

## I. Early Intervention

### A. Introduction to Infant and Toddler Services

Early intervention services target infants and toddlers, from birth until their third birthdays, who are not developing as expected or who have a condition that can delay normal development. These services, available under **Part C of the Individuals with Disabilities Education Improvement Act (IDEA)** (20 USC § 1431 et seq.) are designed to meet the development needs of each child and the family. They include therapies and other services that will help the child develop to his or her potential and mitigate the need for long-term services and supports.

The Part C Office of the **Infant and Toddler Connection of Virginia** administers Virginia's Part HC program. It is guided by state law (Code of Virginia § 2.2-5300–5308) as an entitlement program under IDEA. As an entitlement program, all eligible children must receive services regardless of ability to pay. Seven state agencies share responsibility for oversight of Part C services through the **Virginia Interagency Coordinating Council (VICC)**, which is comprised of the Departments for the Blind and Vision Impaired and the Deaf and Hard of Hearing, and the Departments of Education, Health, Social Services, Medical Assistance Services, and Behavioral Health and Developmental Services.

The **Department of Behavioral Health and Developmental Services (DBHDS)** is designated as the lead state agency for Part C early intervention services. It is accountable to the federal **Office of Special Education Programs (OSEP)** of the US Department of Education for quality of service delivery and for ensuring that Virginia's Part C services meet all applicable federal regulations and guidelines. Services are based on current research and best practices that emphasize (1) empowering parents and strengthening their abilities to meet their children's developmental needs, (2) maintaining consistency of intervention, and (3) avoiding over-utilization of therapy.

The Commonwealth's Part C system is based on the following principles:

- Parents and service providers become partners to make the most effective use of activities and learning opportunities that arise normally throughout the child's and family's daily routine.
- The frequency, structure, and level of services are designed to fit each individual family's schedule, environment, and needs for support.
- Support coordinators facilitate access to and timely delivery of Part C and other services and supports and monitor the evolving needs of the child and family.

DBHDS continues to express reservations in its annual reports to the General Assembly, including in its most recent 2013 report about the reliability of the data reported by local lead agencies responsible for Part C services. DBHDS emphasized in its *2012 Annual Report to the General Assembly* that the numbers provided were estimates and “almost certainly underestimate the number of children receiving each service.” Find the 2012 report at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2612012/\\$file/RD261.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2612012/$file/RD261.pdf).

In its *2013 Annual Report to the General Assembly*, which can be found at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3082013/\\$file/RD308.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3082013/$file/RD308.pdf), the following challenges with data were among those reported by DBHDS:

- Child data is collected in the **Infant and Toddler Online Tracking System (ITOTS)** only at entry into the Part C system and is not collected as child status or needs change.
- No financial data is collected through ITOTS, resulting in a burdensome paper process that impedes collection and reporting of reliable, comprehensive data related to costs and revenue sources.
- ITOTS data reports are limited in scope, and available data does not allow for outcome analysis.

DBHDS has embarked on initiatives to improve the data systems. However, fiscal constraints and other priorities led to delays in developing or purchasing a system with the required functionality. In 2011, the State’s Health and Human Resources Secretariat began a state endeavor to develop a consistent, comprehensive, and non-duplicative data system for use across agencies. This work is ongoing. Because of these concerns, comparative analysis of these data would be presumptive. Therefore, the data in this chapter related to Part C are presented *as reported*.

Some Virginia children with disabilities also receive early intervention services through one of eighteen **Early Head Start (EHS)** programs under the authority of the Head Start Act of 2007 (42 USC § 9801 et seq.). EHS programs serve low-income infants, toddlers, pregnant women, and the families of these populations. In addition to supporting parents in their roles, these programs are designed to enhance children’s physical, social, emotional, and intellectual development. The **Virginia Department of Social Services (DSS) Head Start Office** has administrative and oversight responsibility. Head Start and Part C are required to collaborate and, as lead agency, DBHDS is required to participate on the Head Start State Advisory Council on Early Childhood Education and Care.

This chapter discusses the two programs separately with Part C presented first, followed by Early Head Start services. While these programs operate on the **federal fiscal year (FFY)**, October 1 through September 30, some information is reported by **state fiscal year (SFY)**, July 1 through June 30.

## B. IDEA Part C's Early Intervention Services

### 1. Infant and Toddler Screening and Eligibility for Part C

The Individuals with Disabilities Education Improvement Act (IDEA) defines “**early intervention services**” (hereafter interchangeably referred to as “EI” or “Part C services”) as services designed to meet the developmental needs of each child and the needs of the family related to enhancing the child’s development. EI services are available to children from birth to age three who:

- have a 25-percent developmental delay in one or more areas of development,
- have atypical development, or
- are diagnosed with a physical or mental condition that has a high probability of resulting in a developmental delay.

The 2011 federal regulations on Part C, which can be found at <http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf>, added a **definition of a “child at risk”** as a child younger than three who is at risk of experiencing a substantial developmental delay if EI services are not provided. The regulations also give states the option to serve children at risk. However, Virginia opted not to include “children at risk for delays” in its definition of eligibility. In 2010, Virginia added “**prematurity**” as an automatic eligibility criterion.

Information on **eligibility** can be found on the Infant Toddler Connection of Virginia website at <http://www.infantva.org>, which includes a complete list of eligible conditions at <http://www.infantva.org/documents/pr-PM-PracticeManual.pdf>. Information is also available through the local Part C program, which is included in the Central Directory website at <http://211uwgrp.org/>.

**Referrals** to the Part C system come from a variety of sources, including “self-referral” by a family. Referrals do not require the consent of a child’s parents or legal guardians. Reports from the Department of Behavioral Health and Developmental Services (DBHDS) that cover many years show that the vast majority of referrals have and continue to come from physicians, followed by parents and guardians. With parental consent, all referred children receive a developmental screening using a standardized screening tool unless the child:

- is diagnosed with a physical or mental condition with a high probability of resulting in developmental delay,
- has a documented developmental delay or atypical development, or
- has already received a developmental assessment or screening prior to referral.

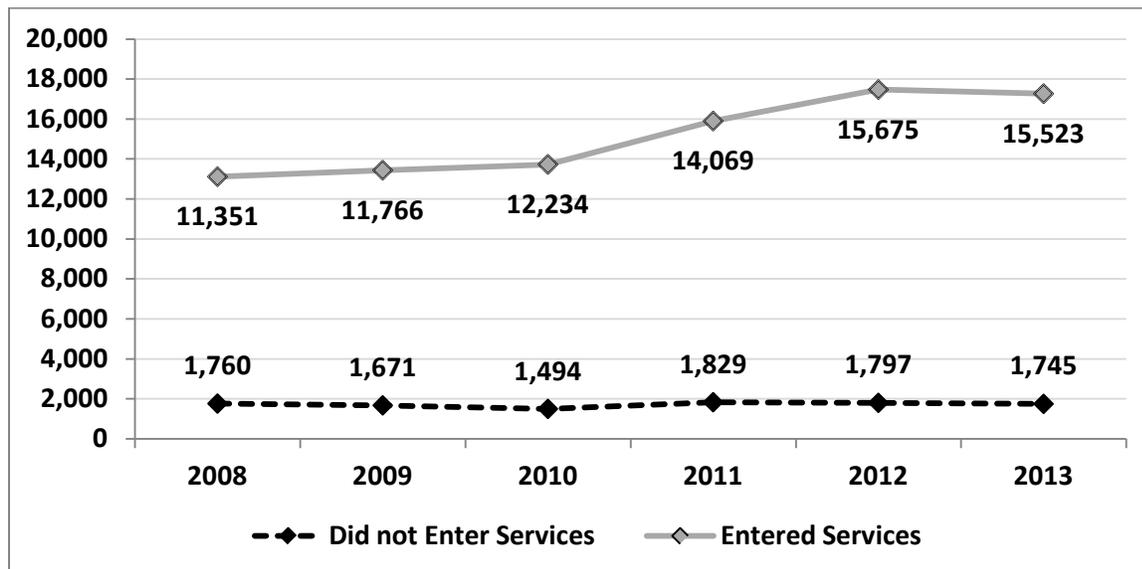
Unless the parent refuses to proceed to an eligibility determination, referred children undergo a multi-disciplinary evaluation that includes a team review of available medical

reports, developmental screening results, parental reports, observations summaries, and any other assessments used. More detailed information on assessments can be found in the “Virginia Part C Policies and Procedures” section of the Individuals with Disabilities Education Improvement Act (IDEA) at <http://www.infantva.org/documents/ovw-PGuideStateDefinition.pdf>.

Annual data on the unduplicated number of infants and toddlers receiving Part C services is calculated two ways: (1) a point-in-time-count required by the federal government, which tallies the number of individual children served on December 1 of each year, and (2) an annualized count that shows the total, unduplicated count of all infants and toddlers who are served over the course of the state fiscal year (SFY), July 1 to June 30.

**Figure 1** shows the number of infants and toddlers being served each year rising significantly and steadily until SFY 2013 when the number of children served decreased by 147 from SFY 2012. There also have been a fairly steady number of infants and toddlers who are found eligible but do not receive services because services are declined, contact is lost, or families choose to obtain private services.

**Figure 1. Eligible Infants and Toddlers who Entered Part C Systems and those who were Eligible but did not Enter Services**



## 2. Access to and Use of Part C Services

As the lead agency, the Department of Behavioral Health and Developmental Services (DBHDS) supervises and monitors Virginia’s Part C early intervention system. The system emphasizes local decision-making and autonomy in service implementation with state-level accountability. Through its **Office of Child and Family Services**, DBHDS establishes regulations and adopts statewide policies and procedures to ensure consistent, equitable access to quality services and compliance with statutory and regulatory requirements. Part C regulations,

statutory provisions, policies, and procedures can be found at <http://www.infantva.org/Overview.htm>.

DBHDS contracts with 40 **local lead agencies** (referred to as “**local Infant and Toddler Connection programs**”) to deliver Part C services. Currently, 30 **Community Services Boards (CSBs)** serve as local lead agencies. Lead agencies for the remaining localities include 2 local education agencies, 4 universities, 2 health departments, and 2 local governments. All local lead agencies are designated by local city or county governments and are responsible for:

- designating a single point of entry for the system (usually itself),
- managing the budget and allocating federal and state Part C funds,
- collecting and reporting data,
- conducting IDEA-mandated **Child Find** activities, including public awareness campaigns, to identify infants and toddlers who may be eligible for services, and
- delivering services, either through their agency or through contractors, or both.

Some Part C local lead agencies determine eligibility and provide service coordination through case managers. Case managers guide families through the early intervention process and facilitate the development and implementation of a required **Individualized Family Services Plan (IFSP)**. An IFSP lists the developmental outcomes that the family and Part C team would like the child to achieve, and it identifies the services and supports needed to meet those outcomes. The IFSP process emphasizes family participation and a holistic approach that brings together medical, developmental, psychosocial, and educational resources to ensure that the needs of the child and family are met in the most effective manner. The frequency of services and supports in the IFSP are adjusted as the needs of the child and family change.

Federal Part C regulations require that early intervention services be provided in “**natural environments**” that meet the needs of the child to the maximum extent possible. Natural environments are defined as the home and other community settings that include children without disabilities and that are typical for the child’s same-age peers. Providing services in other settings is appropriate *only* if outcomes cannot be achieved in natural environments. For more information, see <http://www.infantva.org/ovw-WhatIsPartC.htm>.

Although allowed under federal statute and regulations, Virginia does not provide EI services to children beyond age 3. States are required to ensure “**a smooth and effective transition**” between Part C programs and IDEA Part B (special education) preschool programs, or to Early Head Start, Head Start, childcare programs, or other appropriate services. The regulations require that the local lead agency notify the state and local education agencies no fewer than 90 days before the child’s 3<sup>rd</sup> birthday that the child will be reaching the age of eligibility for Part B services. Currently, Virginia is the only state that makes Part B services available to children ages 24 to 36 months.

A child cannot receive Part C and Part B services concurrently. Parents must decide whether or not to remain in the Part C early intervention system or to transition to the Part B special education system when the child reaches 24 months. If a child requires special education services under Part B, public schools and Part C local agencies must both participate in transition planning and in the development and implementation of an **Individualized Education Program (IEP)**. Transition planning must be completed at least 90 days before, but no sooner than 9 months before, the child's 3<sup>rd</sup> birthday. (For more information about IEPs, see the **Education** chapter of this report).

Local geography, service availability, populations, political jurisdictions served, and organizational structures are among the variables of local systems. In some areas, personnel shortages and the weakening economy have contributed to a wide variability in services between localities. Waiting lists, which are prohibited under the Individuals with Disabilities Education Improvement Act (IDEA) Part C, were used in Virginia in both 2012 and 2013.

**Table 1** compiles information on the number of children who received various types of early intervention services between SFYs 2011 and 2013. Earlier data were not included for the following reasons:

- Between 2008 and 2010, there were significant differences in recorded usage of some services due to (1) how the counts were derived, (2) different naming conventions, and (3) the elimination of the reporting of aggregate services.
- In SFY 2010, the reported data was altered to reflect services actually delivered versus those listed on initial IFSPs. DBHDS stated in its SFY 2010 *Report on Virginia's Part C Early Intervention System* to the General Assembly that these data were more accurate as they looked at actual (versus anticipated) services. However, in SFY 2011 and beyond, the reporting was changed back to its original form.
- Since SFY 2010, DBHDS has continued to state in its annual reports to the General Assembly that because of inconsistencies in local reporting of services-delivered data, it could not ensure a non-duplicative count between services reported by public agencies and private providers.

It is noteworthy that nearly 600 fewer children received initial evaluations in SFY 2013 than in the previous two fiscal years. This is likely due to resource constraints that lessened Child Find activities during that year.

<b>Table 1. Part C Services Listed on Initial IFSPs by SFY</b>			
<b>Service</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>Assistive technology</b>	<b>42</b>	<b>19</b>	<b>16</b>
<b>Audiology</b>	<b>253</b>	<b>235</b>	<b>78</b>

Table 1. Part C Services Listed on Initial IFSPs by SFY			
Service	2011	2012	2013
Counseling	3	2	16
Developmental services	2,532	2,947	2,717
Initial evaluation/assessment	9,903	9,882	9,305
Health services	0	0	0
Nursing services	0	0	0
Nutrition services	14	2	5
Occupational therapy	2,110	2,163	2,226
Physical therapy	3,813	4,154	3,943
Psychological services	0	0	5
Service coordination*	14,069	15,676	15,523
Sign language and cued language services**	N/A	N/A	16
Social work services	11	31	15
Speech-language pathology	5,276	5,534	5,076
Transportation	4	0	5
Vision services	84	91	109
Other entitled EI services	98	78	155

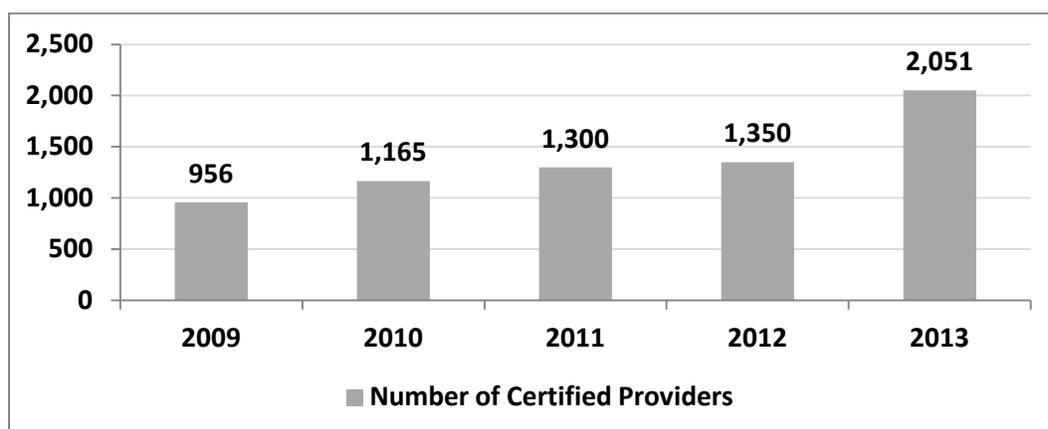
\*All eligible children receive “service coordination.”

\*\*SFY 2013 is the first year in which “sign language and cued language services” were reported as a separate service.

Sources: DBHDS’s *Report on Virginia’s Part C Early Intervention System* (Budget Items 305 H.2, 315 H.2., 2011–2013 Appropriations Acts, respectively).

Although some local systems experienced financial difficulties in SFY 2013, access to Part C service providers has improved since Virginia implemented its **Medicaid Early Intervention Services** program. **Figure 2** depicts this improvement. In just the last year, the number of provider certificates issued has increased by over 59 percent.

**Figure 2. Medicaid-certified Part C Providers by SFY**



As shown in **Table 2**, the number and proportion of children receiving Part C services through the Medicaid Early Intervention Services program also continue to grow. Both measures have more than doubled since 2009.

Table 2. Children Enrolled in Medicaid Early Intervention Services (annualized numbers)			
State Fiscal Year	# with Medicaid	Total # Served	% of Children with Medicaid
2009	2,830	11,766	24.05%
2010	5,091	12,234	36.19%
2011	7,179	14,069	51.03%
2012	8,945	15,676	57.06%
2013	9,212	15,523	59.34%

### 3. Available Part C Services

Services available under Part C Early Intervention are those that the infant or toddler needs in order to meet the goals of the Individualized Family Service Plan. Specific available services are listed in **Table 1**. If the child is Medicaid eligible and participates in the Medicaid Early Intervention Services program, he or she also can obtain all of the acute care and related services available under the **Medicaid State Plan** and its **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** program. See the **Medicaid** chapter for more information on State Plan services.

### 4. Cost and Payment for Part C Services

This section first describes the various funding sources and program expenditures for the Part C early intervention services system statewide. Following this information is a brief

overview of public (Medicaid) and private health insurance resources for early intervention services.

The Department of Behavioral Health and Developmental Services (DBHDS) manages the budget of Virginia’s Part C early intervention system. While children and families determined eligible for Part C services are entitled to receive those services, not all services are free. Fees may be charged according to ability to pay. Part C federal regulations 34 CFR 303.520 and .521 specify that federal IDEA funds for Part C can be expended only after other sources, such as public (Medicaid) and private insurance, donations, and fees (based on a family’s ability to pay) have been applied.

Virginia’s annual allocation from the federal government to support Part C services is based on the proportion of the state’s population from birth to three years old as compared with the national total for those ages. The Virginia General Assembly also allocates state General Funds to support Part C services; these funds can only be used for **direct services**. While the Code of Virginia does not mandate that localities provide funding for Part C costs, localities are involved in identifying alternative funding sources. Among others, local contributors of cash and in-kind support include community services boards, health departments, and schools as well as the Part C local lead agencies themselves.

An improvement in state funding has been accompanied by a decrease in the number of localities opting to provide local funding. **Table 3** presents the amounts and sources of Part C revenue over a five-year period. The category of “other state General Funds” represents state funds other than those designated for Part C—i.e., funds that were originally state revenue awarded by DBHDS to the Community Services Boards (CSBs), such as for Intellectual Disability services, or other state funds awarded to a non-CSB local lead agency or another participating public agency. Although not designated for Part C, the CSB or other local agency chose to use those state funds for Part C. Prior to SFY 2012, they were reported as “local funds,” “other,” or “aggregated non-Part C revenue.”

<b>Table 3. Amounts and Sources of Part C Revenues by SFY</b>					
<b>Revenue Source</b>	<b>2008</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>Federal Part C funds</b>	<b>\$9,881,918</b>	<b>\$9,087,761</b>	<b>\$8,194,088</b>	<b>\$9,545,592</b>	<b>\$8,251,515</b>
<b>Federal ARRA (stimulus) funds</b>	<b>N/A</b>	<b>4,301,650</b>	<b>8,272,737</b>	<b>2,251,526</b>	<b>N/A</b>
<b>State Part C funds</b>	<b>7,203,365</b>	<b>6,861,337</b>	<b>4,617,087</b>	<b>10,020,426</b>	<b>9,602,586</b>
<b>Other state General Funds</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>712,630</b>	<b>1,194,843</b>
<b>Medicaid</b>	<b>1,095,727</b>	<b>3,656,354</b>	<b>13,145,090</b>	<b>15,230,981</b>	<b>19,733,600</b>
<b>Local funds</b>	<b>8,370,228</b>	<b>7,727,982</b>	<b>8,093,276</b>	<b>7,992,093</b>	<b>7,970,999</b>

Table 3. Amounts and Sources of Part C Revenues by SFY					
Revenue Source	2008	2010	2011	2012	2013
Family fees	322,915	485,983	371,738	702,005	1,040,757
Targeted case management	1,538,804	2,576,568	4,778,659	3,986,948	5,665,675
Private insurance	1,049,697	2,512,116	1,966,475	5,096,825	5,283,510
Grants, gifts, donations	293,697	22,668	4,652	12,472	149,087
Other	624,754	2,800,611	1,461,622	1,575,081	1,223,915
Local report of aggregated non-Part C revenue	2,066,283	N/A	N/A	N/A	N/A
In-kind	N/A	210,504	282,511	322,604	54,259
<b>TOTAL</b>	<b>\$32,447,388</b>	<b>\$40,243,534</b>	<b>\$52,683,167</b>	<b>\$57,449,183</b>	<b>\$60,170,745</b>

Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and 2008–2013 Appropriations Acts, respectively).

In the October 2010 and 2011 editions of its *Report on Virginia's Part C Early Intervention System*, DBHDS identified the need to change the way in which federal and state Part C funds are allocated to local systems in order to ensure the stability of the Part C funding structure. The change accounted for differences in funding needs for local systems that have a higher population of children dually enrolled in Part C and Medicaid, compared to those that have a higher population of children without insurance or with private insurance that reimburses at a rate lower than Medicaid.

In SFY 2011, local systems initially received 75 percent of their allocations. Fourth-quarter allocations were based on a DBHDS review of the local system's overall child count and the number of children with Medicaid. The new allocation method resulted in major changes in the amount of funding for some local systems. In SFY 2012, allocations were adjusted based on the weight of various factors to allow local systems time to accommodate for the change. The new allocation formula was to be fully implemented in SFY 2013.

In its SFY 2012 *Report on Virginia's Part C Early Intervention System* to the General Assembly, DBHDS warned that the fiscal climate for Part C was less stable due to the end of stimulus funds provided by the **American Recovery and Reinvestment Act of 2009 (ARRA)** and the rapidly increasing number of children receiving services. In that year, DBHDS was able to offset some local system shortfalls with one-time additional funds saved from other areas; however, three local systems reduced or cut services to eligible children and families in violation of federal Part C regulations. Deficits in excess of \$8.5 million were anticipated for SFY 2013. The 2013 report to the General Assembly says that, in SFY 2013, 26 out of 40 systems that requested additional funds could not be helped. Eight of those systems reduced or

completely eliminated services to eligible children and families, and localities were cited for noncompliance.

In recognition of the severity of the situation, not only in terms of compliance with federal requirements but with respect to the impact on children, an additional \$2,250,000 in state General Funds was allocated in SFY 2013, and an additional \$6 million was allocated in SFY 2014. As a result of the increased allotment, at the time of the DBHDS's *2013 Report on Virginia's Part C Early Intervention System* to the General Assembly, only one system remained out of compliance. However, DBHDS notes that unless funding keeps pace with the growth in eligible children, the situation could repeat, putting federal funding and children at risk.

**Figure 3** depicts how the key sources of revenue for Part C have changed over the last five years. (See also **Table 3**.) While the federal allotment has remained relatively stable, the system benefitted from the infusion of ARRA stimulus funds in SFYs 2010 and 2011. Approximately \$2.2 million in ARRA funds were also available for spend down in the first quarter of SFY 2012. Those funds are no longer in the picture. In its *2013 Report on Virginia's Part C Early Intervention System* to the General Assembly, DBHDS reports that the system continues to grow and continues to be stressed.

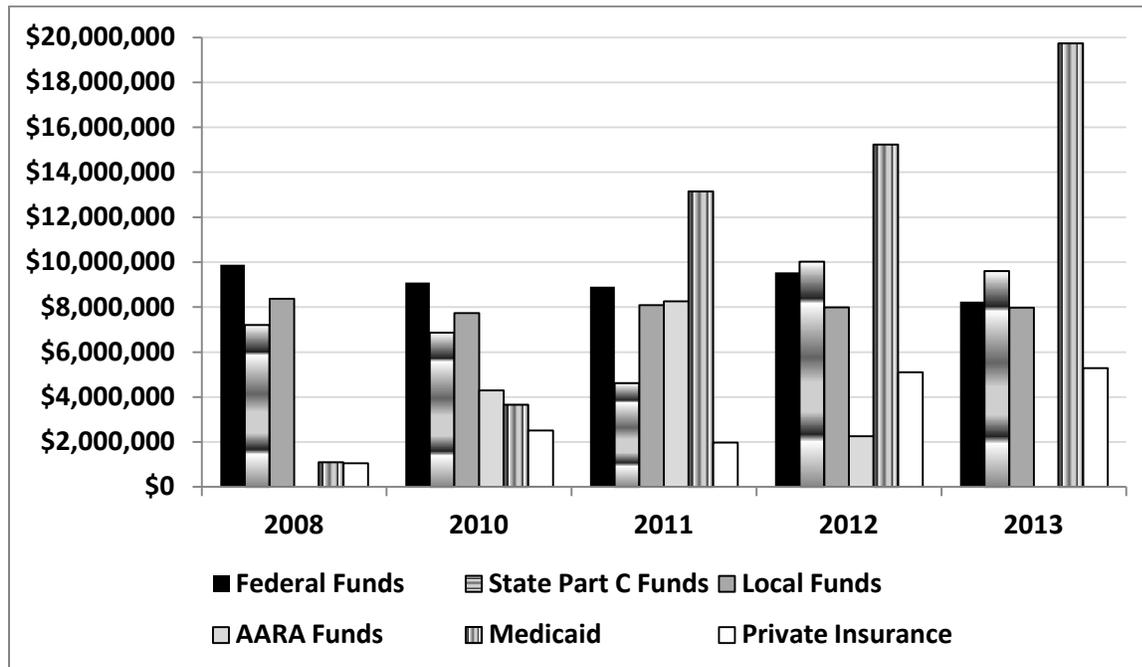
**Federal sequestration** has also affected the system, resulting in a decrease of \$424,650 in federal Part C funds for FFY 2014. DBHDS was able to absorb the cut for SFY 2014 using funding that had been set aside. However, additional sequestration action will result in cuts from allocations to local systems.

Because additional state funds were allocated for SFY 2013 and 2014, Child Find efforts have resumed, and the number of children who will be served will likely increase. The Part C report notes that since April of 2013, the number of children enrolled in early intervention on the first day of each month has been higher than any previous year. Should funding not keep pace with this growth, the Commonwealth may once again end up out of compliance and unable to serve children in need.

The Medicaid Early Intervention Services program continues to have a positive impact, providing an exponential increase in Medicaid dollars to support Part C, and private insurance usage is now steady. The impact of the Affordable Care Act (H.R. 3509) on the use of private insurance will be something to monitor.

It is important to note that some of the changes, including the increased use of Medicaid, may be due to better reporting. DBHDS also notes that non-duplication of revenue reporting (for sources other than Medicaid and Medicaid-targeted case management revenue) cannot be reliably achieved until a statewide mechanism is implemented to collect or import data from local systems on the source and amount of revenue associated with every service delivered.

**Figure 3. Principal Sources of Reported Part C Revenue by SFY**



Sources: DBHDS’s *Report on Virginia’s Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and the 2006–2010 Appropriations Acts, respectively).

It is important to note that while **revenue** reported as state Part C funds appears to have declined between SFY 2012 and SFY 2013 as shown in **Figure 3**, the amount **allocated** to local systems in SFY 2013 was actually higher than in 2012. In SFY 2012, the allocated amount was \$8,280,219. In SFY 2013, the amount allocated to local systems was \$9,530,044. According to DBHDS, the amount spent was higher in 2012 than in 2013 because, in SFY 2012, some local systems had carried over state funds from previous years, and these carry-over funds are included in the revenue figures. The reported revenue figures (rather than the allocated amounts) are used here to maintain consistency with the amounts reported to the General Assembly by DBHDS.

Part C System expenditures are categorized as direct service or non-direct service expenditures. **Table 4** lists **direct service expenditures** for each Part C category of services in SFY 2008 as compared with SFYs 2010 through 2013.

Expenditure	2008	2010	2011	2012	2013
Assessment for service planning*	\$992,858	\$2,112,026	\$2,303,261	2,425,514	\$2,337,794
Assistive technology	92,554	64,222	64,600	46,784	21,453

**Table 4. Reported Direct Part C Expenditures by Category and SFY**

Expenditure	2008	2010	2011	2012	2013
Audiology	14,496	8,239	10,253	11,719	4,631
Counseling*	97,339	183,757	111,785	138,152	59,702
Developmental services*	2,277,328	3,514,105	3,813,546	4,084,723	3,732,217
Evaluation for eligibility*		370,422	687,516	799,184	971,012
Health	500	32,426	55,451	138,183	68,254
Nursing	500	498	3,555	9,346	7,203
Nutrition	1,035	57,461	84,048	82,715	41,408
Occupational therapy	1,157,256	3,011,633	2,239,431	4,965,330	1,890,873
Physical therapy	1,947,473	4,062,847	4,076,249	6,376,486	2,585,505
Psychology**	2,000	0	0	N/A	N/A
Service coordination	5,295,426	8,552,563	10,063,508	12,307,059	11,304,694
Social work	13,160	17,579	15,041	30,260	45,047
Speech/language pathology	3,187,203	8,143,435	8,247,839	18,107,586	8,452,672
Transportation	49,864	19,200	146,976	200,465	102,799
Vision	32,240	20,912	18,313	22,112	31,815
Other entitled Part C services	452,236	1,404,581	580,472	676,539	14,441,988
<b>TOTAL DIRECT SERVICES</b>	<b>\$15,565,389</b>	<b>\$31,575,906</b>	<b>\$32,521,844</b>	<b>\$50,421,958</b>	<b>\$46,737,250</b>
<b>TOTAL REPORTED EXPENDITURES</b>	<b>\$33,616,357</b>	<b>\$37,492,250</b>	<b>\$39,527,844</b>	<b>\$57,873,922</b>	<b>\$53,720,994</b>

\*In 2008, "Counseling" was reported as "family training and counseling," and "developmental services" was reported as "special instruction." In addition, in 2008, these were combined into one category called "evaluation and assessment." These are now divided into "assessment for service planning," and "evaluation and eligibility."

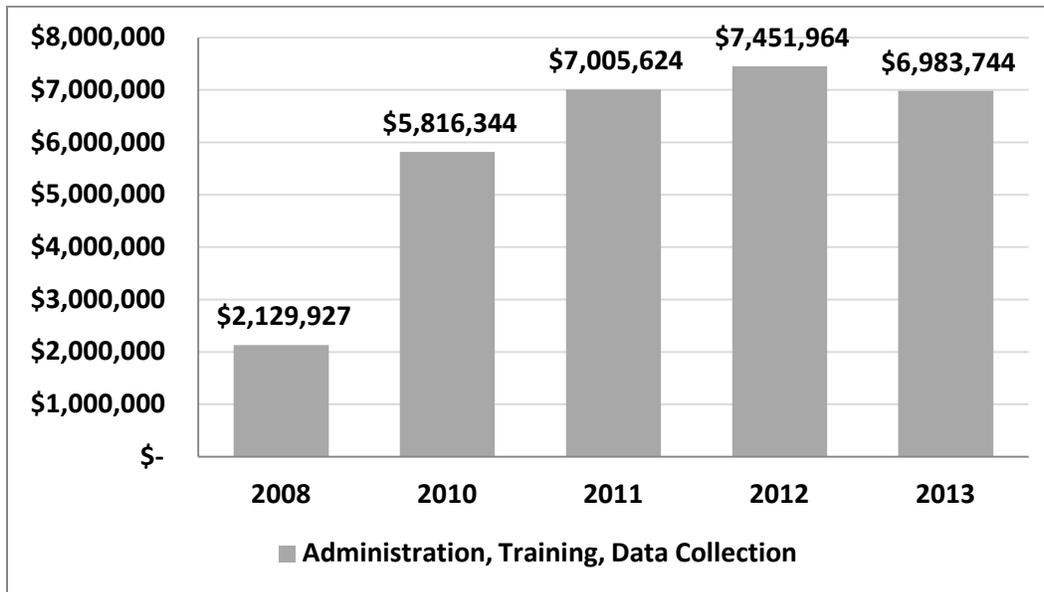
\*\*"Psychology" is no longer reported as a separate service.

Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, 315 H.2, and the 2008–2013 Appropriations Acts, respectively).

**Non-direct expenditures** relate to administration, system management, data collection, and training. DBHDS reported in its SFY 2010 report to the General Assembly that in SFY 2010, ARRA (stimulus) funds were used to address one-time expenses related to improved data collection,

systems management, and training, resulting in higher non-direct costs. However, levels of non-direct spending have continued to trend upward since that time. Other expenses not necessarily reported are local funds used for expenses other than direct services. See **Figure 4**.

**Figure 4. Non-direct Part C Expenditures by SFY**



Sources: DBHDS's *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 305 H.2, and 315 H.2, and the 2008–2012 Appropriations Acts, respectively).

The Commonwealth's Medicaid Early Intervention Services program was established through its **Part C Systems Transformation Initiative**, jointly led by the **Department of Medical Assistance Services (DMAS)** and the Department of Behavioral Health and Developmental Services (DBHDS). This program is the only way for Medicaid-eligible families to access funding for most Part C services. Prior to this initiative, DMAS was not able to identify children enrolled in early intervention because providers billed using reimbursement codes for specific therapies (e.g., physical therapy, occupational therapy, etc.). The same was true for children being served through Medicaid's managed care organizations (MCOs). In addition, DMAS did not reimburse for all costs associated with providing services in natural environments and did not reimburse all types of providers eligible to deliver Part C services.

In 2012, the General Assembly appropriated state funds needed to increase the Medicaid reimbursement rate for early intervention targeted case management from \$120 per month to \$132 per month. This rate went into effect July 1, 2012. DBHDS notes in its *2013 Report on Virginia's Part C Early Intervention System* that this change helped reduce—but did not eliminate—the gap between revenue and expenses associated with service coordination for children who have Medicaid.

As a result of the transformation process, Medicaid-funded Early Intervention services are now available for children eligible for Medicaid's Family Access to Medical Insurance Security

(FAMIS or FAMIS Plus) after eligibility screening through those programs. More detailed information on FAMIS and FAMIS Plus, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) can be found in the **Medicaid** chapter of this report and at [http://www.dmas.virginia.gov/Content\\_pgs/mch-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx).

Consistent with state and federal law, Part C has **family cost share** provisions, and families may be required to contribute to the cost of some Part C services, such as specific therapies or equipment. Services that are provided at **no cost** to the family include the following:

- identification, eligibility evaluation, and assessments to identify needed services and supports;
- service coordination (case management) with development, review and evaluation of the Individualized Family Services Plan (IFSP); and
- procedural safeguards and all activities related to the rights of the child and family.

Family contributions are made on the basis of a sliding fee scale with a monthly maximum amount for which the family is financially responsible. This monthly cap is the same regardless of how many agencies provide services or whether more than one child in the family is receiving services. Families cannot be denied services if they are unable to pay towards their cost. However, they must be willing to provide financial information to the Part C system if they wish to participate in the sliding-scale fee structure. Otherwise, they are held responsible for the full charges of the services received. Financial cost determinations can be appealed or reevaluated if the family's financial situation changes, and there is an annual reevaluation of each family's cost share.

**Private health insurance** may also cover early intervention services. The state employee health insurance program is required to provide coverage for early intervention services that are medically necessary. There is no dollar maximum for services to be provided; coverage cannot be denied for a pre-existing condition; and the cost of these services cannot be applied to any maximum lifetime benefit [Code of Virginia § 2.2-2818 B(4)]. Find the text of the law at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+2.2-2818>.

The mandate to cover early intervention services also applies to Virginia-regulated accident and sickness insurance policies provided by private companies operating in the state—albeit with a \$5,000 maximum benefit. (The Code of Virginia § 38.2-3418.5 is available online at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+38.2-3418.5>.)

Federal and state Part C funds are used to make up the difference between the lower insurance rates that private insurers pay and the Medicaid rate, and to pay for services not covered, such as service coordination and developmental services. Self-insured companies were exempted from the requirement, but some have elected to include this benefit.

Coverage for treatment of **autism spectrum disorders (ASD)**, including an annual \$35,000 maximum for applied behavior analysis therapy, is addressed in Code of Virginia (§ 38.2-3481-17) and is online at <http://lis.virginia.gov/cgi-bin/legp604.exe?000+coh+38.2-3418.17+700124>.

It is important to note that there may be a number of changes in the required benefits and services offered by the State and private insurers, depending on the benefits specified as **essential health benefits** under § 1302(b) of the federal Patient Protection and Affordable Care Act [(H.R. 3590) as amended the Affordable Care Act]. A number of Virginia Code provisions have changed and will continue to change as a result of the Affordable Care Act. For additional information, see the **Health Care** chapter of this report.

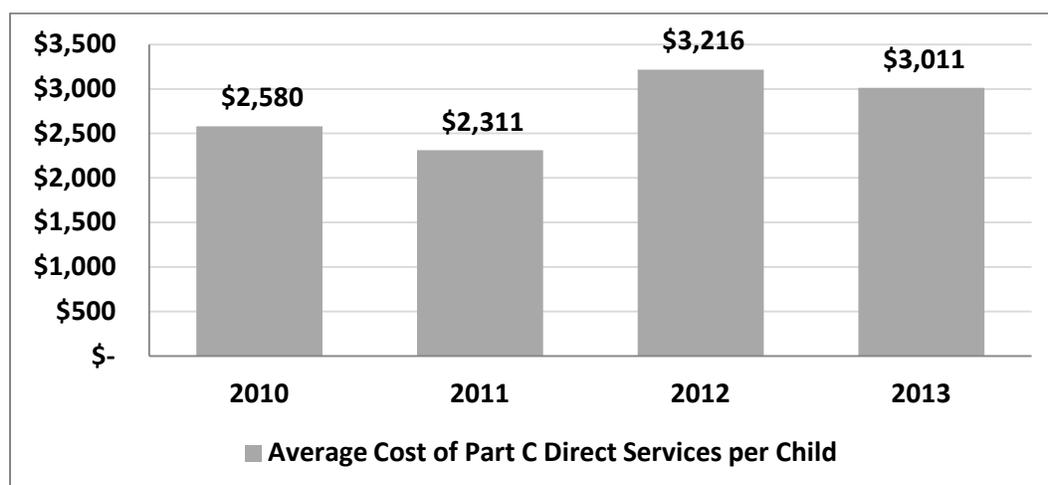
The reported proportion of Part C system **revenues from private insurers** shows significant changes. However, it is unclear how much of this growth is due to increased usage as opposed to new reporting requirements. Effective July 1, 2009, DBHDS required local lead agencies to report revenue by source, including private insurance (rather than aggregate revenue), and it required reporting by private providers. In SFY 2008, private insurance accounted for only three percent of total Part C revenues. It jumped to six percent in SFY 2010 and to nine percent in SFY 2012. DBHDS attributes the increase to more complete and accurate reporting.

## **5. Monitoring, Evaluation, and Outcomes of Part C Services**

As noted, Part C is serving significantly more children. Between SFYs 2008 and 2013, the number of children served increased by nearly 37 percent. This increase has been due both to efforts to identify and enroll all eligible children per federal Child Find requirements as well as implementation of Medicaid Early Intervention Services. In previous years (as reported in the 2008 and 2011 editions of this *Assessment*), Virginia had been below national averages and state targets in the identification of eligible infants and toddlers, especially in the birth-to-one-year-old population. As part of efforts to address this weakness, “prematurity” was added as an automatic eligibility criterion in December 2010. The increases in identified children have resulted in and been combined with significant financial stressors on the Part C system as noted by DBHDS in the SFY 2012 and 2013 editions of its *Report on Part C Early Intervention System*.

Reviewing the reported direct-expenditure data and the reported number of children served, the cost per child has fluctuated over the last four years as shown in **Figure 5**. Inadequate fiscal resources that resulted in waiting lists in several localities may have contributed to lower per child costs in SFY 2013. As noted earlier, the accuracy and consistency of data/cost reporting may also be an issue.

**Figure 5. Average Cost of Part C Direct Services per Child by SFY**



Each state receiving federal financial assistance under Part C of the Individuals with Disabilities Education Improvement Act (IDEA) is required to establish an advisory interagency coordinating council to support the lead agency and other agencies in providing and paying for Part C services. The Virginia Interagency Coordinating Council (VICC) fulfills this requirement by providing guidance on implementing and evaluating statewide early intervention system services, including helping toddlers with disabilities make the transition to preschool and other appropriate services. VICC’s membership includes parents, public or private providers of early intervention services, state agency representatives, a legislator, and an individual involved in the preparation of personnel who provide early intervention services.

Forty **Local Interagency Coordinating Councils (LICCs)** provide advice and assistance to their respective local lead agencies and help them to identify existing early intervention services and resources, identify gaps in the service delivery system, and develop local strategies to address those gaps. LICCs also assist their local lead agency in facilitating interagency agreements, developing service coalitions, and establishing local policies and procedures in accordance with federal and state laws and regulations.

The Department of Behavioral Health and Developmental Services (DBHDS) monitors all state and local public and private agencies and providers of early intervention services, regardless of whether those services are funded by IDEA Part C. To ensure compliance with state and federal laws and regulations, all public and private early intervention service providers must agree to comply with Part C requirements in writing through an interagency agreement, memorandum of understanding, or contract.

The Medicaid Early Intervention Services program must also meet federal monitoring requirements. Compliance reviews must be conducted to ensure that services are appropriate, obtained from appropriate providers, and medically necessary, a requirement for Medicaid reimbursement. The Department of Medical Assistance Services (DMAS) conducts Quality

Management Reviews (QMRs). Information on QMRs can be found in the **Medicaid** chapter of this report.

The US Department of Education Office of Special Education Programs (OSEP) is the federal program monitor for Part C. Each state must have an approved State Performance Plan (SPP) that evaluates its efforts to implement Part C requirements and describes how the programs are or will be implemented. Each state must also submit an Annual Performance Report (APR) to OSEP.

The APR describes Virginia's system of supervision and monitoring, including how data are gathered and verified. APRs run two years behind, and the latest APR is for FFY 2011, submitted in February of 2013 (<http://www.infantva.org/sup-ReportsOSEP.htm>). The APR also details progress made on targets established in its *State Performance Plan for 2005–2012*. States are required to report publicly on a variety of SPP indicators, including but not limited to:

- timely initiation of services,
- primary service setting,
- family outcomes,
- Child Find,
- 45-day timeline for assessment and IFSP meeting, and
- effective transitions to Part B services.

OSEP reviews the APR information and determines if a state has “met requirements,” “needs assistance,” “needs intervention,” or “needs substantial intervention” in order to meet its targets. Based on submitted data on the above indicators, in 2010 OSEP determined that Virginia “met requirements.” In 2011 and 2012, the determination was that the Commonwealth “needed assistance.” In 2013, the Part C system once again “met requirements.”

These same determinations are made for each local system. The FFY 2011 **Local Early Intervention System Determinations** for data collected between July 1, 2010 and June 30, 2011 can be found online at <http://infantva.org/documents/sup-cqi-DetermStatus2012.pdf>. It shows that 28 local systems “met requirements,” some for multiple years in a row, and 12 local systems “needed assistance,” some for multiple years in a row. For example, **Crater District** and **Henrico** have been in the “needs assistance” category for 6 years, whereas **Goochland-Powhatan** and **Rockbridge** have “met requirements” for 6 consecutive years. During this time period, no local system was found to “need intervention” or to “need substantial intervention.” Local systems not meeting their target or meeting less than 93 percent of their target must develop an **improvement plan**.

All children receiving Part C early intervention services are included in the federally required **System for Determination of Child Progress**, which began in 2006. Under this system, a child's

Individualized Family Services Plan Team rates the child’s status using the OSEP’s Child Progress Outcomes Indicators 3A through 3C:

- A. Positive social and emotional skills (including positive social relationships)
- B. Acquisition and use of knowledge and skills (including early language and communication)
- C. Use of appropriate behaviors to meet needs

Baseline data were gathered for children who exited the system between July 1, 2008 and June 30, 2009 as well as for infants and toddlers exiting between July 1, 2009 and June 30, 2010. Targets were then set for FFYs 2009 and 2010 through FFYs 2012 and 2013. The baseline data and targets are in the *Part C State Performance Plan for 2005–2012*, which was amended in 2013. Results for FFYs 2011 and 2012 are shown in **Table 5**. The amended plan is online at <http://infantva.org/documents/SPP%20-20amended%20Feb%202013%20clean.pdf>.

<b>Table 5. Part C Annual Performance Report: Determinations of Child Progress Outcomes for FFYs 2011 and 2012</b>			
<b>Federal Fiscal Year</b>	<b>Indicator 3 A Social and Emotional</b>	<b>Indicator 3B Skills and Knowledge</b>	<b>Indicator 3C Appropriate Behavior</b>
<b>Percent who did not improve functioning</b>			
FFY 2011	0.60	0.50	0.50
FFY 2012	0.60	0.50	0.40
<b>Percent who improved but not sufficient to move nearer to functioning of same-age peers</b>			
FFY 2011	18.0	19.0	17.6
FFY 2012	16.2	17.1	16.5
<b>Percent who improved nearer to same-age peers but did not reach same level</b>			
FFY 2011	16.2	24.5	26.0
FFY 2012	15.9	25.2	26.9
<b>Percent who improved to reach level comparable to same-age peers</b>			
FFY 2011	28.7	39.4	46.9
FFY 2012	30.1	40.8	44.6
<b>Percent who maintained functioning at a level comparable to same-age peers</b>			
FFY 2011	36.5	16.6	10.1

<b>Table 5. Part C Annual Performance Report: Determinations of Child Progress Outcomes for FFYs 2011 and 2012</b>			
<b>Federal Fiscal Year</b>	<b>Indicator 3 A Social and Emotional</b>	<b>Indicator 3B Skills and Knowledge</b>	<b>Indicator 3C Appropriate Behavior</b>
<b>FFY 2012</b>	<b>37.3</b>	<b>16.5</b>	<b>11.6</b>

The results show significant improvement, as would be expected for those who participated in early intervention services, with the highest level of improvement in achieving social and emotional skills comparable to same-age peers. Performance on the indicators was stable between FFYs 2011 and 2012 with slight increases on some indicators and decreases on others. In both FFYs 2011 and 2012, actual performance on the indicators did not meet established state targets; about half of the local systems met a number of the established targets, which can be found in the Part C Annual Program Performance Report.

A number of activities have taken place to improve performance, not only on these indicators but on others as well. DBHDS reported in its 2011 and 2012 *Annual Program Performance Reports* that additional resources on evidence-based practices were provided as was support to address quality data collection on the indicators. (Note that these reports run two years behind. The FFY 2012 report was submitted in February of 2014.)

A **Child Indicators Workgroup** was established to determine how to integrate the federal indicators into the Individual Family Service Plan (IFSP) process. Changes to the IFSP form and process were recommended, and a statewide implementation of these changes began on July 1, 2013. As a part of this effort, the IFSP form was revised to integrate child indicators into the assessment section. Seven regional training sessions and three statewide webinars were provided to support focus on the child indicators in each step of the early intervention process. Written resources were provided to assist service providers. Other efforts in FFYs 2011 and 2012 included the following:

- Improved communication and information for families and providers through the expanded use of technology, including social media and changes to the Part C website located at <http://www.infantva.org>. These additions include, but are not limited to, information on evidenced-based practices in early intervention, eligibility, assessment, outcome planning, support strategies for specific disabilities, as well as infant mental health. Both the **Arc of Virginia Family Involvement Project**, funded by Part C, and the **Early Intervention Professional Development Group** are now on Facebook.
- Continued participation in **Communities of Practice in Autism (CoPAs)** of which there are nine around the state. The CoPAs serve as a means of regional problem solving, learning about evidenced-based practices, and building local expertise in the area of individualized services and supports for children with autism spectrum disorders.
- Support by the Part C office to the Arc of Virginia in establishing an Early Intervention Family Support Network through its local chapters, entitled **New Path**. Find New Path

online at <http://new-path.thearcofva.org/>. Two part-time early intervention support specialists were hired for New Path, and a monthly newsletter with resources and information for families was launched. Next steps include a blog and message boards.

- Training sessions on a *Family-centered Approach to Developing Quality Outcomes*, which explored differences between the medical model and a supports-and-service approach to early intervention.
- A year-long focus on coaching, which began in early FFY 2012 to include intensive training and technical assistance follow-up for twenty master coaches who will each mentor colleagues and provide training for additional providers. Training was completed in four of six regions, with the other two scheduled for spring 2014. Regional communities of practice on coaching have started in some regions.
- A statewide webinar on the **Child Outcome Indicators (3A-C)** was presented in early FFY 2012 that included information on measuring each indicator. In addition, a two-sided, laminated, quick-reference card about child outcomes was developed for providers. A child-development indicator booklet was revised and disseminated.

As part of federally required monitoring procedures, the state lead agency (DBHDS) must also conduct an annual **Family Survey**. This survey addresses the Office of Special Education Programs' (OSEP) Indicators 4A-C, which measure the percent of families participating in Part C who report that services have helped:

- A. the family to know their rights,
- B. the family to effectively communicate the child's needs, and
- C. the child to develop and learn.

To accomplish this, each year DBHDS surveys the families who received early intervention services during the month of May. It selects a random sample of respondents, which reflects the race/ethnicity of the total population served, for analysis. The full reports for 2012 and 2013: *Analysis of the Virginia Family Survey Data Addressing Part C SPP/APR Indicator #4* can be found at <http://www.infantva.org/documents/sup-FamilySurvey-2012-expl.pdf> and <http://www.infantva.org/documents/Virginia%20Family%20Survey%20Data%20Addressing%20Part%20C%20SPP%20APR%20Indicator%204%20Final%20Report%202013%20July29.pdf> respectively. The reports contain details on survey methodology.

As shown in **Table 6**, results for those two years show improved performance in the FFY 2013 survey as compared to the FFY 2012 survey. Survey results are used for improvement planning. The 2012 survey results were updated in the 2013 survey and appear here.

<b>Table 6. Annual Family Survey</b>			
<b>Percent of Respondents Meeting or Exceeding Each Standard for Indicator 4</b>			
<b>Federal Fiscal Year</b>	<b>Indicator 4A Know their rights</b>	<b>Indicator 4B Effectively communicate child's needs</b>	<b>Indicator 4C Help child develop and learn</b>
<b>2012 Survey</b>	<b>75.4</b>	<b>72.2</b>	<b>84.2</b>
<b>2013 Survey</b>	<b>76.9</b>	<b>74.5</b>	<b>84.8</b>

For many years, OSEP found Virginia to be out of compliance in the number of infants and toddlers ages **birth to one year** identified for early intervention services, reaching far fewer in this age range than the national average. As a result, Child Find identification activities have been targeted as a focus area for monitoring and improvement for quite a few years. In 2011, new federal Part C regulations added a requirement that the Child Find system be coordinated with a variety of state agencies, including those that administer the Children’s Health Insurance Program (DMAS), child care programs (DSS), the early hearing detection and intervention system, and the home visiting programs under the Maternal and Child Health program (VDH) and the Child Abuse Prevention and Treatment Act (DSS).

In FFY 2011, Virginia **exceeded its state target** for identifying needs in the birth-to-one-year population. In FFY 2010, 24 local systems had not met the state target. In FFY 2011, 15 of those systems met the target; 7 showed progress, and 2 showed slippage. DBHDS reports that the key factor for the State’s improved performance was the focus on referral of premature infants. A variety of efforts contributed to this success, including training and technical assistance to local systems and providers, contact with Neonatal Intensive Care Units at hospitals in Virginia and D.C. regarding the referral of preterm infants, work with the Department of Health to ensure early identification of children with hearing loss or congenital anomalies, as well as addressing insurance-reimbursement barriers with private insurance and TRICARE (health insurance for active, Reserves, National Guard, and retired military). The state target was adjusted upward for FFY 2012 as a result of the progress seen in FFY 2011.

In addition to improvements in identifying needs in the birth-to-one-year population, efforts have been undertaken to increase the percentage of infants and toddlers from **birth to age three** with Individualized Family Services Plans (IFSPs). Virginia’s performance in FFY 2011 was above the state target and close to the national figure of 2.79 percent with 2.77 percent of infants and toddlers having IFSPs.

Of the 40 systems in Virginia, 29 “met” the state target; 2 “substantially met” the target and 9 did “not meet” the target. Those 9 systems were required to submit an improvement plan. This represents significant progress from FFY 2010 when 25 local systems did not meet the state target. Of those, 14 reached the target in FFY 2011. Local improvement strategies included the following efforts:

- increasing public awareness through TV, radio, interagency collaboration, and participation in community events,
- reviewing data to determine referral outcome by source and identifying patterns to better focus outreach efforts,
- training referral sources, and
- reviewing instruments being used to determine eligibility.

Additional activities to improve Part C services for infants and toddlers since the 2011 edition of this *Assessment* were reported in the most recent *Annual Performance Report for FFY 2011* and include the following:

- completing statewide training and technical assistance in a variety of venues and formats, including videos, webinars, and in-person training in numerous areas related to provision of quality services to infants and toddlers.
- requiring new local system managers and all managers of systems with identified non-compliance to participate in a webinar on conducting accurate record reviews and using the reviews for ongoing local oversight and monitoring (April, 2012).
- establishing workgroups to address key issues, such as securing private insurance and TRICARE, reimbursement for Part C services, fiscal management of local issues, prematurity, and coaching strategies. The work of these groups resulted in the addition of prematurity as an automatic eligibility criterion, a number of trainings and written documents to support access to insurance reimbursement for EI services, and statewide technical assistance to improve local system managers' skills in fiscal management and oversight.
- implementing the **Targeted Case Management Program** that provides Medicaid reimbursement for service coordination for all children dually enrolled in Medicaid and Part C. The program, which has now been in place for two years, ensures dually enrolled children and their families are getting service coordination (case management) appropriate for infants, toddlers, and their families and that this service is being reimbursed by Medicaid.

As **Table 7** shows, formal complaints in the Part C early intervention system continue to be rare.

Table 7. Part C Dispute Resolution Utilization					
Resolution Method	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012
Due Process	0	0	1*	0	1*
Formal Complaints	NA	2	3	2**	3**

Table 7. Part C Dispute Resolution Utilization					
Resolution Method	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012
Mediation	<10	1	1	0	2

\*Complaint withdrawn.

\*\*1 of 2 complaints was withdrawn in FFY 2011; the other was resolved within the 60-day-timeframe. In FFY 2012, 2 of 3 complaints were withdrawn within the year. Both FFY 2012 requests for mediation led to mediation agreements. The 1 formal complaint that was not withdrawn was resolved within 60 days and determined to be founded. The noncompliance identified through that complaint has been corrected.

The February 2013 amendment to the *Part C State Performance Plan for 2005–2012* reported activities being undertaken to improve performance with respect to dispute resolution procedures and timelines, and ensuring that families are aware of their rights. Those activities included the following:

- Developing and implementing a mechanism to collect data on the number of potential complaints that are resolved informally through the Part C Office or the Family Improvement Project, to capture any trends emerging from concerns expressed by families, and to document whether families were informed of their options prior to resolution. This included a 2011 plan to explore tracking options used in other states to determine the best electronic tracking option for Virginia.
- Reviewing the results of the **Parent Education Advocacy Training Center (PEATC)** parent survey with staff of the Family Involvement Project and the Virginia Interagency Coordinating Council (VICC). The survey, which was conducted prior to the 2009 verification visit, was reviewed to assess why the concerns expressed by respondents did not lead to complaints and, if necessary, to develop additional strategies to ensure parents are aware of and empowered to use their dispute resolution options. As a result, the Family Involvement Project has developed additional resources on parents' rights, including dispute resolution options.

### C. Early Head Start Services

Head Start is a federally funded program that works directly with localities. The **Virginia Head Start State Collaboration Office (HSSCO)** oversees the program and represents its interests on the state level. According to the Virginia Department of Social Services' HSSCO web page, <http://www.dss.virginia.gov/family/cc/headstart.html>, the **Head Start State Collaboration Grant** was created as a state-level partnership to support development of multi-agency and public-private partnerships. These partnerships are designed to facilitate development of early childhood systems, enhance access to comprehensive services for low-income children, and involve Head Start in state policies affecting low-income families.

Principal goals are to (1) foster working coalitions that include federal **Administration for Children and Families (ACF)** staff, state officials, Virginia Head Start Association members, Head

Start program staff and early childhood professionals; (2) create a link between local Head Start programs and the State's early childhood initiatives; and (3) facilitate a more coordinated approach to service delivery. There are seven priority areas for Virginia's grant:

1. Improve access to health care services.
2. Improve the availability, accessibility, and quality of childcare services.
3. Improve collaboration with social services systems.
4. Expand and improve educational opportunities in early childhood programs.
5. Initiate interaction with the AmeriCorps service program.
6. Improve access to family literacy services.
7. Improve opportunities for children with disabilities.

The purpose of **Early Head Start (EHS)** is to promote healthy prenatal outcomes for pregnant women, enhance early childhood development, and promote healthy family functioning. It is a family-oriented program that provides guidance, information, and direct services in the home. According to the *2012 Virginia Head Start Association Annual Report*, 13 percent of infants and toddlers are eligible for services through the Part C Early Intervention program.

### **1. Infant and Toddler Screening and Eligibility for Early Head Start**

Although criteria for each local Head Start program can vary, child eligibility for **Head Start** is primarily based on:

- the child's **age** (Early Head Start serves children under age 3.),
- the family's **income** (federal poverty guidelines available at <http://aspe.hhs.gov/poverty/12poverty.shtml>), and
- whether the child has a **disability**.

Other factors taken into consideration include the following:

- **Parental status** (emancipated minor, one- or two-parent household, foster care, non-biological custodian, etc.)
- **Social conditions** (terminal illness or death in the family, abuse, substance abuse, other siblings attending Head Start programs, referrals from other agencies, mental health of the parent, homelessness, education of parent, non-English speaking family, etc.)

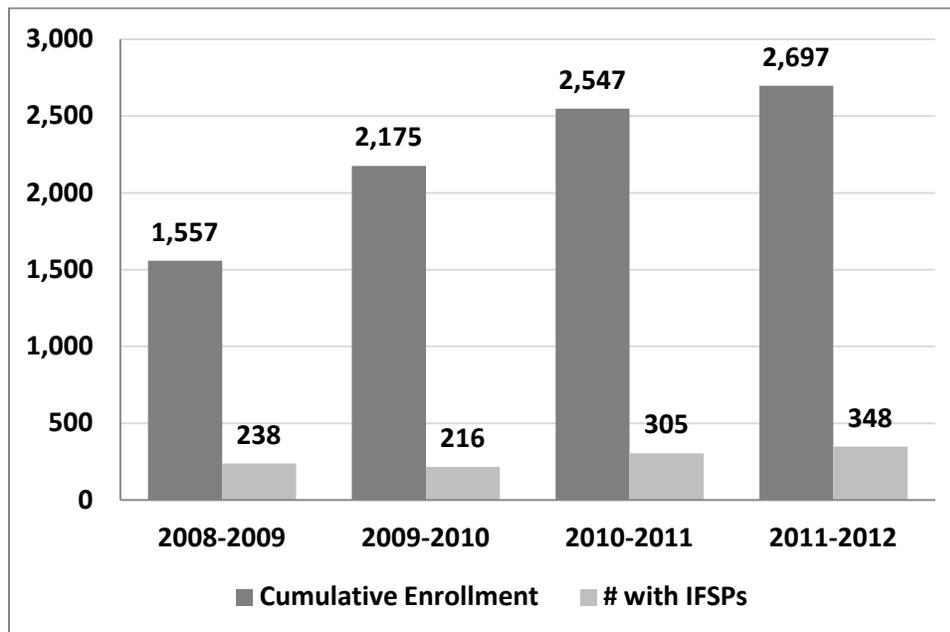
### **2. Access to and Use of Early Head Start**

The Head Start grantee (or the agency delegated by the grantee to deliver Head Start services) is responsible for coordinating with the Part C local lead agency with respect to serving children with disabilities who are eligible for both programs. According to the 2011

through 2012 edition of the *Head Start Program Information Report*, only 18 of the 65 Head Start programs in Virginia provided Early Head Start, thus limiting access to this program by geographic availability. This number has remained the same since 2010 when 5 programs were added to 13 existing programs. Families can find a local Early Head Start program with the locator service at <http://www.headstartva.org/>.

Statewide, Early Head Start programs must make at least **10 percent** of their enrollment opportunities available to children with disabilities who are eligible for Part C early intervention services. As **Figure 6** shows, the program has consistently met this target or slightly exceeded it. In 2008–2009, 15 percent of children in EHS had an Individualized Family Services Plan. That number dropped to 10 percent the following year, rose to 11.9 percent, and rose again to 12.9 percent of the cumulative enrollment figure.

**Figure 6. Early Head Start Cumulative Enrollment and the Number of Children with IFSPs by School Year**



Sources: 2008–2009 *Head Start Program Information Report, Enrollment Statistics Report, State Level*; 2011–2012 *Head Start Program Information Report; Disability Services Multi-Year Report, State Level*.

Federal Head Start Program Performance Standards (45 CFR, Chapter XIII, Part 1308.4) requires each Early Head Start program to develop a **Disabilities Service Plan** to ensure the needs of children with disabilities and their families are met. This plan must be updated annually and include the following components:

- provisions for children with disabilities to be included in the full range of activities and services normally provided to all Head Start children, and provisions for any modifications necessary to meet the special needs of the children with disabilities;

- recognition of the need for small group activities with modifications of large group activities, and individualized special help;
- designation of a disabilities coordinator and arrangement for the preparation of disability service plans;
- procedures for timely screening and making referrals to the local education agency to determine if there is a need for special education and related services for a child as early as the child's third birthday;
- assurances that facilities are accessible along with plans to provide any needed specialized furniture, equipment, and other materials; and
- strategies to ensure the transition of children from Early Head Start (ages 0 to 3) into Head Start (ages 3 to 5) or into their next placement.

The Head Start Act of 2007 requires formal linkages with providers of early intervention services for infants and toddlers with disabilities as established in Part C of the Individuals with Disabilities Education Improvement Act (IDEA) and with the agency responsible for administering section 106 of the Child Abuse Prevention and Treatment Act (42 USC § 5101 et seq., 42 USC § 5116 et seq.).

### 3. Available Early Head Start Services

The federal Early Head Start website provides detailed information about this program. Early Head Start programs serve families through a full-day, full-year program option that best meets the needs of their families. Local programs provide different options that are determined through community needs assessments and dialogue with families. Find it at <https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/about.html>.

The program is meant to be flexible so that as needs change, services offered and programs provided can evolve to support them. EHS programs focus on child and parent development, family education, and increasing family access to available resources. Service options include the following:

- **Center-based services** provide early learning, care, and enrichment experiences in an early care and education setting with family home visits at least twice a year.
- **Home-based services** provide weekly home visits to each enrolled child and family. The home visitor provides child-focused visits that promote the parents' ability to support the child's development. Twice per month, the program offers opportunities for parents and children to come together as a group for learning, discussion, and social activity.
- **Family child care services** provide care and education to children in a private home or family-like setting.
- **Combination services** combine both home- and center-based services.

Direct and indirect (referral) services for infants and toddlers enrolled in Early Head Start in Virginia include early education, medical and dental services, and family supports. Infants and toddlers with disabilities receive all of the services specified by their Individualized Family Services Plan (IFSP) as well as standard Early Head Start services.

The IFSP specifies which services are to be provided directly by Head Start and which will be provided by other agencies. As provided for in federal Head Start Program Performance Standards, IFSP services may include, but are not limited to: audiology, physical and occupational therapy, speech and language services, psychological services, assistive technology, and transportation.

#### **4. Cost and Payment for Early Head Start**

Available information does not differentiate between **Early Head Start** and **Head Start** in terms of cost and payment. For additional information, see page 55 of the **Education** chapter. Available information is included there as many more children are served through Head Start's preschool services than through Early Head Start.

#### **5. Monitoring, Evaluation, and Outcomes of Early Head Start**

Monitoring and evaluation of Virginia's Head Start programs are also covered in the **Education** chapter of this *Assessment* beginning on page 55. There are no separate data available regarding Early Head Start outcomes. A national study was completed in 2006. Outcome information on the national level in terms of the benefits of Early Head Start can be found at <http://www.acf.hhs.gov/programs/opre/resource/early-head-start-benefits-children-and-families-research-to-practice-brief>.

### **D. Chapter References**

Links to websites and online documents reflect their Internet addresses in June of 2014. Some documents retrieved and utilized do not have a date of publication.

#### **1. Websites Referenced**

##### **Code of Virginia: Part C**

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##### **Head Start**

###### **About Head Start**

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###### **Fact Sheets**

<http://eclkc.ohs.acf.hhs.gov/hslc/data/factsheets>

**Early Head Start**

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<https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/about.html>

**Virginia Head Start**

[http://www.headstartva.org/.](http://www.headstartva.org/)

**The Arc of Virginia**

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**Virginia Department of Behavioral Health and Developmental Services**

<http://www.dbhds.virginia.gov>

**Infant and Toddler Connection of Virginia**

<http://www.infantva.org>

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