

II. Early Intervention

A. Introduction

Early intervention services target infants and toddlers, from birth until their third birthday, who are not developing as expected or who have a condition that can delay normal development. **When appropriate services and supports are made available as soon as possible to these infants and toddlers, significant long-term benefits for those children and their families result.** The need for special services later in life may be decreased or eliminated, and even if continued supports are needed, a child's opportunity to grow and develop to her or his full potential is enhanced.

Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA, 20 USC 1431 *et seq.*), as amended in 2004, specifically defines "early intervention services" as those designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Referencing this definition, services authorized under IDEA are typically and interchangeably referred to as early intervention (EI) or "Part C" services and focus on increasing a child's ability to participate in family and community life. An "early intervention coordinator" works with the child and family to ensure identification of treatment needs, gather resources and information, and coordinate therapy and other intervention services. In Virginia, most early intervention services are provided through the **Infant and Toddler Connection of Virginia, Part C Office.**

Some Virginia children with disabilities also receive early intervention services through one of 18 **Early Head Start (EHS)** programs in geographic areas where those exist, 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 their families. They are designed to enhance children's physical, social, emotional, and intellectual development; assist pregnant women in accessing comprehensive prenatal and postpartum care; support mothers' and fathers' efforts to fulfill their parental roles; and help parents move toward self-sufficiency.

A provider of Part C services since their inception in 1974, Virginia's efforts are guided by state statute (*Code of Virginia 2.2-5300-5308*). Eight state agencies share responsibility for providing Part C services through the **Virginia Interagency Coordinating Council** 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, as well as the Virginia Office for Protection and Advocacy. Of these, the **Department of Behavioral Health and Developmental Services (DBHDS)**, formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services

(DMHMRSAS), is designated as the lead state agency accountable to the federal Office of Special Education Programs of the U.S. Department of Education for quality of service delivery and ensuring that Virginia's Part C services meet all applicable federal regulations and guidelines.

In 2008, there was significant discussion of changing Virginia's Part C state-level lead agency to the Department of Health from DMHMRSAS, as it was still called then. The October 2008 *Virginia Interagency Coordinating Council Retreat Summary Report* noted that Part C programs were housed in health departments in 40 states, a growing trend, and projected a number of benefits for children, their families, and providers if Virginia made the change. Under this initiative, Community Services Boards, partners with DMHMRSAS, would still have served as local lead agencies for Part C services.

Ultimately, it was determined to retain DMHMRSAS as Virginia's lead agency for Part C services, and a focus was placed on data system improvements and development of the **Medicaid Early Intervention Program**. Prior to this decision, DMHMRSAS was also identified as the agency that would coordinate autism services in Virginia. With the Part C program as a natural and appropriate component of the newly broadened range of services to be offered by DMHMRSAS, the agency was reconfigured and given its current name, the Department of Behavioral Health and Developmental Services (DBHDS).

With its role as lead agency reaffirmed, DBHDS has worked closely with its state agency and local partners to enhance the Part C program as a whole and improve early intervention services for infants and toddlers throughout Virginia. As noted in the 2008 edition of this *Assessment*, Part C Systems Transformation has been ongoing since 2007 and significant progress has been made. In coordination with a stakeholder group and Solutions Consulting Group, LLC, which published a key report and recommendations that year, DBHDS has identified four priorities for these improvements. From its November 2009 *Report on Virginia's Part C Early Intervention System* (Budget Item 316 K.21, 2009 *Appropriations Act*) to the General Assembly, those priorities are to:

- Develop and implement the Medicaid Early Intervention Initiative to expand Medicaid reimbursement for Part C early intervention services,
- Improve data systems to ensure the availability of accurate and complete data to address state and federal reporting requirements,
- Revise the funding formula by which federal and state Part C funds are allocated to local systems to ensure equity and parity, and
- Revise Virginia's family cost participation practices to ensure consistency statewide and to ensure that children and families are not denied services due to inability to contribute financially.

In addition to the identification of these priorities, significant training and technical assistance has been provided to professionals throughout the state. The federal Part C oversight

agency, the U.S. Department of Education's Office of Special Education Programs (OSEP), has recognized those improvements. After designating the Commonwealth in the "needs assistance" category for three years, OSEP's most recent determination letter, issued in Spring 2010, categorized the state's Part C system as "meets requirements."

Virginia's *Part C Annual Program Performance Report* for federal fiscal year 2008, the latest available report, details the progress that has been made toward the priority areas above and others. System improvement activities have included, but are not limited to, the following:

- Emergency regulations supporting changes in Medicaid reimbursement for Part C services went into effect on November 2009.
- A Service Pathway was developed to provide a visual representation of the flow of steps that take place as children and families move through the Part C system from referral to implementation. A Part C Practice Manual and new statewide forms were developed to support implementation of this Service Pathway.
- A Part C practitioner database was developed to track and manage provider certification and family choice of providers.
- DBHDS hired an autism specialist to work across agencies and with families and providers. Additionally, Communities of Practice in Autism (CoPA) training and advanced level training focused on strategies to support families with young children with autism spectrum disorders (ASDs) in natural environments was provided to 180 participants in six areas: Abingdon, Northern Virginia, Richmond, Roanoke, Tidewater and the Valley region.
- The Virginia Interagency Coordinating Council held a planning retreat to better determine its role in advising the lead state agency and in addressing issues and challenges identified through its work.
- Approximately 46,000 copies of Virginia's Part C developmental checklist brochure were included in New Parent Kits distributed through local departments of social services and other local agencies. Those materials are now available on the Smart Beginnings website as well.
- Statewide public awareness efforts continue and include radio spots, media kits, posters, and other materials, including strategies to reach traditionally underserved populations.

According to information provided by DBHDS and the Department of Medical Assistance Services (DMAS), Virginia was one of 19 states and territories selected to participate in the Assuring Better Child Health and Development (ABCD) Screening Academy. Individuals in leadership positions from DMAS, the Department of Health, and the Virginia Chapter of the American Academy of Pediatrics worked with stakeholders to increase the use of a standardized developmental screening tool by primary care providers as part of well child care. The goal was to identify and treat developmental concerns before a child reaches kindergarten, and as a result, program improvements were made.

In recent years, early intervention for infants and toddlers with autism spectrum disorders (ASDs) has received a great deal of long needed attention, and improvements in interventions have occurred. The lack of private insurance coverage for children with autism has also been a significant issue. (See Cost and Payment section of this chapter.) As mentioned above, there has been implementation of the Communities of Practice in Autism (CoPA) model in which practitioners shared information, resources, experiences, and best practices with their peers. Additionally, the Joint Legislative Audit and Review Commission's (JLARC) 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders* (House Document #8, available at www.jlarc.virginia.gov) has served as a foundation for developing strategies and plans for better serving this population across the lifespan. The JLARC report presents a comprehensive review of the needs of individuals with ASDs as well as recommendations for development of a comprehensive system of services. Specific details can be found in the JLARC report and in the DBHDS response to it.

In the following description of Virginia's Part C and Head Start programs, please note that they operate on the federal fiscal year (FFY), October 1 through September 30; however some information is reported by state fiscal year (SFY), July 1 through June 30. The appropriate abbreviation, FFY or SFY, followed by the year is used to indicate which applies.

B. Eligibility for Early Intervention Services

Early Head Start: Eligibility for Head Start is income based, and federal poverty guidelines are used to evaluate family income. Early Head Start programs may also elect to target services to a particular population to best meet the unique needs of children and families in their community.

Statewide, Early Head Start programs must make at least ten percent of their enrollment opportunities available to children with disabilities who are eligible for Part C services under the *Individuals with Disabilities Education Improvement Act* (www.ehsnrc.org/ChildEligible.htm). According to data from the *Head Start Program Information Report* provided by the Virginia Department of Social Services Head Start Office, for FFY 2008, approximately 15 percent of the enrollees (238 of 1,592) in the state's Early Head Start programs during that year were children with disabilities receiving services under a Part C Individualized Family Services Plan (IFSP), exceeding the federal minimum. In FFY 2010, 37 percent more children were serviced by Early Head Start, however, only nine percent (195 of 2,175) received services under an IFPS, below the minimum requirement. No reasons for this decline in the proportion of children served under an IFPS were provided.

Part C Early Intervention: Every state develops its own definition of eligibility for Part C early intervention services. In the Commonwealth, as required in the *Code of Virginia* (2.2-5300), children from birth to age three (*i.e.*, until their third birthday) and their families are eligible for Part C services when a determination has been made that the child has:

- ✓ A developmental delay of at least 25 percent in one of the developmental domains of cognition, communication, motor, adaptive, or social/emotional; and/or

- ✓ Atypical development or behavior; and/or
- ✓ A diagnosed physical or mental disability that has a high probability of resulting in developmental delay (e.g., significant central nervous system anomaly, congenital or acquired hearing loss, chromosomal abnormalities, inborn errors of the metabolism, severe attachment disorders, autism spectrum disorder, and brain or spinal cord trauma).

More detailed information on how these are assessed can be found in the Virginia Part C Policies and Procedures for Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) at www.infantva.org/documents/ovw-PGuideStateDefinition.pdf . A complete list of eligible conditions can be found at www.infantva.org/documents/pr-PM-PracticeManual.pdf.

Part C services are available to all eligible children regardless of their families' ability to pay. (See Cost and Payment section of this chapter.) Eligibility for Part C is determined by a multidisciplinary team at the local **Infant and Toddler Connection** system. As recently as 2008, some children referred to Part C were "screened out" prior to receiving a multidisciplinary team evaluation of their eligibility, but that process has changed.

The Part C program now requires that, with parental consent, all referred children receive a developmental screening using a screening tool unless there is (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay, (2) documented developmental delay or atypical development; or (3) the child has already received a developmental assessment or screening prior to referral. Unless the parent refuses to proceed to an eligibility determination all children receive a multidisciplinary evaluation to determine eligibility. This includes a multidisciplinary team review of medical reports, developmental screening results, parent reports, observations summaries, and assessment reports, if any. The team then determines if eligibility criteria are met. These changes described in the 2008 *Part C Annual Program Performance Report* are designed to ensure accurate and timely eligibility determinations. The process was a collaborative effort between Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services.

C. Access to and Delivery of Early Intervention Services

Early Head Start: According to the Virginia Department of Social Services' Head Start Office, 18 of the 48 Head Start grantees in Virginia during FFY 2010 provided Early Head Start, thus limiting access to this program by geographic availability. (Two of the grantees provided only Early Head Start.) This was an increase of seven Early Head Start programs since the 2008 program year. Families can determine if a program exists in their area using the Head Start locator at <http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices#map-home>.

Federal regulation 45 CFR 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;
- The need for small group activities, 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 0-3) into Head Start (ages 3-5) 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.*).

Part C Early Intervention: As the state lead agency for Part C services (*Code of Virginia 2.2-5304*), the **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for supervising and monitoring Virginia's Part C early intervention system and for ensuring both the quality of service delivery and compliance with federal regulations. Through its **Office of Child and Family Services**, DBHDS establishes regulations and adopts statewide policies and procedures to ensure consistent and equitable access to Part C services. It also manages the statewide interagency system that coordinates early intervention services. The resulting Part C system emphasizes local decision-making and autonomy in service implementation with state-level accountability for consistency in quality and availability of services.

Virginia's Part C system is further designed to accentuate understanding by the professional and lay communities of the wide range of developmental delays and disabilities encountered in early childhood, the recognition of the benefits of early identification and response, and the importance of a team approach focusing on the individual needs of each child and family. Local geography, service availability, populations and political jurisdictions served,

and organizational structure are among the variables of local systems. In some areas, personnel shortages contribute to a wide variability in services between localities.

In administering the system, DBHDS currently contracts with 40 local lead agencies, local **Infant and Toddler Connection** programs, which are designated by local city or county governments. Currently, 30 Community Services Boards (CSBs) serve as local lead agencies for Part C services. Lead agencies for the remaining localities include two local education agencies, four universities, two health departments, and two local governments. The local lead agency is required to designate a single point of entry for the local system, which is usually itself.

Local lead agencies are responsible for budget management, federal and state Part C fund allocation, data collection and reporting, and conducting **Child Find** activities. Child Find, a federal mandate under the *Individuals with Disabilities Education Improvement Act* (IDEA), requires that the local lead agencies identify infants and toddlers who may be eligible for Part C services and conduct public awareness campaigns that encourage referrals to and use of the early intervention system.

Service delivery is also the responsibility of local lead agencies, and they have flexibility in its administration. Some provide Part C services directly through their agencies, some contract for direct services, and others do both. Local lead agencies determine eligibility and provide service coordinators (case managers) who guide families through the early intervention process and facilitate the development and implementation of required **Individualized Family Services Plans (IFSP)**. An IFSP lists the outcomes that the family and Part C team would like to see for the child and identifies the services and supports needed to meet those outcomes. Family participation is a fundamental part of the IFSP process, ensuring that it corresponds to their resources, concerns, and priorities.

Referrals to the Part C system can come from a variety of sources, including “self-referral” by a family, but referrals for evaluations and Part C services do not require the consent of a child’s parents or legal guardians. All families referred to Part C are eligible to receive a multidisciplinary evaluation to determine their children’s eligibility for services.

In comparing referral data over time, the 2007 *System of Payments Summary Report* by Solutions Consulting Group found that, in SFY 2006, 39 percent of referrals came from physicians, 12 percent came from hospitals; 23 percent came from parents or guardians, and three percent came from friends, neighbors, and relatives. Similar data from the DBHDS Infant and Toddler Online Tracking System (ITOTS) for SFY 2010, shows referrals from physicians (45 percent) and parents and guardians (22 percent) to be stable with an expansion of referrals from other sources: six percent from the Department of Social Services and about two percent each from the Department of Health, Community Services Boards, and the category of Friends/Neighbors/Relatives.

Annual data on the unduplicated number of infants and toddlers receiving Part C services is calculated two ways. Each year, DBHDS produces a “point-in-time” count by tallying the

number of individual children being served on the same day, December 1, to produce the “December Child Count.” It is important to note that this count does not reflect all children served throughout the year. The total unduplicated count of infants and toddlers who are served over the course of the state fiscal year (SFY, July 1 to June 30) is referred to as the “Annualized Count” (previously known as the “Aggregate Count”). The table below depicts both counts for the past five years.

NUMBER OF INFANTS AND TODDLERS ELIGIBLE AND ENTERED PART C SERVICES

Type of Count	2006	2007	2008	2009	2010
December Child Count	4,619	6,023	6,321	6,288	7,378
Annualized Count	10,212	10,330	11,351	11,766	13,421

Sources: December Child Count: ITOTS database reports provided by DBHDS on August 2, 2010 and February 1, 2011. Annualized Count: DBHDS: *Report on Virginia’s Part C Early Intervention System* (Budget Items 312 K.2, 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2006-2010 Appropriations Acts, respectively).

The number of children receiving Part C services is trending upward. The overall increase in the Annualized Count from 2006 to 2010 was 30 percent, with an increase of 14 percent from 2009 to 2010, following a relatively stable 3.5 percent increase from 2008 to 2009. From 2006 to 2010, the December Child Count increased by nearly 60 percent, with a 17 percent increase over just the last year. It will be important to note future trends. While DBHDS has not analyzed why the numbers increased so significantly from 2009 to 2010, it can be presumed that some of the increase was due to the implementation of the new Medicaid Early Intervention Program. The temporary infusion of federal *American Recovery and Reinvestment Act* (ARRA) stimulus funds may also have been a factor.

DBHDS continues to work with its local partners to improve the Part C program and services for infants and toddlers throughout the state. The following table reflects data now being collected to track an important statistic, the proportion of infants and toddlers who were referred for but are not known to have received services.

NUMBER OF INFANTS AND TODDLERS EVALUATED BUT DID NOT ENTER SERVICES

Federal Fiscal Year (FFY)	2006	2007	2008	2009	2010
Did not Enter Services			1,760	1,671	1,494
Eligible and Entered Services	10,212	10,330	11,351	11,766	12,234

Sources: DBHDS: *Annual Report on Virginia’s Part C Early Intervention System* for 2008, 2009, and 2010

Comparable data is not available for FFY 2006 and 2007, but for FFY 2008, 13.4 percent (1,760) of a total of 13,111 infants and toddlers determined by evaluations to need Part C services are not known to have moved forward to receive them. The proportion dropped to 12.4 percent (1,671 of 13,347) in FFY 2009 and even further in FFY 2010 to 10.9 percent (1,494 of 13,720). These children all received a multidisciplinary team evaluation and assessment, but they were found to be ineligible for Part C, services were declined, or they were lost to contact.

Although Virginia is improving with respect to the number of infants and toddlers served overall, the Commonwealth continues to be less successful than other states in its identification of those needing services. DBHDS set a target for FFY 2008 of serving 0.77 percent of infants and toddlers birth to one year who may have a developmental delay or a disability likely to result in a developmental delay and be in need of services. According to the FFY 2008 *Part C State Annual Performance Report (APR)*, the last report submitted, the December Child Count showed that Virginia actually served 0.67 percent. The comparable figure at the national level was 1.04 percent. Of the 39 local Part C systems in FFY 2008, 15 met the 0.77 percent target, and two were within 95 to 99 percent of reaching it. Twenty-two local systems reached only 42 to 86 percent of the target. All local systems were notified of their need to improve performance, and the 22 local systems that met less than 93 percent of the target were required to develop a Service Enhancement Plan. Specific strategies undertaken to correct deficiencies can be found in the 2008 APR.

The number of systems not achieving the target in FY 2008 was an increase over FFY 2007 when only 18 local systems did not reach that year's target. The FFY 2008 APR noted that this slippage was in part due to budget constraints, citing that funding and personnel that would normally have been available for public awareness and Child Find efforts were redirected to ensure that direct services and supports were available to eligible children. It is expected that the Medicaid Early Intervention Program will continue to help increase revenue to the Part C system, freeing funds for enhanced awareness and Child Find.

The *Part C State Performance Plan for 2005-2010*, amended in February 2010, set the target for serving the birth to age one population at 0.87 percent for FFY 2009. Data on whether this target was achieved will not be known until publication of the next APR. Data on the birth to one population were not included in the October 2010 *Part C Annual Report to the General Assembly* (Budget Item 305 H.2., 2010 *Appropriations Act*).

With respect to serving the birth to age three population, a target of 2.1 percent was set for FFY 2007 and a 2.6 percent target was set for FFY 2008. Neither target was met. The 2008 December Child Count showed that Virginia served 1.99 percent vs. 2.66 percent served under Part C nationally. The 2008 APR reported that 20 local systems met the FFY 2008 target, five substantially met the target, and 14 did not, serving between 52 and 93 percent of the target. The statewide percent served remained unchanged in the 2009 December Child Count, but there has been slight improvement from FY 2007 when the percent served was 1.92 percent. As above for the birth to age one population, systems that did not meet the target were required to develop a Service Enhancement Plan, and the APR noted that budget constraints contributed to less than expected progress because money for Child Find and public awareness were redirected to direct services.

Virginia has also been cited for a lack of proportionality between the number of infants and toddlers served by its Part C system and related state spending. In a presentation before the Virginia Interagency Coordinating Council on September 12, 2007, the authors of the *System of Payments Summary Report*, Solutions Consulting Group, stated "The infusion of new state funds

has had little impact on the number of children in service using the point in time count.” Following this, in its 2008 *Report on Virginia’s Part C Early Intervention System* to the General Assembly, DBHDS indicated that the disproportionate growth in state funding compared to numbers served could stem from higher costs for serving children in natural environments, including the rising cost of gasoline, a higher intensity of services required for children with more significant disabilities such as autism, lower local contributions toward the total cost of Part C services as state funding has increased, or other causes still to be determined. DBHDS staff track this data and have recognized and supported the need for further review of Part C expenditures that would include an assessment of whether sufficient funds are being directed to Child Find. Efforts in this area remain underway, and the 2010 Part C report to the General Assembly did not address this specific issue.

The trend in infants and toddlers served, however, has been slowly upward. The number of children served increased by four percent from FFY 2009 to FFY 2010, and it is anticipated that it will increase further with the Medicaid Early Intervention Program.

In August 2010, DBHDS convened a new workgroup to focus on Early Intervention Prematurity. The minutes of this meeting identify the following goals that will be considered at further meetings scheduled into the spring of 2011:

- Determining how to identify which premature infants should be referred to early intervention and when,
- Ensuring providers are able to identify children who may be eligible and provide the appropriate education and supports to children and families,
- Decreasing (eliminating) the number of children who fall through the cracks,
- Developing a better system for identifying premature babies who may be in need of services and reaching their families, and
- Improving collaboration with Neonatal Intensive Care Units (NICUs), including improving the transition process from the NICU to home and community based services.

Efforts such as these are reflected in the October 2010 *Report on Virginia’s Part C Early Intervention System* which notes that DBHDS is exploring the potential impact on children and the Part C system of eliminating the current policy of “age adjustment” for children born prematurely and examining other aspects of eligibility to ensure that children are identified accurately and as early as possible.

D. Available Early Intervention Services

Early Head Start: As reported in the Virginia Head Start Association’s 2008-2009 *Annual Report*, the last report available, the mission of Early Head Start 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.

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. 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 eligible for both programs. As previously noted, 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 regulations, IFSP services may include, but are not limited to: audiology, physical and occupational therapy, speech and language services, psychological services, assistive technology, and transportation.

Part C Early Intervention: The Commonwealth's early intervention system, as described by Virginia's Part C Office, envisions an optimum that may or may not occur in practice, particularly with extensive variability in local systems, provider capacity, and funding. Services are based on current research and best practices that emphasize empowering parents and strengthening their abilities to meet the developmental needs of their children, encouraging consistency of intervention, and avoiding over-utilization of therapy. Parents and service providers become partners, working closely together to make the most effective use of learning opportunities and other activities that arise normally throughout the child's and its 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 clinical and support services and monitor the evolving needs of the family and child over time.

The foundation for these Part C services is the **Individualized Family Services Plan (IFSP)** and subsequent follow-up that emphasizes a holistic and seamless approach that brings together medical, developmental, psychosocial, and educational resources to ensure that the comprehensive needs of the child and family are met most effectively. Frequency and intensity of IFSP activities are adjusted as the child's and family's needs for support and guidance changes. Individual components of the plan may include:

Assistive technology	Occupational therapy
Audiology	Physical therapy
Developmental services	Psychological services
(previously called specialized instruction)	Respite care
Family training, counseling and home visits	Social work services
Health services	Speech/language pathology
Medical diagnostic and evaluation services	Transportation
Nursing and nutrition services	Vision services

In order to increase family's participation in their children's therapies and to provide continuity and consistency in service delivery, federal regulations stipulate that early intervention services must 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 normal for the child's same-age peers. The provision of services in other settings is deemed appropriate only if outcomes cannot be achieved in natural environments.

A key component of an IFSP addresses a child's transition from services under the Part C early intervention portion of the *Individuals with Disabilities Education Improvement Act* (IDEA) to the Part B special education portion of that act or to other community services, if needed. Family planning and preparation for transition from Part C to Part B services include training parents on timelines, future placement options, and other matters; transmission, with the parents' consent, of information about the child to the local educational agency; and preparing the child to adjust to changes in service delivery.

Federal regulations under IDEA require that states have policies and procedures on file with the U.S. Department of Education that ensure a smooth and effective transition between Part C programs and Part B preschool programs. Public schools must participate in transition planning with Part C local lead agencies, and an **Individualized Education Program (IEP)** must be developed and implemented for each child receiving Part C services before his or her third birthday if that child requires special education services under Part B.

Virginia is the only state that makes Part B services available to children ages 24 to 36 months, creating a potential for overlap between the Part C early intervention and Part B special education systems. Since a child cannot receive Part C and Part B services concurrently, parents must decide whether the child will remain in the early intervention system during this period or make an early transition to the special education system. Information on Part B special education eligibility and services is covered in the Education chapter of this report.

The chart below shows the estimated number of children who received various types of early intervention services for state fiscal years (SFY) 2007 to 2010. The significant differences for some services between SFY 2010 and previous years are due at least in part to differences in how the counts were derived. In SFY 2010, some of the services were reported under different names that may not exactly replicate the services reported in previous years. Other differences relate to changes in data collection and estimation processes.

PART C EARLY INTERVENTION SERVICES LISTED ON INITIAL IFSPs

	SFY 2007	2008	2009	2010
Assistive Technology	72	204	188	196
Audiology	258	341	318	12
Counseling*	52	79	35	184
Developmental Services**	2,407	2,542	2,200	2,484
Initial Evaluation/Assessment	6,768	7,811	7,609	9,296
Health Services	2	2	0	4
Medical Services (for evaluation/diagnosis)	8	11	4	<i>not reported</i>
Nursing Services	4	2	0	24
Nutrition Services	21	68	71	86
Occupational Therapy	1,498	1,862	1,600	1,248
Physical Therapy	2,965	3,950	3,236	2,068
Psychological Services	12	2	0	0
Service Coordination	10,3330	11,351	11,766	12,234
Social Work Services	93	125	106	6
Speech-Language Pathology	4,855	4,801	4,177	3,132
Transportation	6	5	2	281
Vision Services	83	148	129	49
Other Entitled Early Intervention Services	62	68	71	***2,083

* Counseling was formerly reported as Family Training and Counseling.

** Developmental Services were formerly called and reported on as Special Instruction.

*** DBHDS reports that the significant increase from previous years in the final category, Other Entitled Early Intervention Services, occurred because of a change in the SFY 2010 reporting form. The change to the form eliminated the option of reporting aggregate expenses for local systems whose accounting did not allow identification of the specific services purchased. The increase, therefore, most likely represents the use of the Other Entitled Early Intervention Services category to capture what were formerly called aggregate expenses for direct services rather than an actual increase in Other Entitled Early Intervention Services.

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

Prior to SFY 2010, the DBHDS data system captured only the planned services identified on a child's initial IFSP. It did not update with services added on subsequent IFSPs or represent services actually delivered, which can be quite different than those listed on an initial IFSP. In addition, the Part C data system previously only provided information on children included in the annual December Child Count. To obtain the estimated count for a service for all children for a state fiscal year, the percentage of children in the Part C system on December 1 whose initial IFSP included a service was applied to the Annualized Count of children receiving services throughout the year. This method also overestimated some services, such as audiology, that might be used only for screening purposes.

Beginning in SFY 2010, DBHDS instituted a new system requiring both local lead agencies and private providers to report the number of children actually receiving each service in

each quarter. Based on questions related to the changes in its reporting forms, DBHDS determined that there may have been problems with the accuracy of data regarding the number of children served during the first two quarters of SFY 2010. As a result of these concerns and to account for duplication across multiple quarters, the total number of children receiving each service in the fourth quarter was then used to estimate the total for the full fiscal year. DBHDS notes that this estimate was more accurate than in previous years because the data is now based on actual services delivered rather than initial or planned services. Reservations expressed in the October 2010 *Report on Virginia's Part C Early Intervention System* (Budget Item 305 H.2, 2010 *Appropriations Act*) about the reliability of data reported by local lead agencies remain, however, as there is still no mechanism for determining its accuracy.

E. Cost and Payment for Early Intervention Services

This section provides information on the varied public funding sources and expenditures for the Part C services system statewide. Following this information, a brief overview of health insurance resources, both private and public, is provided.

Early Head Start: In Virginia, Head Start programs greatly outnumber Early Head Start programs (46 to 18, respectively), and reports do not differentiate allocations or expenditures between the two; therefore, expenditure information will be covered under Head Start in the Education chapter of this assessment.

Part C Early Intervention: As the state's lead agency, the Department of Behavioral Health and Developmental Services (DBHDS) manages the budget of Virginia's Part C early intervention system. Children and families determined eligible for Part C services are entitled to receive those services, but not all Part C services are provided free of charge, and fees may be charged in accordance with state law. Regulations 34 CFR 303.522 (a)(1) and 34 CFR 303.527 governing expenditures of funds under Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) specify that they may be expended only after other sources, such as public (Medicaid, etc.) 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 proportional based on comparison of the state's population from birth to three with the national total for those ages. This allocation had been fairly stable over many years until it was increased by nearly a million dollars in federal fiscal year (FFY) 2008. Significant economic challenges since then, however, resulted in reductions of over \$100,000 in FFY 2009 and nearly \$700,000 in FFY 2010. The result was smaller allocations by the state to localities in FFY 2009, mitigated in FFY2010 by an infusion of stimulus funds and thus increased financial stability through FFY 2011. The federal allocation for direct services for the last five years are as follows:

PART C FEDERAL FUND ALLOCATIONS FOR DIRECT SERVICES

Federal Fiscal Year	Allocation
2006	\$8,419,704
2007	8,839,815
2008	9,881,918
2009	9,782,026
2010	\$9,087,761

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

As indicated, the amounts listed above represent only the federal allocations for direct services. Total federal allocations are higher and include funds expended on state and local infrastructure costs. The Virginia General Assembly also allocates state General Funds to support Part C services, and while the *Code of Virginia* does not mandate that localities provide funding for any costs under the Part C system, 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.

Despite declines over the past two years, significant progress had been made with respect to increasing the amount of state funding for Part C services. Unfortunately, however, this improvement in state funding has been accompanied by a decrease in localities opting to provide local funding. Combined with significant budget shortfalls due to the nation's economic challenges, the Part C program, like others, has suffered in terms of adequate funding. The state General Fund appropriations shown below must be used for direct services.

PART C STATE GENERAL FUND ALLOCATIONS

State Fiscal Year	Allocation
2006	\$3,125,000
2007	7,203,365
2008	7,203,365
2009	7,104,850
2010	\$6,861,337

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

In October 2010, DBHDS released its annual *Report on Virginia's Part C Early Intervention System* (Budget Item 305 H.2., 2010 *Appropriations Act*) for the state fiscal year ending June 30, 2010. This report notes that the fiscal climate for Part C has improved as a result of increased Medicaid revenue following the implementation of the Medicaid Early Intervention Initiative and the availability of over three million dollars in federal stimulus funding under the *American Recovery and Reinvestment Act* (ARRA). It further notes that the fiscal outlook for SFY 2011 remains positive due to these continuing funding infusions. ARRA

funding, however, ends on September 30, 2011, and there remains a need to closely monitor revenue and expenditure data and to identify the amount and sources of funding that will be needed to ensure the Part C program's long-term financial stability.

The table below summarizes all revenue sources for Virginia's Part C system, as reported by the 40 local lead agencies for the last four state fiscal years (SFY):

AMOUNT AND SOURCE OF PART C REVENUES, STATE FISCAL YEARS 2007-2010

Revenue Source	SFY 2007	2008	2009	2010
Federal Part C Funds	\$8,839,815	\$9,881,918	\$9,782,026	\$9,087,761
State Part C Funds	7,203,365	7,203,365	7,104,850	6,861,337
Federal ARRA Funds	(not applicable)	(not applicable)	555,107	4,301,650
Local Funds	7,427,535	8,370,228	8,131,851	7,727,982
Family Fees	367,346	322,915	358,611	485,983
Medicaid	1,081,489	1,095,727	1,486,253	3,656,354
Targeted Case Management	971,609	1,538,804	1,948,032	2,576,568
Private Insurance	825,931	1,049,697	1,052,112	2,512,116
Grants/Gifts/Donations	304,412	293,697	371,286	22,668
Other	1,008,074	624,754	1,424,765	2,800,611
Local Report of Aggregated Non-Part C Revenue	2,623,750	2,066,283	5,276,318	(not applicable)
In-Kind	(not applicable)	(not applicable)	(not applicable)	210,504
TOTAL	\$30,653,326	\$32,447,388	\$37,491,211	\$40,243,534

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2007-2010 Appropriations Acts, respectively).

As noted previously in the table under Available Early Intervention Services, beginning in SFY 2010, aggregate expenses that do not identify specific services can no longer be reported. In a positive step toward greater clarity and accountability, all expenses must be attributed to a service category. This change is just one outcome of the doubling of resources dedicated to improving tracking of revenues and expenditures between SFY 2007 and 2010. Further information on the steps being taken by DBHDS to improve its data systems is detailed in the Monitoring and Evaluation section of this chapter.

Costs related to administration, system management, data collection, and training totaled \$1,962,120 in SFY 2007; \$2,097,160 in SFY 2008; \$2,139,927 in SFY 2009; and \$5,816,344 in SFY 2010. According to DBHDS, the substantial increase in SFY 2010 reflects the expenditure of ARRA funds for one-time costs related to improved data collection and related training. It should also be noted that some Part C revenues, such as local funds, may be used for expenses other than direct services and, therefore, are not reflected in the data showing expenditures for direct services.

Virginia's Part C program's expenditures exceeded revenues by \$1,168,969 in SFY 2008 and by nearly double that amount, \$2,196,942, in SFY 2009. A carryover of unspent federal and state Part C funds from SFY 2007 was used to offset the SFY 2008 shortfall. Then, according to the 2009 *Report on Virginia's Part C Early Intervention System*, this enabled SFY 2008 to end with \$1 million in unspent funds which were applied to the SFY 2009 shortfall. That year, in addition, a number of providers agreed to lower their rates to ensure continued service to families.

The infusion of federal stimulus (ARRA) funds and the implementation of the Medicaid Early Intervention Program in SFY 2010 eliminated the deficit. As shown in the table above, Medicaid revenue increased from just under \$1.5 million in SFY 2009 to more than \$3.6 million in SFY 2010. Medicaid revenue is expected to further increase in SFY 2011, which will expand the availability of federal and state funds as payer of last resort for services for children without insurance and for services not covered by private insurance.

The next table lists service expenditures for each category of Part C direct services for SFY 2007 through 2010.

PART C DIRECT SERVICE EXPENDITURES BY CATEGORY, STATE FISCAL YEARS 2007-2010

Expenditure	SFY 2007	2008	2009	2010
Assessment for Service Planning				\$2,112,026
Assistive Technology	\$34,629	\$44,475	\$92,554	\$64,222
Audiology	12,691	14,496	8,533	8,239
Counseling*	50,097	97,339	89,164	183,757
Developmental Services**	1,810,959	2,277,328	2,319,073	3,514,105
Evaluation and Assessment	840,445	992,858	909,382	370,422
Health	3,290	500	4,220	32,426
Nursing	1,599	500	500	498
Nutrition	1,733	1,035	734	57,461
Occupational therapy	903,419	1,157,256	1,060,017	3,011,633
Physical therapy	1,623,660	1,947,473	1,812,654	4,062,847
Psychology	1,500	2,000	4,372	0
Service coordination	4,238,341	5,295,426	4,852,787	8,552,563
Social work	62,567	13,160	6,600	17,579
Speech/language pathology	2,195,039	3,187,203	2,980,410	8,143,435
Transportation	68,906	49,864	36,575	19,200
Vision	42,627	32,240	77,818	20,912
Other Entitled Part C Services	403,555	452,236	315,352	1,404,581
ARRA Funds for Services			535,771	
TOTAL	\$12,295,057	\$15,565,389	\$15,106,516	\$31,575,906

* Counseling was formerly reported as Family Training and Counseling.

** Developmental Services were formerly called and reported on as Special Instruction.

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2007-2010 *Appropriations Acts*, respectively).

In reviewing the table above, it is important to note that the sources and labeling of data are not consistent for all years. Local systems that received ARRA funds in SFY 2009 were not required to report on their use until October 2009, after the close of the federal fiscal year (FFY), too late to be included in the report for the state fiscal year (SFY) which closed at the end of June. One system, however, did include its expenditure of ARRA funds by service category in its SFY 2009 report. The remaining SFY 2009 ARRA expenditures by the other systems are listed separately at the end of the list. Information specific to ARRA funds was not reported in SFY 2010, and a new category, Assessment for Service Planning, was added. Improved data collection efforts by DBHDS also resulted in an increase in the number of reports by private providers from five in SFY 2009 to 54 in SFY 2010.

Total expenditures rose 156.8 percent from SFY 2007 to SFY 2010. The largest increases were for assistive technology, counseling, developmental services, health, nutrition, occupational and physical therapies, services coordination, and speech/language pathology. Significant differences in annual spending distributions can also be seen; however, while comparisons can be made among SFY 2007 through SFY 2009, the changes seen in SFY 2010 cannot be compared with earlier years because of programmatic changes to the system. For example, nutrition expenditures increased significantly in SFY 2010 because this is now a Medicaid covered service through the Medicaid Early Intervention Program.

Public Health Insurance: For many families of children with disabilities, public health insurance is a critical benefit that provides access to needed services. Basic information on eligibility, coverage, and administration for Virginia's public health insurance plans can be found in the Medicaid chapter of this assessment. Specific elements of these plans of particular relevance to the provision of early intervention services for infants and toddlers are covered below.

The state's **Medicaid FAMIS Plus** program provides coverage for **early and periodic screening, diagnosis, and treatment (EPSDT)** for children determined to be eligible for Medicaid. This includes children eligible for Medicaid as a result of receiving services under one of the Home and Community Based Services (HCBS) Waivers described in this assessment's Community Supports chapter. EPSDT services are intended to help ensure that a child's health problems are diagnosed and treated early before they become more complex and their treatment becomes more costly. EPSDT provides comprehensive coverage including assessment/diagnosis and the medically necessary services that are required to correct an identified condition, ameliorate its effects, prevent it from worsening, or prevent the development of secondary conditions. In the past, EPSDT was an underutilized funding source for Part C services; however, Medicaid eligible children can now access Part C services through the Medicaid Early Intervention Program.

Families not eligible for Medicaid FAMIS Plus may qualify for coverage under the state's Children's Health Insurance Program (CHIP), which in Virginia is known as the **Family Access to Medical Insurance Security (FAMIS)** program. Coverage under this plan is similar, but not identical, to that provided by FAMIS Plus. In addition to medical, vision, and dental

coverage, medically necessary services such as speech/language, physical, and occupational therapies and durable medical equipment are covered. Nursing and personal assistance services may also be covered. Some services are covered in full, while others may require copayments.

The Commonwealth's new **Medicaid Early Intervention Program** was established through its Part C Systems Transformation initiative and is now the only way for Virginia families to access funding for most Part C services under Medicaid. A 2009 joint presentation by the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS), entitled "Early Intervention Services," noted that prior to the transformation initiative, DMAS was not able to identify children enrolled in early intervention services because providers billed using reimbursement codes for particular therapy services (such as physical therapy, occupational therapy, etc.). The same held true for children being serviced through Medicaid managed care organizations (MCOs) In addition, DMAS neither reimbursed for all costs associated with providing services in natural environments (although it had been a federal requirement) nor reimbursed for all types of providers who could deliver early intervention services consistent with Part C regulations.

Priorities identified for the Part C System Transformation, and the process by which they were developed, were detailed in the Introduction to this chapter. The anticipated results of their implementation were (1) a more stable and equitable funding structure for Part C services, (2) compliance with federal fiscal requirements and assurances, (3) reimbursement for effective practices (teaming, consultation, and service provision in natural settings), and (4) improved provider recruitment and retention.

With these priorities and anticipated results in mind, the Medicaid Early Intervention Program was implemented on October 1, 2009. The October 2010 *Report on the Part C Early Intervention System* (Budget Item 305 H.2, 2010 *Appropriations Act*) lists the following initial outcomes:

- DMAS funded early intervention services are now available to children eligible for FAMIS or FAMIS Plus after eligibility screening through those programs.
- Reimbursement rates were increased for physical and occupational therapy and speech/language pathology services.
- Medicaid coverage was added for developmental, counseling, nursing, psychological, and social work services provided in accordance with a child's Individualized Family Services Plan (IFSP).
- Personnel are required to meet discipline-specific qualifications and individual practitioners other than physicians, audiologists, and registered dietitians must be certified by DBHDS as either an early intervention professional, specialist, or service coordinator.

- Standard rates were established for early intervention services to be used statewide regardless of reimbursement source in order to ensure equity and parity across local systems and maximize use of available funding.
- A rate structure consistent with Part C service delivery requirements and effective practices was established. For example, rates now take into account travel costs associated with providing services (as federally required) in the child's natural environment and support routine consultation and teaming among service providers. They are also more competitive with other service delivery systems in order to facilitate recruitment and retention of providers, a concern which has been cited in previous editions of this assessment.

To address reimbursement and other issues related to implementation of the Medicaid Early Intervention Program, DMAS submitted State Plan Amendment (SPA) 09-20 Part C Early Intervention Services) to the federal Centers for Medicare and Medicaid Services (CMS), which approved the amendment on August 10, 2010. This amendment enables reimbursements for Part C services under certain Medicaid categories, such as audiology under medical services for evaluation purposes, nutrition under Medicaid's outpatient rehabilitation program, and assistive technology as durable medical equipment.

The number of approved providers has continued to grow since the program's implementation. According to the October 2010 Part C report, there were 1,165 certified early intervention professionals, specialists, and service coordinators in Virginia. This was a 22 percent increase from the 956 reported in the December 2009 DBHDS System Transformation Update.

Both the number and proportion of children receiving Part C services enrolled in the Medicaid Early Intervention Program also continue to grow. The minutes of the December 2009 meeting of the Virginia Interagency Coordinating Council (VICC) reported 2,830 children, representing approximately 40 percent of children receiving Part C services, were enrolled in the program. More recently, VICC reported that on July 1, 2010, there were 3,216 children enrolled in the program, constituting 51 percent of the 6,302 children receiving services under Part C.

In its October 2010 Part C report, DBHDS identifies the need to change 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 would account for local systems that have a higher population of children dually enrolled in Part C and those that have a higher population of children without insurance or with private insurance that reimburses at a rate lower than Medicaid's. These differences impact the amount of Part C funding each local system needs. For the current year, SFY 2011, local systems are receiving only 75 percent of their allocations. DBHDS plans to review local expenditures and data so that allocations to local programs can be adjusted in the fourth quarter of the fiscal year, April through June, 2011.

Family Cost Share: Consistent with state and federal law, families may be required to contribute to the cost of some Part C services such as specific therapies or equipment. This was formerly called the “Ability to Pay” system but has been renamed Family Cost Share. Services that are provided at no cost to the family include Child Find activities, eligibility evaluation, assessments to identify needed services and supports, service coordination (case management), the development, review, and evaluation of the Individualized Family Services Plan (IFSP), and all activities related to child and family rights and procedural safeguards.

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. 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 a family’s cost share.

Private Health Insurance: In July 1997, coverage of early intervention services up to an annual limit of \$5,000 per insured child became a required part of the Commonwealth of Virginia’s employee health insurance program (*Code of Virginia 2.2-2818*). In July 1998, that mandate was extended to Virginia-regulated accident and sickness insurance policies provided by private companies operating in the state (*Code of Virginia 38.2-3418.5*). Self-insured companies were exempted from this requirement, but some have elected to include this benefit.

The reported proportion of Part C system revenues from private insurers has changed significantly in recent years. The 2004 *Virginia Cost Study* estimated Part C revenues from private insurers to be 12.08 percent of the total, a proportion that remained stable through SFY 2006. In SFY 2007, the percentage dropped to 2.7, followed by 3.2 in SFY 2008 and 2.8 in SFY 2009. It then rose to 6.2 percent in SFY 2010. According to the Part C program, the increase for SFY 2010 was most likely due to a combination of factors related to the Part C Systems Transformation. As indicated on the revenue sources table above, local lead agencies no longer had the option to report an aggregated revenue amount in SFY 2010, and reporting was required of private providers. As a further part of Systems Transformation, DBHDS notes in the 2009 *Report on Virginia’s Part C Early Intervention System* (Budget Item 316 K.2, 2009 *Appropriations Act*) that, in SFY 2011, it will work with the Bureau of Insurance to have private insurance companies implement standard rates for Part C services.

As noted in this chapter’s Introduction, private insurance for children with autism has been a significant issue for more than ten years. The Virginia legislature has considered numerous bills to mandate coverage of certain services including, but not limited to, applied behavioral analysis, an evidence-based practice of intensive intervention advocated by many practitioners in the field. Although strongly supported by parents, many advocates, and professionals, none of these previous bills passed the General Assembly due in part to concerns expressed by the insurance industry about potential increases in the cost of insurance for

businesses and consumers. The Joint Legislative Audit and Review Commission (JLARC) was directed to look into that and other concerns, and in its response to JLARC's 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders*, DBHDS recommended further examination of the autism insurance issue. In 2011, the General Assembly passed House Bill 2467 which provides for mandated private insurance coverage for the diagnosis of an autism spectrum disorder (ASD) and treatment of ASD for children between the ages of two and six. The bill sets a maximum benefit of \$35,000 for applied behavioral analysis and includes other specific parameters, limitations, and exclusions on the mandated coverage. The Governor proposed a number of amendments to the bill after its passage, several of which the General Assembly approved during its reconvened session. The amendments include a requirement for state certification of applied behavioral analysis (ABA) providers, preauthorization of treatment, and an independent review of individual treatment plans.

F. Monitoring and Evaluation of Early Intervention Services

Previous sections of this chapter have already mentioned a number of recent efforts to improve services for infants and toddlers requiring early intervention services. This section will focus on formal monitoring and evaluation mechanism, as well as the on-going efforts to improve the system's data collection and reporting processes.

Early Head Start: Monitoring and evaluation of Virginia's Head Start programs are covered in the Education chapter of this assessment.

Part C Early Intervention: 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 providing and paying for Part C services. The **Virginia Interagency Coordinating Council (VICC)** fulfills this requirement by providing guidance on the implementation and evaluation of the statewide early intervention system, including the transition of toddlers with disabilities 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 engaged in early intervention services.

Forty **Local Interagency Coordinating Councils (LICCs)** provide advice and assistance to their respective local lead agencies and help 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, support development of service coalitions, and establish local policies and procedures in accordance with federal and state laws and regulations.

Virginia law requires the **Department of Behavioral Health and Developmental Services (DBHDS)** to monitor 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. New federal Part C regulations were expected to be finalized in August 2010 but, as of the time of this assessment, were still in process. The most recent description of Virginia's system of supervision and monitoring, including how data are gathered and verified, can be found in the *Part C State Annual Program Performance Report for FFY 2008*.

As noted in previous sections, DBHDS has made significant improvements to various components of the Part C system over the last several years. Data collection and reporting system improvements have been among the most challenging. Citing the findings of federal oversight authorities described below, both the 2006 and 2008 editions of this assessment discussed past difficulties in determining exactly how much of total Part C funding was derived from federal, state, local, and fee-based services and how those funds were expended.

In 2006, DBHDS completed an analysis of its existing early intervention data system, the **Infant and Toddler Online Tracking System (ITOTS)**, as well as its other data systems and all federal and state reporting requirements. Following this analysis, its 2007 Part C report (Budget Item 312 K.2., 2007 *Appropriations Act*) cited the following challenges to accurate fiscal reporting: (1) no systemic collection of data regarding planned service levels, (2) no systemic cost information captured, (3) no systemic delivered service information, and (4) no central listing of providers.

To address these issues, DBHDS worked with a long-time collaborator, Solutions Consulting Group, LLC, to develop a plan to improve data collection and reporting. Additional revenue and expenditure reporting elements for local lead agencies were to be phased in beginning in February 2007 and to be operational by July 1, 2009. According to a February 2008 discussion paper (www.infantva.org/documents/wkg-itots-DeliveredSvcInfo.pdf), the following were among the outcomes anticipated through the system improvements proposed by the consultants:

- Ability to accurately project costs based on “actual delivered service” information,
- Ability to monitor actual services vs. planned services in an automated manner,
- Availability of data on staff shortages, cancellation rates, no shows, enrollment, and types of services being provided,
- Existence of an automated mechanism to ensure that subcontractor billing is accurate and billed services have been delivered,
- Ability to provide accurate and comprehensive information as well as cost projections to support funding requests,
- Ability to assess volume of services and funding sources to ensure equitable distribution of funding between state agency and the local lead agencies,

- Automatic computation of Office of Special Education Programs (OSEP) indicator regarding start for time of services (which when done at all, was done manually and was very time consuming), and
- Ability to determine whether the services provided achieved the anticipated or desired outcome.

Full implementation of these improvements was postponed until SFY 2011. The October 2009 Part C report (Budget Item 316 K.2., 2009 *Appropriations Act*) lists the following reasons for the delay:

- As a result of state General Fund reductions for SFY 2009, many local lead agencies were faced with cuts in state funding for Part C. To minimize the impact of those budget reductions on direct services, DBHDS allotted additional federal Part C funds to local systems, thereby reducing funding available for data system enhancements.
- DBHDS and the Department of Medical Assistance Services (DMAS) entered into a collaborative effort to expand Medicaid reimbursements for Part C services through the new Medicaid Early Intervention Program. Additional changes to ITOTS were required to ensure collection and exchange of data between the two departments. These data enhancements were prioritized in SFY 2009 to ensure adequate funding for early intervention services.

Using federal stimulus (ARRA) funding, DBHDS resumed work in SFY 2010 on data system enhancements, design specifications were completed in SFY 2010, and plans for the new data system await administrative approval. While significant challenges remain and the future of the ITOTS system remains under review, DBHDS' October 2009 and 2010 Part C reports (Budget Items 316 K.2 and 305 H.2, 2009 and 2010 *Appropriations Acts*, respectively) identify the following data system improvements to-date:

- As previously mentioned, the revenue and expenditures reporting form now requires information on the number of children receiving each service in each quarter of the fiscal year.
- A separate revenue and expense reporting form was developed in collaboration with private providers to facilitate collection of accurate quarterly financial data.
- A data exchange agreement initiated between DBHDS and the Department of Medical Assistance Services (DMAS) will enable DMAS to report the exact amount of Medicaid funds used to support Part C services each year.

Improving the quantity and quality of service providers has also been an on-going challenge for the Part C system. In the April 2008 *Virginia Cost Study Update* by Solutions Consulting Group, reimbursement rate structures, service costs, and salaries were extensively examined. Detailed information on the process leading to the update's findings can be found in that report, and its recommendations laid the foundation for recent improvements to salary and

rate structures for Part C providers. As noted in the discussion on public health insurance above, implementation of these recommendations is producing significant positive results.

Office of Special Education Monitoring: The U.S. Department of Education Office of Special Education Programs' (OSEP) most comprehensive recent site visit to Virginia's Part C services system was conducted in 2005. That review focused on the data system, monitoring and supervision, and the complaint process. OSEP sought to determine if information collected and reported by the state is reliable, credible, and accurate, as well as to what extent it is used to make policy decisions and ensure compliance with federal regulations. Findings from this visit were reported in detail in the 2006 and 2008 editions of this assessment, as noted above, and will not be repeated here. In brief, many of the deficiencies cited by OSEP related to inadequate data collection and tracking systems, leading to an inability to ensure that data were accurate and could be verified. Significant progress, described above, has been made in this area, but there is still much work to be done.

Additional areas cited by OSEP in 2005, were the need to ensure timely compliance with corrective action plans and establishment of effective sanctions. Progress in all of these areas was noted by DBHDS in its February 2007 *Part C State Performance Plan Update* to OSEP and also covered in the 2008 edition of this assessment.

OSEP conducted its last verification visit to Virginia's Part C services system in 2009 and issued a response to the Commonwealth's submission of its FFY 2008 *Annual Program Performance Report* and revised *State Performance Plan* in June 2010. In its response letter, OSEP found that Virginia met the requirements of Part C of the *Individuals with Disabilities Education Improvement Act (IDEA)* and noted high levels of compliance in a variety of indicators, including some previously found to be noncompliant. Indicators OSEP commended were:

- Percent of infants and toddlers who receive the early intervention services in their Individualized Family Services Plans (IFSP) in a timely manner (94%, up from 89% in FFY 2007; target: 100%).
- Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or in community based settings (97%; target: 98%).
- Percent of families participating in Part C who report that these services helped the family:
 - Know their rights (70.8%, up from 66.1% in FFY 2007; target: 66.9%).
 - Effectively communicate their children's needs (67.3%, up from 62.3% in FFY 2007; target: 62.7%).
 - Help their children develop and learn (80.6%, up from 77.5% in FFY 2007; target: 78%).

- Percent of infants and toddlers with IFSPs who demonstrate improved:
 - Positive social-emotional skills (including social relationships).
 - Acquisition and use of knowledge and skills (including early language/communication).
 - Use of appropriate behaviors to meet their needs.

The last indicator listed is new and uses baseline data submitted for federal fiscal year (FFY) 2008 and accepted by OSEP. Its specifics are discussed later in this section.

OSEP noted the need to improve performance on the following indicators reported for FFY 2008:

- Percent of infants and toddlers birth to age one with IFSPs compared to national data (0.67%, down from 0.70% in FFY 2007).
- Percent of infants and toddlers birth to three with IFSPs compared to national data (1.99%, up from 1.92% in FFY2007; target: 2.1%).
- Percent of eligible infants and toddlers with IFPS for whom an evaluation and initial IFSP meeting were conducted within the required 45 day timeline (98%, unchanged from FFY 2007; OSEP required target: 100%).
- Percent of children exiting Part C who receive timely transition planning to preschool or other appropriate services by their third birthday:
 - IFSPs with transition steps and services (98%, down from 99% in FFY 2007; OSEP required target: 100%).
 - Notification to LEA if child is potentially eligible for Part B (99.7%, down from 100% in FFY 2007; OSEP required target: 100%).
 - Transition conference if child is potentially eligible for Part B (96% unchanged from FFY 2007; OSEP required target: 100%).
- General supervision system including monitoring complaints, hearings, etc. and identification and correction of noncompliance as soon as possible but no later than one year from problem identification (98%, improved from 77% in FFY 2007; OSEP required target: 100%).

More recent data from the minutes of the March 2010 Virginia Interagency Coordinating Council (VICC) show that the proportion of infants and toddlers birth to age one with IFSPs has declined further to 0.59 percent, and the proportion of infants and toddlers birth to age three with IFSPs has further increased to 2.03 percent. Neither, however, meets their targets. Further discussion related to this can be found in the Child Find section below.

Virginia's Part C system failed to meet the general supervision indicator above for three years in a row, FFY 2005 through FFY 2007, and was an area that had been found to be in need of assistance. Further discussion of this can be found in the next section on Dispute Resolution.

For these and the other areas cited for noncompliance, DBHDS has initiated a number of corrective activities. These activities are numerous and can be found in the *2005-2010 State Performance Plan's* February 2010 update at www.infantva.org.

Dispute Resolution: Unlike Part B of the *Individuals with Disabilities Education Improvement Act* (IDEA) that covers the special education system, formal complaints in the Part C early intervention system are rare. The *State Performance Plan/Annual Performance Report Response Table* included in the Office of Special Education Programs (OSEP) June 2010 verification letter to the Department of Behavioral Health and Developmental Services (DBHDS) reports that no due process hearing requests were received in federal fiscal year (FFY) 2008. In addition, fewer than ten mediations were held during that fiscal year, and the state is not required to provide targets or improvement activities until a fiscal year in which ten or more such sessions are held.

As noted in the OSEP monitoring section above, only 70.8 percent of families in FFY 2008 indicated that they knew their rights. While this was an increase from 66.1 percent in FFY 2007, it is possible that there is little use of dispute resolution mechanisms in the Part C system because a fair number of families are unaware of or do not know how to exercise their rights with respect to this system.

The 2008 edition of this assessment described plans by DBHDS to develop a dispute resolution handbook; however, the February 2010 amendment to the *2005-2010 State Performance Plan* reported that other means are being used to provide information about resolving disputes and that this activity was discontinued. Activities listed in the amended plan to improve performance with respect to dispute resolution procedures and timelines are:

- Development and implementation of a mechanism to collect data on the number of potential complaints resolved informally through the Part C Office or the Family Improvement Project to determine if there are trends to the concerns expressed by families and to document whether families were informed of their options prior to resolution. This includes a 2011 plan to explore tracking options used in other states and determine the best electronic tracking option for Virginia.
- Reviewing, with staff of the Family Involvement Project and the Virginia Interagency Coordinating Council (VICC), the results of the Parent Education Advocacy Training Center (PEATC) parent survey conducted prior to the 2009 verification visit 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.

Child Find/Children Served: Activities to identify infants and toddlers in need of early intervention services, known as Child Find, have been targeted as an area of focus for monitoring

and improvement for quite a few years. The 2006 and 2008 editions of this assessment noted the fairly significant number of local systems that were required to develop corrective action plans for this performance indicator. Since the 2008 assessment, which described improvement activities at that time, additional efforts have been undertaken, particularly towards serving a greater percentage of the birth to age one population. These are described in the Annual State Performance Plan for 2005-2010, updated in February 2010, and include, but are not limited to:

- Working with the Virginia Department of Health (VDH) and the Virginia Department of Education (VDOE) to develop the statewide VISITS database system that will link to the DBHDS Infant and Toddler Online Tracking System (ITOTS) and use unique child identifiers to automatically refer all children with hearing loss or congenital anomalies to the Part C service system.
- Working with VDH to determine the feasibility of studying outcome data on low birth weight and preterm infants who receive Part C services and contacting states with broad eligibility definitions to see how premature birth is included in those definitions. As a part of this effort, data sharing agreements are being developed by VDH, VDOE, and DBHDS to track these outcomes, and as mentioned in the Access and Delivery section of this chapter, a multidisciplinary, multi-agency workgroup has been convened to study the impact of eliminating the current policy of age adjustment for infants born prematurely and make other eligibility changes to ensure that children needing early intervention services are identified accurately and as soon as possible.
- Contacting states with broad eligibility definitions that serve a high percentage of the birth to age one population to determine their effective public awareness practices and Child Find activities.
- Exploring the feasibility of developing interagency agreements between DBHDS and regional children's hospitals to ensure timely referrals to Part C.
- Partnering with the Virginia Children with Special Health Care Needs (CSHCN) and Virginia Early Hearing Detection and Intervention (VEHDI) programs, described in the Health chapter of this assessment, to enhance procedures and practices that will increase the percentage of infants with permanent hearing loss enrolled in Part C by age six months.

Additional efforts have also been undertaken since federal fiscal year (FFY) 2008 to increase the percentage of infants and toddlers from birth to age three with Individualized Family Services Plans (IFSP). The *2005-2010 State Performance Plan* lists:

- Continuing to revise public awareness materials to ensure appropriateness for underserved populations.
- Facilitating the participation of local systems in a special screening project that involves meetings with referring physicians to discuss referral procedures, available services and supports, and communications between physicians and the local Part C system.

- Developing and implementing a mechanism to track and report specific referral sources through ITOTS.
- Revising the state interagency agreement for Part C to clarify responsibilities with respect to Child Find and referral to the Part C system, including the need to collaborate with Early Head Start and Migrant Head Start to ensure that children served through these systems who may be eligible for Part C are referred.
- Revising family financial contribution procedures to ensure that fees are not a barrier to seeking or accepting Part C services, and implementation of new Family Cost Share practices. (See the Cost and Payment section for details of Family Cost Share.)
- Placing referral information on the Infant and Toddler Connection website.
- Providing training to managed care organizations regarding services and supports available through Part C, how to make referrals, and the role of managed care case managers.
- Implementing a service pathway to ensure a consistent framework for intake, screening, eligibility determination, assessment for service planning, and IFSP development.
- Establishing a state level Child Find and public awareness workgroup focused on strategies for increasing the number served.

Planned activities also include (1) convening a focus group of primary referral sources, including physicians and hospitals, to determine what encourages or discourages referrals to Part C, what type of information would be helpful, and how referring entities would like to receive information and (2) expanding and strengthening partnerships at the state and local level to improve coordination and collaboration for Child Find and public awareness activities.

Medicaid Program Reviews: Implementation of the new Medicaid Early Intervention Program has required additional monitoring. Compliance reviews must be conducted to ensure that services are appropriate, obtained from appropriate providers, and medically necessary, a requirement for Medicaid reimbursement. Quality Management Reviews (QMRs) are conducted by the Department of Medical Assistance Services (DMAS). They include the following components detailed in a joint DMAS/DBHDS Training Presentation on Early Intervention Services:

- Continuing review and evaluation of Medicaid funded care and services,
- Providing technical assistance as needed, and
- Determining whether a compliance review may be necessary.

QMRs can take the form of “desk audits” requiring only access to billing and other records or they may include announced or unannounced onsite visits requiring access to records and facilities. Their activities can include, but are not limited to, observation of service delivery, review of monitoring and supervision activities, and interviews with the child, family, or others. Reviewers look at eligibility determinations, medical necessity, delivered vs. planned and billed

services, delivery of services in natural environments, and appeal rights. Review findings are provided to the audited entity along with recommendations, requirements and timelines for corrective actions, and any additional documentation needs.

Family Survey: As part of federally required monitoring procedures, the state lead agency conducts an annual survey to address the Office of Special Education (OSEP) Indicator #4A-C, the percent of families participating in Part C who report that services have helped the family (1) know their rights, (2) effectively communicate their child's needs, and (3) help their children develop and learn. Each year, families who received early intervention services during the month of May are surveyed, and a random sample of those responding to the survey, which reflects the race/ethnicity of the total population served, is selected for analysis.

In 2008, surveys were returned by 1,883 families, and 1,280 of those responses were selected for analysis. The percentage who responded favorably to each question, the target percentages, and comparable data for 2007 were reported earlier in this section under OSEP Monitoring. For 2009, responses were received from 1,957 families, of which 1,201 were analyzed. The amounts by which favorable responses exceeded their targets showed a small increase from 2008 to 2009 of four percentage points for #4A, knowing their rights; five percentage points for #4B, effectively communicating their child's needs; and two percentage points for #4C, helping their child develop and learn. For families receiving Part C services, this denotes a small increase in positive outcomes in these three areas.

Target percentages remained unchanged from 2009 for 2010, when 1,911 families returned surveys and 1,188 were used to compute the OSEP Indicators. Favorable responses again slightly exceeded their targets by two percentage points for #4A, three percentage points for #4B, and a half percentage point for #4C. Complete information, including methodological considerations, is provided in each year's *Analysis of the Family Survey Data Addressing Part C SPP/APR Indicator #4: Final Report* at www.infantva.org/sup-FamilySurvey.htm.

System for Determination of Child Progress: Effective March 2006, Virginia implemented the federally required System for Determination of Child Progress. All children new to early intervention services with an Individualized Family Services Plan (IFSP), beginning on or after March 1, 2007, are included in the system. The child's IFSP team rates the child's status on three indicators using a seven-point scale upon entry into the system and again upon exit. The three indicators are:

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

Aggregated progress data for all children who exit the system during the reporting timeframe are reported annually to the Office of Special Education Programs (OSEP) in the *Part*

C State Annual Performance Report. For each indicator, the report notes the percentage of the total number of enrolled infants and toddlers who:

- Did not improve functioning,
- Improved functioning but not sufficient to move nearer to functioning comparable to same-age peers,
- Improved functioning to a level nearer to same-age peers but did not reach it,
- Improved functioning to reach a level comparable to same-age peers, or
- Maintained functioning at a level comparable to same-age peers.

The 2008 edition of this assessment reported that performance would be measured against data collected during state fiscal year (SFY) 2008 (July 1, 2007 through June 30, 2008); however, baseline data was gathered instead for children who exited the system during SFY 2009 (July 1, 2008 through June 30, 2009) for whom there was both entry and exit data and who had participated in the Part C system for at least six months. That baseline data can be found in the *Part C State Performance Plan for 2005-2010* as amended in February 2010 at www.infantva.org/documents/ovw-OSEP-PartC-SPP-2007amend2010Feb.pdf. Comparison data are not yet available.

Efforts to improve the Part C early intervention system continue. Ongoing technical assistance is being provided to local systems managers, including a series of five online training modules, available on the Infant and Toddler Connection website, that were developed to ensure consistent training of new providers and existing providers who are new to the system. In addition, a resource manual, *Determining the Status of Infant and Toddler Development in Relation to the Three OSEP Outcomes*, was developed. The Department of Behavioral Health and Developmental Services (DBHDS) notes in the February 2010 amendment to the Part C State Performance Plan for 2005-2010 that this information will be used not only to assess child outcomes, but also to guide service delivery as well as local and state system improvements.

G. Early Intervention Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Head Start

<http://eclkc.ohs.acf.hhs.gov/hslc/About%20Head%20Start>

<http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Head%20Start%20Program%20Factsheets>

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

Virginia Department of Behavioral Health and Developmental Services:

www.dbhds.virginia.gov

Infant and Toddler Connection of Virginia

www.infantva.org

www.infantva.org/ovw-DeterminationChildProgress.htm

www.infantva.org/ovw-PoliciesProcedures.htm

www.infantva.org/ovw-Transformation.htm#PersDev

www.infantva.org/pr-PartCUpdates.htm

www.infantva.org/SupervisionMonitoring.htm

www.infantva.org/wkg-ITC.htm

Virginia Department of Medical Assistance Services

www.dmas.virginia.gov

Virginia Department of Social Services

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