what we expected a C+ or B-.

10. *What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?*

Number one you must know that collaborative processes such as this requires intensive investment of staff time for communication. It is not a quick fix it is not something that can happen overnight. It takes time for the people to gather the knowledge and internalize the concepts and work through the levels of change that have to come about for it to be effective. You need to have your eyes wide open for that part of it and to have realistic expectation of what you can accomplish in a given period of time. I would recommend it to anyone. I think it has made good improvement and developed a good foundation. I'm not sorry at all. It is worth it. Do it. You just have to know it is time intensive and the levels of change you have to go through. Collaboration is done by individual people and people have stages of concern about change. After an awareness level or information level individual persons want to know how it is going to affect them personally. How's this going to affect my life? Where am I going to park my car? Do I have the expertise to do this? Then they want to have a picture of the consequences of the collaboration before collaboration can take place. After collaboration there is always refining that takes place. I don't think that it can be overemphasized that individual go through stages. It's like any growth process. Some people move through them more quickly than others. It's a process. It's process intensive. There is no such thing as overnight collaboration. It takes time. If your going to do this you want to make changes that endure over time and that requires careful

planning, lots of people and lots of time. There is not an automatic button that you push. Mental and emotional readiness must be there for it to happen. Support must be there at the administrative level. At all levels. Things must happen at all levels of the organization.

Start small. We bit off too much of a chunk.. I would limit the scope, build a foundation then start from there. Obtain agreements from other organizations before you start.

I believe we have decreased barriers for others such as Medicaid. Through the learning process we have decreased some problems of developing such a program. Each community is different and unique and their process will be unique but they can learn from our process and out mistakes. There are basic things generally. Identify a small enough size project or goal. Involve people that can make /commit an agency to the task. You may have to go high enough up in an agency for that. Like I said before I don't think our federal level people involved the right state level people in Oklahoma early enough in the project so that it would have moved as quickly as it could have. So involve people who can make decisions for their agency before you make too many concrete plans. Budget time and give staff freedom to do what they need to. We pretty much did ours on top of what we were already doing. We were fortunate through the grant to employ one person and two for awhile to help with the process. Job descriptions need to be designed to allow for the time needed to develop the plan.

School Psychologist/Special Education Program Specialist

1. *How did comprehensive, school-based multidisciplinary services facilitate interagency cooperation and/or participation?*

This was accomplished by setting a framework for process of collaboration. By active participation in monthly interagency advisory meetings like the District IV and Region XI we were able to develop more personalized professional relationships with the individuals that perform agency services. When agreements and contracts were developed the players were familiar with one another. This would break some of the barriers to collaboration. By obtaining support from the federal and state level for cooperation the project facilitated increased probability of local participation. The local agencies were secure that they had the latitude to collaborate with the school for service provision. When we implemented the cluster meetings we actually brought the interagency team together for problem solving for individuals. Mutual goals were identified and specific agencies took on the responsibility for providing for services.

2. *Describe the services for children and youth provided or paid for by an agency outside of the local school district.*

Health services through the Health Department reduced the cost to the schools. Especially when referrals were made to the school for provision of related schools.

Medicaid in turn reimbursed the school, at least in part, for occupational therapy, physical therapy, speech/language therapy and related evaluations. Psychological services were obtained through contracts with private facilities at no cost to the school. The day treatment facilities actually reimbursed the school for the cost of hiring a teacher to provide educational services at their facilities. A significant amount of mental health services were provided through the alternative school. We began this in a seventh and eighth grade program and have expanded it to include grades six through twelve. We have plans to expand the alternative school from the second grade to twelfth grade. The mental health services are an option for any of the students in the alternative school, at no cost to the district. The students can receive as much as one half day of treatment including various therapies. The private mental health facility does not refuse services to any of the services even if they cannot bill Medicaid for the services. They do try to keep a 70/30 split for billing.

Other costs for equipment and supplies have been reduced by helping families access SSI, and other programs that they might be eligible for. The regional guidance center began providing group therapy at the school site, again at no cost to the school. They also provide some individual counseling at school and participate in developing behavior management plans that go across environments.

3. *Did the comprehensive, school-based multidisciplinary services provide for an increase in services to children and youth?*

Yes they did. By developing a data base our information level was increased for more appropriate referral. Interagency collaboration increase our spectrum of services. We worked together to fill the gaps in service provision. We were able to decrease the gaps in the continuum of services for the children and youth in our area. The options were not limited to students in McAlester schools. We were able to increase the number of actual service providers, although, we still have a need for PT/OT service providers in our quadrant of the state.

4. *Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.*

Because outside agencies provide services the school is able to spend that money for other or increased services for our students. The reduction of out of district placement for psychological services reduced our school's cost by more than thirty thousand dollars in one year. Because we do not limit educational services to McAlester students and include services to other small rural schools through contracts we have been able to reduce the cost of service provision for our students. This has increase funds to provide more comprehensive services to a greater number of students.

5. *Did the comprehensive, school-based multidisciplinary program increase the families', children and youth's ability to access available services?*

Most certainly, it did. Yes. It empowered the families by providing them with the information and technical assistance needed to access services they were eligible for or entitled to. The families were able to obtain services on the school site which reduced problems of transportation and accessibility. With interagency planning we could address difficulties of obtaining particular services and through a team effort facilitate more comprehensive services. By including families in the ground level planning stages we were more aware of issues that might inhibit accessibility.

6. *How does the family receiving comprehensive, school-based multidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?*

Of the families I have had contact with most have shown a positive regard for the services. Most often they feel as though the entire team is working together to help their child. Just this past year, I have received notes, calls or visits from six families who were pleased with the level of assistance they received. One family wrote a letter to the superintendent to express their satisfaction with the comprehensive services their child received. We have had a few rough roads to travel especially with families who have had to fight previous schools for services for their children. But these smoothed out after a

few meetings. There is only one specific family that stands out as not seeing the program as being effective. I do not have a grasp on why because the parent has not provided specifics. The child receives full day educational services with occupational therapy, physical therapy, speech and language services, psychological services through school and Developmental Disabilities Services, medical services, forty hours of habilitation training per week which occurs after school and on weekends, and twenty-four hour respite care for thirty days a year. Still, the parent remains cooperative and positive, she gets along with the school staff. More than 400 families have been involved at some level of the program. I suspect that the absence of any formal complaints implies effective programming.

7. *What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?*

The school facilitated a community effort to improve and increase services for children and youth. We obtained federal and state level support for local interagency collaboration. Once the foundation was laid the cluster meetings helped to delineate responsibility for service provision. Which, by reducing duplication of services we were able to increase appropriate services. When the planning process involved multiple agencies and families we were able to identify gaps in the continuum of services. Then we approached private providers to locate in our community.

Services could have been increased in a more timely manner if we could have had

more cooperation at the state level for policy change so that schools could become Medicaid providers. This activity was difficult and time consuming. The individual responsible for providing us with the technical assistance was not always straight forward or timely with responses. It took far too long for this process. The state of Oklahoma, as a result had a limited flow of possible federal Medicaid dollars coming in for services. This is unfortunate for the children that were meant to be served. No additional monies would have come from the state funds because the reimbursable services are provided by the schools. Were we able to access the federal funds we would have had more dollars in the general school fund to improve/increase services. Seventy cents of each dollar that for required services would have been paid by the federal government. The school is required to make to thirty percent match. Perhaps if the federal people would have included the people at the state level that could have expeditated the process our time could have been spent in a more efficient manner. We have yet to obtain permission for reimbursement for school psychologist services. We have federal approval and approval from the State Attorney General for reimbursement but still are unable to convince the state to reimburse schools for these services. We have not been able to access federal dollars for other rehab services such as targeted case management or administrative case management. Our state is losing intended federal dollars each day that goes by.

8. *Of the services that have been provided, which would you say have been the most important?*

The interagency cluster meetings gave us a broader base of options for service planning. They helped us to look at the whole child, not only in relation to the school, but the family and the community. The specific service would be the significant increase in coordinated comprehensive psychological services.

9. *How would you rate the overall effectiveness of the comprehensive, school-based community service program?*

Oh, I will try to be objective in this. We have set a standard, a level of comprehensive services that have not been offered previously. We have developed a process for obtaining services through multiple agencies. We have helped eliminate the red tape and barriers so all schools in Oklahoma can become Medicaid providers. We have taken a grassroots approach to program development and have included families and community members in the process. We are maintaining more children in the community with family supports. I give us a grade of A for the foundation we have laid. Of course it is not 100% but at least 90%. I'd say that the time that it took to accomplish these tasks combined with the far reaching scope of our intended outcome would bring the overall grade down to a B. We have gained vision we are not limited to what always was acceptable before. We see not only our students and their families as a part of the

community, but, we see ourselves and our school as part of the community. We are not isolated service providers in and of ourselves. The possibilities are limited only by our vision. We are in effect a critical mass.

10. *What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?*

Do not delay. Begin the process as soon as possible. It takes time to collaborate. Be sure to involve all possible agencies in the planning process. Seek technical assistance through OCCY and the Special Services Board. Training is available through the State Department of Education. Become a Medicaid provider, each dollar reimbursed is another dollar you would not have received otherwise. If your community is very small and the options are limited consider joining efforts with other small school districts for co-op services. Set goals and objectives during planning meetings. Put your plan in writing. Identify individuals/agencies that will be responsible for specific objectives. Include a time line for completion of specific objectives. Ask for help from anyone and everyone. Allow staff members to attend meetings and encourage training and staff development in areas of identified need. Attend OCCY district planning and coordinating board meetings and Special Services regional advisory board meetings. You can be a change agent, your voice can be heard. Start today.

Nurse

1. *How did comprehensive, school-based multidisciplinary services facilitate interagency cooperation and/or participation?*

Interagency cooperation and participation was increased by agreements made with other agencies. Once we developed a contract with the Health Department we worked together to provide EPSDT physicals for our students. We also made agreements with local doctors that provide those physicals to make referrals back to the school for related services that are appropriate.

2. *Describe the services for children and youth provided or paid for by an agency outside of the local school district.*

The Health Department worked in cooperation with the school to develop a school-based clinic for the provision of EPSDT physicals. They provided staff and equipment for these. When they weren't provided at school they were at the Health Department or the doctor's office. Because we are now Medicaid providers some of our services provided at school are paid for by Medicaid. I am limiting my answers to the services I am directly involved in. If a child has a physical or health concern I am more routinely involved in planning teams. We have identified other agencies and providers that will pay for some services a child needs if they do not qualify for Medicaid. For

instance, obtaining corrective lenses.

3. *Did the comprehensive, school-based multidisciplinary services provide for an increase in services to children and youth?*

Yes. As I mentioned before the health related services have increased. We are serving more children in this capacity than we ever have before.

4. *Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.*

The school's cost for services decreased because of Medicaid and because other agencies are taking responsibility for services. The project has shifted the conception that it is the sole responsibility of the school to pay for all of the services a child requires. It is more of a community effort. Once we started the process other doors opened to obtain services for our students.

5. *Did the comprehensive, school-based multidisciplinary program increase the families', children and youth's ability to access available services?*

Yes. We helped to educate our families of how to obtain services. When we provide services at school the children are already here so the problem of transportation

is reduced. The number of community services have increased since the project began, so families do not have to go out of town to access partial hospitalization for day treatment.

6. *How does the family receiving comprehensive, school-based multidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?*

In my experience parents are positive. They are cooperative and seem to appreciate the united effort to serve their children. The parents have been pleased with the quality of the services. We have a common goal of improving the quality of life for the children.

7. *What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?*

I have not seen a decrease in services since we began the project. The increase in services can be seen as a result of interagency collaboration. The agreements made with the other agencies helped provide us with guidelines of who is responsible or who can be responsible. Our options and roles were more clearly defined.

8. *Of the services that have been provided, which would you say have been the most important?*

As a nurse, I would have to say the increase in health related services. The school-based clinics and the referrals based upon the EPSDT physicals facilitated more appropriate and an increase in services.

9. *How would you rate the overall effectiveness of the comprehensive, school-based community service program?*

Let's see, on a scale of one to ten I would give it a seven. We have done a good job but we are not as far as we hoped to be at this time. It took us a very long time to be able to become Medicaid providers. We did not have the level of cooperation from the state level that we needed for the process. It should have not taken so long. We do have an excellent foundation for service provision. We have made good changes for our students.

10. *What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?*

Try it. Start the process as soon as possible because it will take time. We have been able to cut through some of the red tape and changed polices at the state and local

level. This should help other schools after us. Other agencies are there to provide services for children, take the initiative to include them in a team process. Make a plan of what you want to accomplish and set goals and objectives with a time frame and indicate who is responsible for what. Be sure to include other agencies in the planning stage. Take the attitude that it takes the whole village to raise a child.

Special Education Teacher

1. *How did comprehensive, school-based multidisciplinary services facilitate interagency cooperation and/or participation?*

Well, the thing that the comprehensive, school-based services did to facilitate interagency cooperation was that we began to look at all the possibilities as we undertook the project. We had a broader view of what could be possible. We actively sought the participation from other agencies. Then the agreements or contracts that were made with them helped to assure their cooperation. I think it was much clearer to all of us how things could work. Once we started having cluster meetings the other agencies started taking more responsibility for some of the services for our students.

2. *Describe the services for children and youth provided or paid for by an agency outside of the local school district.*

The EPSDT physicals was a starting point for some of the services to be paid for by some of the other agencies. Once a student was referred for PT/OT, speech or psychological services, or other medical services then DHS, mental health, the guidance center, or therapeutic foster care would pick up the cost of the services. If the school provided part or all of the services then we could possibly bill Medicaid for services.

Juvenile Services Unit would also come to our meetings and the services through them might include family counseling, placement through the court, or routine coordination with the school for helping with behavior problems. They also did drug and alcohol testing. Mental health services now go into the home for counseling if it is necessary. They also use case management for the children and they coordinate efforts with the school, especially with children who have serious behavioral and mental health issues. A private mental health facility provides services for children at risk in our alternative school. The services include different kinds of therapy on a daily basis. There is no charge to the school or the families for these services.

3. *Did the comprehensive, school-based multidisciplinary services provide for an increase in services to children and youth?*

Yes, I think that some of the services were out there and available but we were not sure of how to access them. Our family services coordinator helps to bring the necessary people together so we have a team effort. Then the families and the school can work with the necessary agencies to make a more comprehensive plan that can include more services if they are needed. I know that we have greatly increased the number of students that now receive SSI which opens up more possibilities for services. We now have options for psychological services in our community that we did not have before the project.

4. *Describe how the services provided by outside agencies affected the school's cost and/or ability to provide additional services.*

Because of the coordinated effort the other agencies are taking responsibility for picking up the bill for some of the services for our students. Those monies that might have been paid for by the school are freed up to pay for other services or programs for more children. The school becoming a Medicaid provider also decreased the amount of money that we have to pay for services, again, that gives us more dollars for more services. Our students receive more appropriate levels of PT/OT services in a more integrated manner. We are able to receive more consultation in the areas of related services.

5. *Did the comprehensive, school-based multidisciplinary program increase the families', children and youth's ability to access available services?*

Yes, it did. One way is bringing the agencies together in one meeting, which was usually at the school. If a parent did not have transportation to the meeting then we would pick the parent up and bring them to the meeting. The families received the help they needed to fill out forms. We helped to educate the parent about the workings of the various agencies. When we increased their knowledge level they felt more competent in dealing with the various agencies. We were able to help them to know what to expect and how to/not to react when they were in meetings. Our school allows us to go with

parents to other meetings, to act as family advocates. Many of our families are seeing the school as partners. If a problem pops up they know they can call on us if they are unsure of what to do.

6. *How does the family receiving comprehensive, school-based multidisciplinary services perceive the effectiveness of the program in meeting the needs of the student and/or family?*

Overall, the families are satisfied. There are parents that come to our system who are angry and feel as though they have to fight to get the services their children need. Some times it takes quite a few sessions with them to help educate them about how we work together as a team. We do not tell the families what we will offer, we work together to make plans for the students. Most families are pleased with the coordination of services. Once they feel empowered to be active members of their child's program they view the school from a different perspective. In the situations I have dealt with there is a positive feeling in more than 90% of the cases. You must understand we are constantly dealing with issues of denial which can greatly effect how a parent will view the provision of services, or the need for services. The parents that feel as though their child does not have a problem/disability or need for services are generally the parents that are not pleased with the program. These families would encompass 10% or less of the population I have dealt with. Even with them we do manage to come to an agreement about a plan for services. I guess you could look at our record and see that we

have not had a due process hearing in more than 15 years.

7. *What factors do you see as having contributed to the increase or decrease in services available to families and individuals with disabilities?*

The school coordinating the EPSDT physicals, the cluster meetings, the school-based clinic, the school being a Medicaid provider, the services from the family services coordinator, and the agreements with the other agencies have contributed to the increased services. As far as decreasing services I still see the scarcity of providers as a major problem. One thing would be a reduction of duplicated services. For instance if a child is already receiving speech/language therapy three times a week through the health department the school might decrease the number of sessions the child would receive at school. In that manner there would be a decrease of services. The efforts for the student would be coordinated so the decrease is not actually negative.

8. *Of the services that have been provided, which would you say have been the most important?*

The cluster meetings have been very effective. Also I think that the health services brought about by the EPSDT physicals and the increase of psychological services have been the most important overall.

9. *How would you rate the overall effectiveness of the comprehensive, school-based community service program?*

We were headed in the same direction before the project. We did not however have the coordinated effort. We did not have the interagency cooperation that we have now. We did not have the time it takes to get comprehensive services for our students and actually teach them. With the project our personal flexibility has increased, we have people we can call on to assist us. We have more options for our students and their families. Many of our students actually have a better quality of services. I think that the program has been effective. We do not have the same options as they do in a larger city but it has improved greatly over the last three years. Nothing is 100% so I guess I would give the project a grade of 85%. A good solid B not an A, yet, but, it is still in progress. The changes I mean, and I can see only more positive changes because of the project. It just takes time. I do not see any negative impacts from the project. We have been able to improve the quality and quantity of services and options for our students.

10. *What advice would you offer to a school district considering comprehensive, school-based multidisciplinary services?*

Do it! Even if you begin by including one or two other agencies. Start viewing your role as expanded and different. Teachers don't just belong in the classroom we can facilitate better service provision for our children. Training and technical assistance in

the process will be important and I believe these are available. You just have to access them. Administrative support is very important. If your school is not a Medicaid provider you can become one without the hassle that we had to go through to become one. Any monies you can recoup can be used to increase services to some extent.

APPENDIXE H

COMMISSION
FOR HUMAN SERVICES

State of Oklahoma
DEPARTMENT OF HUMAN SERVICES
Sequoyah Memorial Office Building
P.O. Box 25352
Oklahoma City, Okla. 73125
(405) 521-3646

DEPARTMENT
OF HUMAN SERVICES

TO: Oklahoma Public School Superintendents

RE: School-Linked Services Handbook

This handbook contains basic information on how your district can become a federally funded provider of diagnostic and health services for Medicaid-eligible students. Enclosed are step-by-step guidelines on conducting a feasibility study, coordinating with your local agencies and developing a service delivery plan. Also included are sample forms, a suggested parent letter and survey sheet, questions and answers, and a list of the DHS county directors who are key local information contacts.

School-Linked Services are being provided by public schools including Broken Arrow, Choctaw, Cushing, Enid, McAlester, Oklahoma City, Putnam City, Sapulpa, Stillwater, Tulsa and others. The results are encouraging.

A team of DHS field staff developed these materials for use by local school districts, and we hope you will find them useful. Your comments and suggestions will be most welcome. Please feel free to contact your DHS county director. It is a pleasure to share with you a handbook which exemplifies local initiatives at their best.

Sincerely,

George A. Miller
Director of Human Services

Enclosures

VITA

Laqueta Pardue-Vaughn

Candidate for the Degree of

Doctor of Pholosophy

Thesis: A QUALITATIVE STUDY OF THE CREATION AND IMPLEMENTATION OF COMPREHENSIVE SCHOOL-BASED MULTIDISCIPLINARY COMMUNITY SERVICES

Major Field: Applied Behavioral Studies

Education:

Ph.D.	Applied Behavioral Studies	OKLAHOMA STATE UNIVERSITY July 1966, Stillwater, Oklahoma
M.S.Ed.	Special Education	EAST CENTRAL UNIVERSITY July 1988, Ada, Oklahoma
B.S.	Special Education	EAST CENTRAL UNIVERSITY July 1986, Ada, Oklahoma

Certification/Registry:

Severely Emotionally Disturbed	Mentally Handicapped	Multi-handicapped
Physically Handicapped	Learning Disabilities	Visually Impaired
School Psychology	Traumatic Brain Injury	Deaf-Blind
	Autism	

Work Experience:

August 1988- Current	McALESTER PUBLIC SCHOOLS McAlester, Oklahoma	School Psychologist/ Program Specialist
August 1986- July 1988	FIVE COUNTY CO-OP Savanna Public Schools Savanna, Oklahoma	Teacher of pre-school multi handicapped students

Professional Involvement:

February 1994-Current	Oklahoman's for Independent Living	Chairman, Advisory Board for AssistiveTechnology
April 1992-Current	Oklahoma Head Injury Foundation	Member
July 1992-Current	Autism Society of America	Member
February 1991-Current	Oklahoma Commission on Children and Youth (OCCY)/Interagency Advisory Board for Special Services	Representative & Coordinator Southeast Region
January 1991-July 1991	Oklahoma State Dept. of Education (OK SDE)Education of Handicapped Children Act Subcommittee	Review of Oklahoma State Plan for Special Education
February 1989	Teacher Certification Test Development	Physically Handicapped
July 1988-current	Oklahoma School Psychology Association / National Association of School Psychologists	Southeastern Representative, Co-chair of Ethics/ Professional Standards Board
July 1985-current	Oklahoma Federation Council for Exceptional Children (OFCEC)	Past-President of MR and LD Divisions, Past-State Treasurer & Chapter President (3 terms)
April 1985-current	Phi Delta Kappa-ECU Chapter	