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# **Birth to Three Years Study Report 95-14**

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Reporting directly to the legislature, the LBC generally meets on a monthly basis during the interim between legislative sessions.

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The Technical Appendices are available upon request at the Washington State Institute for Public Policy, (360) 866-6000, Extension 6380.

# **BIRTH TO THREE YEARS STUDY**

## **Executive Summary**

This study identifies baseline data necessary for the legislature to: 1) understand the scope of current programs with significant public funding for infants and toddlers with disabilities, and 2) examine the commitment that the state made in accepting federal requirements for early intervention programs under Part H of the federal Individuals with Disabilities and Education Act (IDEA) as of October 1994.

This study concludes that continued participation in Part H at this time is in the state's interest. However, decisions about participation in future biennia should include legislative review as the future fiscal impact of the program on the state is unknown, and program benefits have not been assessed in-depth. While some lack of fiscal and programmatic information can be expected during the first year of implementation, there are also past and current problems with interagency coordination that raise concerns. A legislative evaluation of the program is recommended within five years to address fiscal and programmatic issues and to assess outcomes. To address the coordination issue, the report recommends that joint rules be drafted for agencies participating in Part H.

The Birth to Three Years study was jointly conducted by WSIPP and LBC staff as a follow-up to studies on special education completed in 1994. In those studies, preschool children ages birth to six were identified as one of the fastest growing groups of children receiving special education services.

## **The State's Part H Commitment**

Amendments to IDEA passed in 1986 give states the option of accepting the early intervention requirements outlined in Part H in exchange for incentive grants to be used for planning and implementation. The purpose of Part H is to provide the umbrella or the linkages needed between existing programs for infants and toddlers to ensure that comprehensive services are available throughout each state. Part H requires states to set up a coordinated, family-centered, statewide system that includes a minimum of 18 system components<sup>1</sup> and requires states to make a comprehensive list of 17 services available to all eligible infants and toddlers with disabilities and their families.<sup>2</sup> In October 1994, after extensive planning, Washington began full implementation of Part H. The Department of Social and Health Services (DSHS) was designated the lead

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<sup>1</sup> Examples of the 18 components include a definition of developmentally delayed, a public awareness program for early intervention, assignment of fiscal responsibility, and a dispute resolution process.

<sup>2</sup> Examples of the 17 services include speech therapy, family counseling, service coordination, and transportation.

agency by Executive Order but administers Part H in partnership with four other state agencies.<sup>3</sup>

We conclude that continued participation in Part H of IDEA, at this time, would be in the interest of the state for the following reasons: 1) while research is limited, there is evidence that early intervention can have positive impacts; 2) withdrawing from the program would mean that birth to three programs would continue to exist but without detailed requirements for coordination or federal financial support through Part H; and 3) although implementation has just begun, some benefits of the program have been observed.

## **General Program Description**

The state of Washington funds a variety of programs in multiple agencies that support early intervention services for children with disabilities from birth to age three.

- Public expenditures in Fiscal Year 1995 for birth to three related programs were approximately \$21 million. Fifteen million dollars were state funds, of which \$12 million were state special education funds to local school districts. An additional \$3.5 million were federal Part H money. There is also a significant but unknown amount of private funding coming from various sources, such as insurance and fundraising.
- Approximately 4,200 children with disabilities are receiving early intervention services through school districts, developmental disability centers, neurodevelopmental centers, and from local public health agencies.<sup>4</sup> Services are based on the needs of the children and their families and may include individual therapies, special instruction, family counseling, or some nursing services.
- Based on an analysis of a limited sample of public and nonprofit service providers, annual average operating costs for providers ranged from \$4,500 to \$9,200 per child depending upon the range of services available in each location.
- While we do not expect large increases next biennium in the number of children being served, state funds are the only source of entitlement funding for these services. Therefore, more children may be served at state expense in the future.

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<sup>3</sup> These include: the Office of the Superintendent of Public Instruction (OSPI), the Department of Health (DOH), the Department of Community, Trade and Economic Development (DCTED), and the Department of Services for the Blind (DSB).

<sup>4</sup> This figure was identified by the Office of Research and Data Analysis in a study conducted for the Infant and Toddler Program in DSHS. Children with disabilities are defined as those eligible for Part H under IDEA.



## **Implementation Challenges**

During this first year of implementation of Part H requirements, we found problems with state-level coordination for birth to three programs required by both federal law under Part H of IDEA and by state law (RCW 70.195). Difficulties in state level coordination appear to be hindering the ability of local communities to implement the state's policy for early intervention.

We found that problems with coordination and consistency have meant: 1) a lack of direction for school districts regarding Part H participation, 2) unresolved differences in eligibility for early intervention programs and the continuation of complex funding sources, 3) some duplication in monitoring requirements and child assessments, and 4) a lack of accountability for some Part H requirements.

We also found that outcomes, which will measure the state's progress in meeting the goals of Part H and will gauge the effectiveness of the state's Part H program, need to be developed. These outcome measures are necessary to allow for future evaluation of the program and to provide information for legislative decisions regarding early intervention programs and funding.

As a result of the coordination problems and the questions related to the future of the program, three recommendations are made: 1) to draft a joint set of rules for participating agencies; 2) to examine the possibility of integrating early intervention funding sources; and 3) for the program to develop performance measures to be used in a future legislative evaluation of the program.

## **Agency Response**

The responses from the five agencies participating in Part H appears at the end of this report. The agencies generally concur with all three recommendations, but cite two concerns.

The first is that legislation may be required under Recommendation 1 which charges the agencies with drafting joint rules. The agencies propose to evaluate the legal issues involved, and introduce legislation in the 1996 session, if necessary.

The second concern is that the timelines to develop performance measures and to begin trading data is too short. The agencies prefer a completion date of October 1996, to coincide with the federal fiscal year. The study team finds this date reasonable, and has revised the recommendation so that the new date is reflected in the proposed final report.

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***On November 8, 1995, this report was approved by the Legislative Budget Committee and its distribution authorized. On November 29, 1995, this report was distributed to the Board of the Washington Institute for Public Policy.***

## **Summary of Recommendations**

### ***Recommendation 1***

The five participating state agencies: Department of Social and Health Services, Office of the Superintendent of Public Instruction, Department of Health, Department of Services for the Blind, and Department of Community, Trade and Economic Development should draft a common set of rules by September 1996 that will define agency and provider roles and responsibilities under Part H to improve consistency and clarity of birth to three early intervention services. The Department of Social and Health Services should take the lead in this effort.

|                       |                |
|-----------------------|----------------|
| Legislation Required: | None           |
| Fiscal Impact:        | None           |
| Completion Date:      | September 1996 |

### ***Recommendation 2***

The State Interagency Coordinating Council for Part H should examine the possibility of integrating some or all of the funding sources currently used to support services for infants and toddlers with disabilities and report back to the fiscal committees by September 1996.

|                       |                |
|-----------------------|----------------|
| Legislation Required: | None           |
| Fiscal Impact:        | None           |
| Completion Date:      | September 1996 |

### ***Recommendation 3***

The legislature should conduct an evaluation of the Part H program within five years. The Department of Social and Health Services and the State Interagency Coordinating Council should develop outcome measures for the Part H program by October 1996, and begin tracking the necessary data to document these measures.

|                       |              |
|-----------------------|--------------|
| Legislation Required: | None         |
| Fiscal Impact:        | None         |
| Completion Date:      | October 1996 |

# **I. BACKGROUND**

## **A. Scope of Study**

In December 1994, the Washington State Institute for Public Policy (WSIPP) and the Legislative Budget Committee (LBC) completed two special education studies: one reviewed the funding formula and another examined student outcomes. In these studies, preschool children ages birth to six were identified as one of the fastest growing groups of children receiving special education services.

This study examines the providers, funding, and services for children from birth to age three in detail. Specifically, the study focuses on state supported programs for infants and toddlers with disabilities<sup>1</sup> who receive services under Part H of the Individuals with Disabilities Education Act (IDEA). Washington State has been in full implementation of the federal requirements for Part H since October 1994.

## **B. Research Questions**

At the beginning of this study, it was apparent that some of the descriptive data on early intervention programs and the children served was not available. Therefore, the initial objective was to gather the necessary data which would serve as a baseline of current birth to three services. The next objective was to review how the state is approaching Part H implementation.

The research questions addressed in this study are as follows:

### **1. Scope of Part H Program:**

- What are the current programs/services available for infants and toddlers with disabilities? How do they differ from what is required by Part H?
- Who are the infants and toddlers now served? Who are the infants and toddlers who are potentially eligible?
- Who are the service providers?

### **2. Funding of Part H Program:**

- What are the funding sources and program costs now?
- What are the likely future funding patterns and program costs?

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<sup>1</sup> Disabilities, as defined under Part H, include physical, communication, cognitive, social/emotional, or adaptive developmental delays or disabilities or a physical or mental condition which has a high probability of resulting in developmental delay. States can set their own eligibility criteria within the federal definition of disabilities.

- Is there any difference in services offered, revenue sources, or costs among service providers?
  -
3. Effectiveness of Part H Program:
- Is access to services for children with disabilities limited or restricted by funding, regional availability, or public awareness?
  - What is known about the efficacy and benefits of services?
  - What issues should be addressed with regard to Part H implementation?

## **C. Methods and Data Sources**

WSIPP and LBC staff obtained data on infants and toddlers with disabilities and interviewed staff at the following agencies: the Department of Social and Health Services' (DSHS) Infant Toddler Early Intervention Program, Medical Assistance Program, and Developmental Disabilities (DD) Program; the Office of the Superintendent of Public Instruction's (OSPI) Special Education Program; and the Department of Health's (DOH) Community and Family Health Program. The study team also conducted field interviews and collected cost data from local service providers in five counties representing a cross section of the state: King, Snohomish, Grays Harbor, Spokane, and Benton. OSPI Chapter 1 of Elementary and Secondary Education Act transition forms were used to develop a profile of children who are exiting the program. Headcount data was obtained from OSPI and the Office of Research and Data Analysis (ORDA) in DSHS analyzed trends. A literature review on the efficacy of early intervention (see Technical Appendix) was prepared by the study team and was critiqued by faculty from the University of Washington, Washington State University, and the University of North Carolina. A survey of other states' implementation of Part H (see Technical Appendix) was also conducted by the study team.

## **D. Outline of Report**

Section II presents a description of Part H and a review of Washington State's history of serving infants and toddlers with disabilities. Section III presents a description of the children being served, the programs involved, program costs, and future projections. Section IV describes the benefits and challenges that were observed with Part H implementation and recommendations are made for improvement.

**An extensive Technical Appendix that provides detailed information and support for points discussed in this document is available upon request.**

## **II. LEGAL AND ORGANIZATIONAL FRAMEWORK**

### **A. Part H: History and Focus**

In 1986, Public Law 99-457, Individuals with Disabilities Education Act (IDEA) was amended.<sup>2</sup> One of the amendments was Part H which provided for grants to states to implement a statewide system of coordinated, multidisciplinary, and comprehensive services for infants and toddlers with disabilities (birth to age three) and their families. Grants are initially available for planning purposes and then available to enhance, but not supplement, state and local services. Part H is an entitlement program; however, requirements are not mandatory unless a state chooses to accept Part H funding from the federal government. The program is administered by the U.S. Department of Education.

Part H of IDEA emphasizes that the family has an important role in the development of their child with disabilities. It also recognizes that needs vary among children with disabilities and their families, often cutting across traditional service sectors. Part H of IDEA has 18 system components that must be included in the development of a statewide system. Some examples of the required components are:

- A timetable for ensuring that services will be available to all eligible children.
- A comprehensive and multidisciplinary evaluation of the child with disabilities and the needs of the family to assist the child; this is formalized in a written individual family service plan (IFSP).
- A comprehensive childfind system to locate, screen, and refer Part H eligible children and their families.
- A single line of responsibility in a lead agency to administer the program, coordinate resources, assign financial responsibility, provide for timely resolution of disputes, and develop interagency agreements.
- A system for compiling data on the numbers of infants and toddlers with disabilities requiring services, receiving services, and the types of services provided.

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<sup>2</sup> IDEA was formerly entitled the Education of the Handicapped Act. The new name was adopted by Congress in 1991.

There are also 17 direct services required to be available and accessible in the community to meet the needs of eligible children and their families. These 17 services required by Part H are:

- Early identification, evaluation and assessment
- Assistive technology devices and services (e.g., equipment or products used to increase, maintain or improve functional capabilities, such as computers)
- Audiology
- Family training, counseling, and home visits
- Health services (necessary to enable a child to benefit from other early intervention services)
- Medical services for diagnosis or evaluation
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Service coordination
- Social work services
- Special instruction (designing learning environments and activities, providing families with information, planning curriculum)
- Speech/language services
- Transportation
- Vision (assessing visual function, orientation and mobility training, assisting with related communication)

Note: Required services do not include interventions such as surgery or well-baby care.

## **B. Washington's History with Part H**

For over 20 years, Washington State has permitted public and nonprofit agencies to serve infants and toddlers using state funds from special education, developmental disabilities and children with special health care needs. Public schools, Developmental Disability (DD) centers, local public health agencies, and neurodevelopmental centers have been major service providers that receive public funding. However, hospitals, private therapists, pediatricians, and other

providers are active participants in providing early intervention services in our state.

Washington State began to accept federal grant money in 1986 to plan for the comprehensive, family focused, statewide system envisioned by Part H. During the first three years, planning efforts concentrated on coordinating services at the state and local level. A State Interagency Coordinating Council (State ICC) had primary responsibility to advise and assist the planning efforts at the state level. County Interagency Coordinating Councils (County ICCs) were developed and supported in each county to facilitate the coordination of local services. Additional activities included public awareness materials and pilot projects to address service problems.

Highlights of the second three years of planning included: funding interim family resource coordinators to assist families in accessing services and resources for their child and family, development of procedural guidelines and a self assessment tool to assist providers with direct services, creation of a central directory, and implementation of a 1-800 number for families and service providers to access information.

In October 1994, Washington State moved into its first year of implementation of the Part H program after the seven years of planning.<sup>3</sup> Under full implementation, a statewide system is required to be in place (which includes the 18 components referenced earlier) and comprehensive early intervention services (the list of 17 services referenced earlier) should be available to all eligible children.

### ***Legislative Involvement***

While there were legislative bills in the early 1990s which sought to mandate birth to three services, they did not pass. In 1992, however, the legislature passed a law requiring state coordination of services and payment of early intervention services. The law also placed into state statute the requirement for a State ICC consisting of parents, providers, local representatives, legislators, state agencies, and others as appropriate (RCW 70.195).

Aside from the 1992 legislation, legislative involvement has been indirect. Permissive language continues to exist allowing state funds to be used to serve children with disabilities from birth to age three.

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<sup>3</sup> All states have agreed to implement Part H.

## ***Executive Order 92-10***

The Governor has designated DSHS as the lead agency since 1986. An Executive Order in 1992 confirmed the designation, and aligned the state requirements for the State ICC with the federal regulations.

### ***Part H Administration***

The Infant Toddler Early Intervention Program (formerly the Birth to Six Planning Project) within the Division of Developmental Disabilities at DSHS is responsible for overseeing implementation of Part H. The state's Part H plan includes an interagency agreement which states that Part H must be implemented in partnership with five participating agencies.<sup>4</sup>

Part H is not supposed to be a new program. It is to enhance local early intervention programs that currently exist and ensure family-centered, coordinated services. To fulfill this commitment, the state is working with County ICCs that have representation from providers, parents, and state and local agencies. County ICCs are to work with existing services and providers to coordinate existing services and identify areas where new services or funding are needed.

The next section of this report describes the children being served, the providers involved, and the cost of programs. A discussion of Part H implementation issues and recommendations are included in Section IV of this report.

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<sup>4</sup> These are: Department of Social and Health Services (DSHS), Department of Health (DOH), Department of Community, Trade and Economic Development (DCTED), Department of Services for the Blind (DSB), Office of the Superintendent of Public Instruction (OSPI).



### **III. PROGRAM DETAIL AND TRENDS**

#### **A. Number of Children Served**

The exact number of children currently eligible under Part H criteria and receiving early intervention services is not known, but an estimate has been calculated. A study commissioned by the State ICC and conducted by the Office of Research and Data Analysis (ORDA) in DSHS collected data on children with disabilities who were served by birth to three programs offered through OSPI, DSHS, and DOH in May of 1995. ORDA estimated that approximately 4,200 children eligible for Part H services are currently enrolled in a service program with one or more of the three agencies.<sup>5</sup> These figures represent 1.8 percent of the total population from birth to age three in Washington State.

Two more unduplicated counts of children receiving services from multiple programs are planned for fiscal year 1996 in order to assess trends. In the future, additional data on this population, such as number of children referred for service versus the number found eligible, will be available due to Part H reporting requirements.

#### **B. Examples of Clients and Services**

A wide variety of disabilities are addressed in birth to three programs. There are many ways in which services are combined depending on the family's needs and desires. Below are three hypothetical case studies provided to explain birth to three services:

**Sara** is developmentally delayed in two areas: cognitive skills and communication. At age two, she cannot use words to express herself and shows little understanding of language. She receives special instruction and speech therapy at a developmental disabilities center. Her mother also participates in sessions in order to learn how to stimulate her daughter's recognition of objects with hand signals and sounds.

**Linda** is a 12-month-old who has a form of cerebral palsy. Her parents have little money and English is not their primary language. She receives physical therapy services and nutritional counseling from a neurodevelopmental center. When she is older, she will also receive special education instruction. A social worker with the center has arranged for transportation to and from the center and a translator to work with the parents.

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<sup>5</sup> A child can be receiving services from more than one provider. For example, a child may be getting special instruction through a school district but nursing services from a public health nurse. The 4,200 figure is an unduplicated count where children are not double counted.

**Jamie** is a two-year-old boy who was diagnosed at birth with hydrocephalus (fluid in the cranium). Because of his fragile health and numerous doctor and therapy appointments, his single mother works part-time. An infant educator from the local school district helps his family find and coordinate the services they need and provides services to him at both his home and daycare to help him develop thinking and problem solving skills as well as sign language. In addition, his mother transports him once a week to a nearby town for physical and speech therapy that is funded by medical coupons. A public health nurse monitors his weight at home monthly, and an occupational therapist works with Jamie and the staff at his daycare weekly to stimulate use of his impaired left side.

The study team also conducted a review of OSPI data on 475 children who were leaving a developmental or neurodevelopmental center. Most of the children were transitioning into school district programs at age three.<sup>6</sup> A profile was obtained on the number and types of disabilities or delays the children had and the types of services they had received. A variety of disabilities requiring multidisciplinary treatment were found.

The data showed that with a few exceptions, infants and toddlers by age 3 had similar disabilities as found for students ages 3 to 21 years in the 1994 special education fiscal study. Among children just turning 3 years, there were higher numbers of orthopedic, hearing, and vision impairments than reported in the ages 3 to 21 special education population.<sup>7</sup>

### **C. Providers and Program Costs**

As of May 1995, children with disabilities under the age of three were receiving services from a variety of public and private providers, including: 165 school districts,<sup>8</sup> 28 DD centers, 7 neurodevelopmental centers, and 7 combined neurodevelopmental/DD centers. Individualized services are also offered by private providers (e.g., pediatricians or therapists), and the local health departments. These options may be preferred if a child has insurance, needs only limited service, or has limited access to services. Some school districts contract with DD centers and neurodevelopmental centers to provide services for their infants and toddlers instead of offering direct services themselves.

According to providers, children served by school districts, DD centers, and neurodevelopmental centers have similar kinds of disabilities. However, children at neurodevelopmental centers may also have more medical needs.

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<sup>6</sup> Under IDEA Part B, school districts are responsible for providing special education once a child turns three.

<sup>7</sup> See the Technical Appendix for more detail on conditions found and services received.

<sup>8</sup> Two of the largest school districts, Seattle and Spokane, do not participate in infant/toddler programs; Tacoma provides direct services for a limited group of children who are deaf or visually-impaired.

Traditionally, early intervention in school districts has been organized on an educational model, developmental centers on a developmental model, and neurodevelopmental centers on a medical model. The study team found, however, that exceptions to this framework are common, such as school programs serving family as well as child needs, and neurodevelopmental centers operating social service programs.

Regardless of the model used, the number of Part H services available appears to differ between the service environments. School districts primarily offer special instruction or educational services, some therapy (speech or occupational), and assessment of the child. DD centers usually include more social work and family therapy. Neurodevelopmental centers may offer medical services, nutrition counseling, physical therapy, and assistive technology in addition to the other services. Providing a variety of settings is consistent with Part H. However, if a child attending a center also needs specialized therapy that is unavailable in that setting, the local family resource coordinator is responsible for finding a means for the child to receive additional therapy elsewhere.

Not surprisingly, costs vary by category of provider in a manner consistent with how many services are available in each environment.<sup>9</sup> The figure below shows the results of our analysis with a limited sample of 11 providers.

**Figure 1**

**Part H Services and Operating Costs by Type of Provider**

| Type of Provider                      | Number of Part H Services Offered (17 possible) | Average Cost per Year per Child* |
|---------------------------------------|-------------------------------------------------|----------------------------------|
| School Districts** (serving in-house) | 3-6                                             | \$4,543                          |
| Developmental Centers                 | 4-8                                             | \$6,361                          |
| Neurodevelopmental Centers            | 13-14                                           | \$9,215                          |

\* Some costs for services outside of Part H may be included in these figures.

\*\* School districts that had very small enrollments (fewer than 14) and were serving children in-house were not included in this sample because of their high costs.

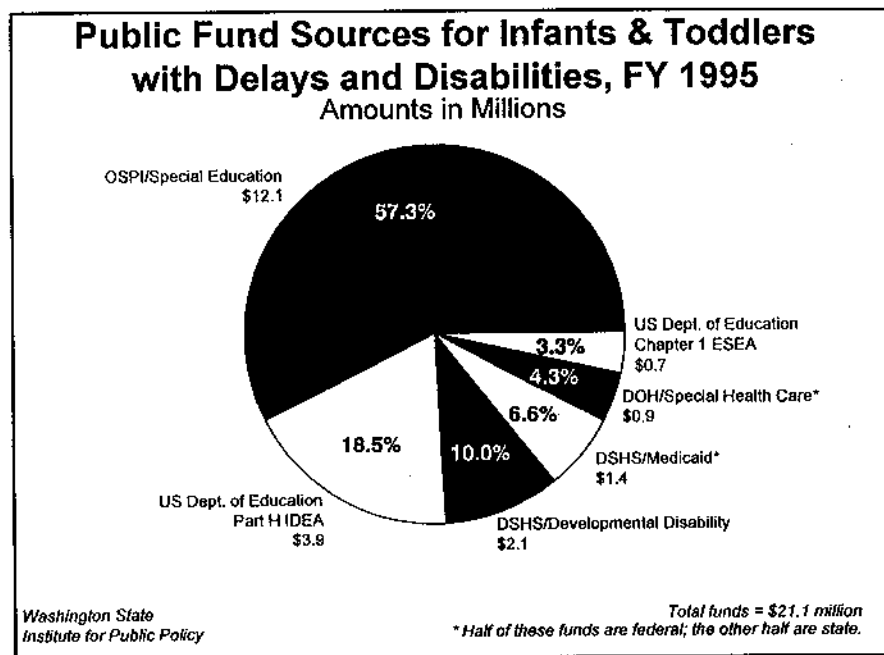
<sup>9</sup> Other explanations were also examined for the cost variation among providers, including size of program, salaries, and amount of therapy. But the relationships between these factors and cost were not strong.

Children in school districts that contract for services with either a developmental center or a neurodevelopmental center have access to the range of services associated with each center. Costs for contracting districts, however, are lower than full program costs since they pay only for educationally related services. According to our sample, in school year 1994 -1995, districts paid centers an average of \$4,200 per child and incurred approximately \$1,500 in additional costs per child, e.g., for contract monitoring or participating in assessments.

## D. Funding Sources

Approximately \$21 million in public funds was available for early intervention services for infants and toddlers in Fiscal Year 1995. While there are six main streams of public funds, state special education funding is the largest. State resources made up 72 percent of these public funds.

Figure 2



The degree to which each type of provider uses state funding varies considerably. For example, state special education funds represents 91 percent of total revenue for school district birth to three programs while state funds account for under 25 percent of total revenue for neurodevelopmental centers. The figure on the next page identifies the average cost to the state for a child in each program and was developed using data from sample providers.

**Figure 3**

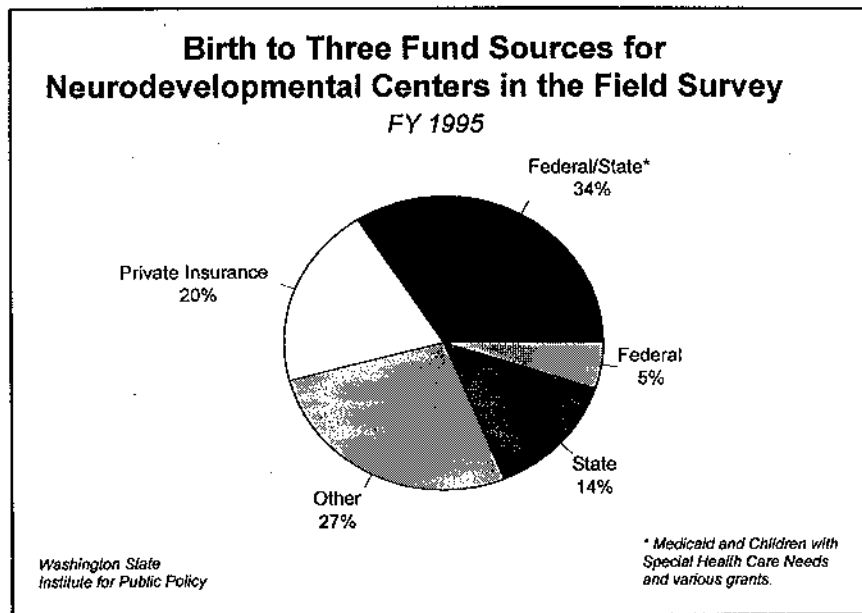
**State Share of Annual Cost, FY 1995**

| Type of Provider                    | Average Annual Cost per Client | State Percent of Provider Revenue | Average Annual State Share |
|-------------------------------------|--------------------------------|-----------------------------------|----------------------------|
| School Districts (serving in-house) | \$4,543                        | 91%                               | \$4,134                    |
| Developmental Centers               | \$6,361                        | 74%                               | \$4,708                    |
| Neurodevelopmental Centers          | \$9,215                        | 24%                               | \$2,212                    |

If a school district (or school or ESD cooperative) is providing birth to three services, the major funding source is state special education funds. Neurodevelopmental and DD centers, on the other hand, leverage both public and private funding sources. Their major *public* fund source is often state DD funds that are distributed at the county level based upon local priorities. If the neurodevelopmental or DD center contracts with a school district, they can also receive special education funds. Last year, school districts paid the contracting centers an average of \$4,200 of the district allocation of \$6,300 per child under age three.

Both neurodevelopmental centers and DD centers depend on leveraging money from multiple sources; something school districts traditionally do not do. School districts can not bill parents and generally do not bill private insurance for services. Neurodevelopmental centers and DD centers usually bill Medicaid and private insurance, conduct major fund raising efforts, and charge some sliding-scale fee to parents. The neurodevelopmental centers also obtain federal funds through DOH and receive special public and private grants. Figure 4 on the next page shows revenue sources for a sample of neurodevelopmental center programs.

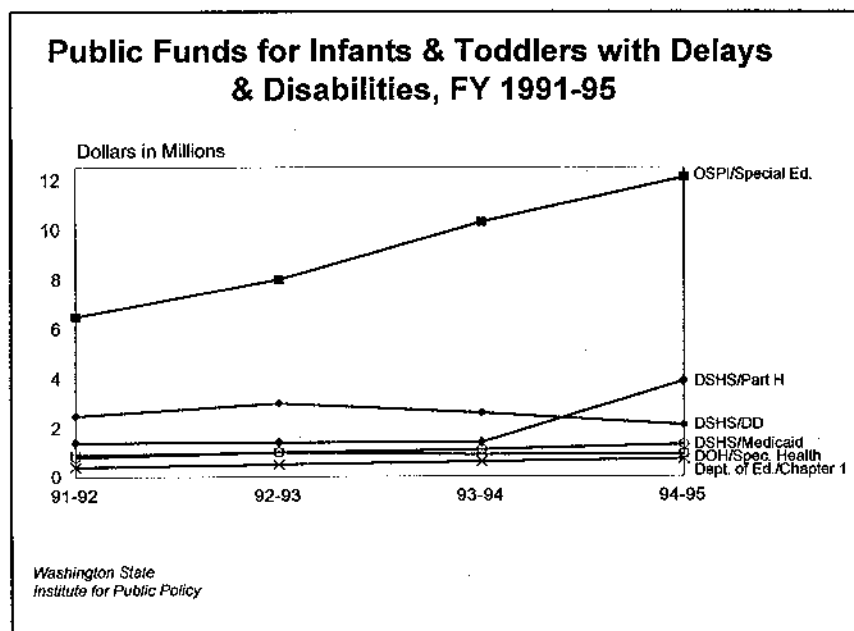
**Figure 4**



## E. Trends in Public Funding Sources

Of the six major public funding sources for early intervention, only two have been increasing--state special education funds and federal Part H funds. The figure below shows the amount of public funds expended over the last four years.<sup>10</sup>

**Figure 5**



<sup>10</sup> There are other, smaller public funding sources, such as Indian Health Services or Washington Migrant Council, that are not included in the graph.

## ***State Special Education Funds***

State special education funds (which support school district programs) have increased the most in terms of actual dollars, almost doubling the amount expended a few years ago. The reason for the increase in these funds is that the number of infants and toddlers reported by districts has increased, thereby generating more funding through the special education formula. This increase in reported children is due in part to more districts serving children under age three. According to the Infant Toddler Early Intervention Program, 23 percent of school districts reported children under age three in school year 1991-1992, with the number growing to 55 percent of districts by school year 1994-1995.

Projections for total special education funds allocated for birth to three programs is expected to drop next year due to changes in the funding formula. The special education funding formula provided approximately \$6,300 per child in the 1994-95 school year for all children ages birth through age five. During the 1995 session, the legislature created a new funding formula for all children ages birth to three. An average of \$3,916 per child will be provided for infants and toddlers beginning in school year 1995-1996.

### ***Part H Funding***

Part H funding has been growing due to increased federal appropriations. This is expected to continue next federal fiscal year with \$4.7 million committed for Washington State by the federal government. Next year, Part H funds are budgeted to support program administration, training, coordination and oversight (27 percent), and direct services (73 percent). Most of the direct service money spent in the first year of implementation paid for Family Resource Coordinators who assist families with determining their needs and with finding services. Part H funds are not to be used until all other funding sources have been tried; they cannot supplant existing resources.

## **F. Future Program Size**

As previously discussed, data recently collected by ORDA on birth to three programs suggests that about 1.8 percent of the total birth to three population is eligible for Part H and receiving services. However, providers and program planners differ in their judgment as to whether the proportion of children accessing services will increase as Part H is implemented.

### ***The Total Eligible Population***

For planning purposes, the Infant Toddler Early Intervention Program at DSHS assumes that 2.5 percent of the population from birth to age three may be

eligible for services under Part H.<sup>11</sup> If this incidence rate of 2.5 percent is accurate, that means that an additional 1,200 children may be eligible for Part H services currently, but are not clients of the larger publicly supported programs. These children could be receiving private services or no services.

Although an estimate of 1,200 additional children may be eligible for publicly supported services, available data tends to support a conclusion that the program is unlikely to grow quickly. This statement is based on the following:

- We identified 11 states with eligibility criteria similar to Washington's. In each of these states, *actual* service rates fall significantly below their planning rates. Nearly two-thirds of the 11 states were serving 1.6 percent or less of their birth to three population, even though three states have had state mandates to serve the birth to three population for ten years.<sup>12</sup>
- We analyzed the enrollment data for school districts with over ten years of providing services to infants and toddlers, and also with reputations for active childfind programs. We found that the ratio of their birth to three population to their three to five population was, on average, twice as high as other districts that offer birth to three services. Using this ratio, we projected the potential for school district enrollment statewide. The result of this hypothetical scenario was that still no more than 2 percent of the birth to three population would be receiving service from public providers.
- Significant growth has occurred over the last four years in school district enrollment. Some children reported by school districts may have already received early intervention services elsewhere, such as a DD center. In these instances, the environment and funding source for the child changed, but this type of shift is not program growth. Thus, we do not know if these children were really new enrollees for early intervention, or just changed providers. Due to a lack of data prior to 1995, the number of new children cannot be separated from those changing providers.

### ***Implications for State Funds***

Increased demand for state funds could occur if large numbers of children who were not previously doing so seek publicly supported services. The discussion above on total eligible population concludes that a large number of new children entering the system is not likely. However, a shift in where children receive services is possible. If the shift is into school district programs that are

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<sup>11</sup> According our survey of 11 states with comparable eligibility criteria, Washington's 2.5 percent planning rate is average.

<sup>12</sup> For more information on Part H in other states, see the Technical Appendix.



significantly funded by the state, such as school districts, there will be an impact on state costs.

For example, according to data collected by ORDA, roughly two-thirds of children currently enrolled in a service plan are clients of DOH. DOH may be shifting its mission away from direct service due to implementation of the Public Health Improvement Plan. Where their clients will seek future services is unknown. Furthermore, as the funding data from OSPI suggests, an increasing number of children are being served through school districts at state cost. Aside from Medicaid, state special education funding is the only entitlement funding available for birth to three services.

While additional growth in school district enrollments of infants and toddlers is possible and would increase the demand for state revenues, the impact of this growth has been diminished by recent legislative actions. Specifically, the legislature lowered the allocation to school districts for children under age three by one-third, which will reduce the total amount of funding apportioned for district birth to three programs. This reduction in the special education allocation may also slow the trend of school districts voluntarily serving infants and toddlers.

## **IV. IMPLEMENTATION OF PART H**

Washington State is in its first year of Part H implementation. The mandate of Part H is to make comprehensive early intervention services accessible to all eligible children under age three. But there are still important implementation questions that no one can fully answer, such as, what are the cost implications in future biennia? And what measurable benefits can be expected? According to the program, Washington chose to participate in Part H because of a belief that reaching out to young children and their families can help enhance their capabilities to address and work within the challenges of their disabilities. The state could also decide not to participate at any time.

As a result of this review, the study team identified some benefits of participating in Part H (or a similar program) and some significant problems with implementation. The study also identified that there are state-level coordination problems which frustrate local efforts to meet Part H goals and which may ultimately jeopardize full implementation.

This section discusses: 1) findings on what is known about the impact of early intervention for children with disabilities under the age of three, 2) the potential impact on Washington if the state withdrew from Part H, 3) benefits observed from the Part H program, and 4) the challenges that continue with implementation. Three recommendations appear in the conclusion.

### **A. Impact of Early Intervention**

Most children with disabilities do not have a condition which can be "cured" by early intervention services. The services most frequently enable enhancements in the quality of life for individual children and their families. While there are significant limitations with current research that must be considered, there is evidence that early intervention programs can have positive impacts in certain areas. Below are results of studies on focused topics.

#### **Child Outcomes**

- Young children with disabilities or developmental delays who participated in early intervention programs experienced improvements in IQ, motor, language, and academic achievement.<sup>13</sup>

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<sup>13</sup> Source: G. Casto and M. Mastropieri, "The Efficacy of Early Intervention Programs: A Meta Analysis," *Exceptional Children*, Vol. 52 No. 5, 1986, pp. 417-424.

## Parent/Family Outcomes

- Parents with children in early intervention programs express a high level of satisfaction with their programs.<sup>14</sup>
- Training parents as teachers does not uniformly lead to improved outcomes for children.<sup>15</sup>

## Program Considerations

- Differences in the amount of direct service provided do not produce significantly different child and/or family outcomes, with some exceptions for very intensive services.<sup>16</sup>

## Limitations of Research

Longitudinal research on early intervention for young children with disabilities and developmental delays is limited. For ethical reasons, it is impossible to conduct a study that contains a "no treatment" group. Conclusions drawn about the effectiveness of early intervention have often been derived from studies that used biomedically at-risk or economically-disadvantaged children.<sup>17</sup> These findings provide compelling evidence of the long-term effectiveness of early intervention with these populations, although they may not necessarily apply to children with disabilities or developmental delays. The literature clearly demonstrates the important and sensitive nature of a child's early years.

Most research to date has supported the ethical perspective of why early intervention should be provided to young children and their families with disabilities. Efforts to evaluate the efficacy of early intervention have been narrowly focused on measures of intelligence, and have largely ignored other areas of child functioning, such as social-emotional growth and adaptive behavior, as well as indicators of family functioning.<sup>18</sup>

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<sup>14</sup> D. McNaughton, "Measuring Parent Satisfaction with Early Childhood Intervention Programs: Current Practices, Problems, and Future Perspectives," *TECSE*, Vol. 14 No. 1, 1994, pp. 26-48.

<sup>15</sup> K. White et al., "Does Research Support Claims About the Benefits of Involving Parents in Early Intervention Programs?" *Review of Educational Research*, Vol. 62 No. 1, Spring 1992, pp. 91-125.

<sup>16</sup> M. Taylor et al., "The Cost-Effectiveness of Increasing Hours Per Week of Early Intervention Services for Young Children with Disabilities," K. White and G. Boyce (eds), *Early Education and Development*, Vol. 4 No. 4, 1993. D. Behl et al., "New Orleans Early Intervention Study of Children with Visual Impairments," *Early Education and Development*, Vol. 4 No. 4, 1993. J. McEachin et al., "Long Term Outcome for Children with Autism Who Received Early Intensive Behavioral Treatment," *American Journal on Mental Retardation*, Vol. 97 No. 4, 1993.

<sup>17</sup> G. Castro and M. Mastropieri, "The Efficacy of Early Intervention Programs: A MetaAnalysis," *Exceptional Children*, Vol. 52 No. 5, 1986, pp. 417-424.

<sup>18</sup> G. Castro and K. White, "Longitudinal Studies and Alternative Types of Early Intervention: Rationale and Design," K. White and G. Boyce (eds), *Early Education and Development*, Vol. 4 No. 4, 1993, pp. 224-235.

Questions not addressed by existing research include the programmatic and economic perspectives: What kind of intervention is appropriate for different kinds of disabilities and developmental delays? How much intervention is needed? At what cost? And to what benefit, taking into consideration the broad range of expectations for outcomes of early intervention? To date, grant funding for research has emphasized program development, not program evaluation.

See the Technical Appendix for a detailed summary of the literature review.

## **B. Impact of Not Participating in Part H**

If the state should decide to discontinue its agreement with the federal government to implement Part H, the immediate impact would be a loss in federal funding. The federal government allotted DSHS \$3.9 million to implement Part H requirements from October 1994 through September 1995. Approximately two-thirds of the money went to direct services while the remaining third supported administration, outreach, the State ICC, and other coordination activities. Federal approval has been received for a \$4.7 million grant to Washington State for October 1995 through September 1996.

If Part H was discontinued, early intervention programs through school districts, DD centers, neurodevelopmental centers, and local public health agencies would not be dramatically impacted in terms of funding. While some centers may be using Part H money, it does not represent a major funding source at this time.

What could be impacted at the local level is the availability of services and the awareness by families of their options. Part H mandates coordination between providers and requires communities to find eligible children and to make services accessible to all that qualify.

## **C. Observed Benefits of Part H**

Although it is early in Part H implementation, some positive impacts can be seen. In the course of this study, the team observed three benefits that can be attributed, at least in part, to Part H: 1) increased focus on a child's family rather than just the child, 2) an organizational forum and responsibility to address early intervention as a community issue, and 3) improved transitions from infant toddler programs to school district special education preschool programs.

While the program expects additional benefits of Part H in the future, outcome measures and a strategy for evaluating the program have not yet been determined.

### ***Increased Focus on the Family***

One of the major purposes of Part H is to help families support the development of their child and provide services to families (e.g., counseling, assessment, etc.) so that they can understand and support their child's needs. According to some local providers interviewed, Part H has provided an opportunity to focus more attention on how to support families as they care for their young children with disabilities. Family Resources Coordinators located in each county (trained by staff from the Infant Toddler Early Intervention Program and funded by Part H) work with the families and community providers to determine eligibility for services and funding, as well as examine alternatives for accessing services. Families participate in developing an Individualized Family Service Plan (IFSP), which enables them to decide what services they want to obtain for their child and their family.

### ***Community Forum for Early Intervention Issues***

DSHS contracts with a local lead agency in each county to support a County ICC. County ICCs assist with the implementation of a coordinated community service system. They are composed of local service providers, parents, state and local agency staff, Indian Tribes, and others as appropriate. Each County ICC supported a local plan submitted to the state which proposes and defines how the geographical area or county will link resources and providers so the Part H list of 17 early intervention services can be provided.

We found that several counties had very active ICCs that met once a month to discuss access, service gaps, service enhancements, and funding. Some of the issues that the ICCs have addressed and provided solutions to include: 1) providing interim services to children who are on waiting lists for services, and 2) reaching out to families from different cultural backgrounds who might have children with disabilities.<sup>19</sup>

### ***Improved Transitions***

Transition to a school's special education preschool program from a neurodevelopmental or DD center occurs when a child reaches age three. At that point, the child may be eligible for school special education services under Part B as well as other options such as Head Start or Early Childhood Education and Assistance Program (ECEAP). Most of the providers interviewed expect that the majority of infants and toddlers who are served in their programs will continue to need special education services after age two.

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<sup>19</sup> Additional examples of notable practices that were identified in our field work appear in the Technical Appendix.

This transition can be difficult for parents who often have become attached to the neurodevelopmental center or the DD center's family-centered approach and greater array of services than is available in most districts. In areas where Part H has increased communication between providers, school districts are now more involved with DD and neurodevelopmental centers in reviewing each child's needs with the family before they transition.

## **D. Implementation Challenges**

In the course of this study, we became aware of certain deficiencies in state level coordination efforts. While statutory direction, interagency agreements, and DSHS policies are in place to avoid these problems, we observed that there is still insufficient coordination. As a result, there is a lack of direction and consistency which frustrates local efforts to implement Part H.

### ***Lack of Clear Direction to Major Providers***

Local districts have been confused about their responsibilities as they relate to Part H, and there has been little clarification from the state or federal government. Yet school districts are major providers of early intervention services to children with disabilities under the age of three. According to recent data collected by ORDA, 30 percent of the infants and toddlers enrolled in early intervention programs associated with the state are clients of school districts. Eighty percent of state funding in Washington for early intervention programs flow to or through school districts.

Since serving children under age three is permissive, rather than mandatory, decisions about whether a school district provides services is locally determined. Decisions about whether a district also participates in their local network of providers for Part H, or tries to fulfill Part H requirements, are made by the individual school. The result is that in some areas of the state, districts are active participants in Part H implementation, and in others, districts are not involved in their County ICCs.

According to districts we interviewed, those providing birth to three services already are confused about how their programs relate to other Part H efforts and whether Part H requirements apply to their programs. In October 1994 OSPI requested direction from the federal government on the role of school districts who traditionally implement Part B of IDEA. A year later, the U.S. Department of Education responded that early intervention services offered by school districts are to be implemented in a manner consistent with the requirements of Part H.

Part H is currently being implemented through DSHS policies and procedures. However, we are told DSHS procedures lack the authority desired by OSPI and local school districts. School districts are accustomed to operating under state

Washington Administrative Codes (WACs), and there are no state regulations for Part H. DSHS, which is comfortable with operating under policies and procedures, has not prioritized the writing of WACs. To date, there is no agreement between the lead program for Part H (DSHS) and the agency which provides the largest share of state funding for birth to three services (OSPI) about what is the appropriate avenue for detailing the roles and responsibilities of agencies and providers under Part H.

### ***Coordination Problems in General***

A lack of coordination is also apparent among agencies other than DSHS and OSPI that have a role in birth to three services. Although there is a state law to coordinate and streamline agency programs to enhance early intervention, we found the state system confusing and, in some cases, inconsistent with Part H.

### **Eligibility and Funding Complexities**

As discussed in an earlier section, we identified at least six public funding sources that are regularly used to support services to children eligible under Part H. Some state programs that are used to deliver early intervention services have eligibility criteria that differ from Part H, e.g., amount of delay, financial qualifications, and/or age of the child.<sup>20</sup> For example, this state has determined that a child from birth to three qualifies under Part H if they have a developmental delay of 25 percent in *one* or more of five developmental areas.<sup>21</sup> However, a two-year-old who qualifies for DD funding must have a developmental delay in *two*, not just *one*, areas.

Certain providers, such as DD centers or neurodevelopmental centers, weave together many sources of state, federal, and private funds. Although the intent of both the federal and state law is to coordinate the various funding streams for birth to three services, the system remains complex.

For example, at one DD center we visited, roughly two-thirds of the enrolled children are supported by their respective school districts whose payment to the DD center covers about 66 percent of their average cost per child. The remaining third is supplied from various sources. If the child qualifies for DD funds or Medicaid, those funds are requested. If a child has private insurance

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<sup>20</sup> See the Technical Appendix for how each state funding source compares to the eligibility criteria for Part H.

<sup>21</sup> Eligibility for Part H was defined by Washington State through its annual application for federal Part H funds. Washington's definition is similar to roughly one-fourth of the states with the remaining states split fairly evenly as having definitions either more broad or more restrictive than Washington's Part H definition. Our state does not include an "at-risk of developmental delay" definition because the numbers of children would be greatly increased. Ten states do serve "at-risk," which can be based on a biomedical or socioeconomic definition.

that includes coverage for neurodevelopmental therapies, the insurance company will be billed. Sometimes, however, a child may use up their private insurance benefits or not continue to qualify for DD funds after age two, and the center must find other funding to support those children. Also, children supported by school district contracts may not receive services over the summer if their districts do not provide funding. Other revenues must be used to cover summer programs. This center also uses extensive fundraising and minimal parent fees to balance the remaining portion of the budget.

Complexity of early intervention funding and the frustration it causes local providers is not unique to Washington. We found that many states are struggling with how to coordinate and streamline their various funding sources that can be used for infants and toddlers with disabilities. In several cases, states are trying to make better use of their resources by combining their multiple funding sources into one early intervention fund.

#### Monitoring Requirements and Duplication of Effort

According to the providers we interviewed, the varying eligibility criteria, different monitoring standards, and billing requirements among state programs and other funding sources generate confusion, duplication, and require a great deal of time. In addition to eligibility criteria, billing methods vary and each can require unique paperwork.

Some funds are based on a fixed amount per child (e.g., state special education and federal Chapter 1).<sup>22</sup> Some funds are based on a fee for service (e.g., Medicaid<sup>23</sup> and some state DD money). Other funds are distributed according to program specifications (e.g., special health care needs and Part H). Part H funds must be used by local service providers as the payor of last resort, which means that every other funding source must be accessed before federal Part H is used. Many counties that received Part H funds for direct services claim that they did not receive clear directions from DSHS about how they could spend their Part H money which resulted in the money not spent this past spring.

From the state's perspective, there is a concern about the resource commitment necessary to have people overseeing, tracking, and auditing the distribution of various state funds. Local providers desire some consistency and streamlining of effort. Evidence of the problem is illustrated in the following example.

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<sup>22</sup> Chapter 1 deinstitutionalization funding of the Elementary and Secondary Education Act is being folded into federal funding for the Individuals with Disabilities Education Act Part B and Part H.

<sup>23</sup> Medicaid uses a means test: if a child's family is 200 percent of the federal poverty level (\$15,150 for a family of four), the child but not the family will qualify for Medicaid. A family can qualify at 185 percent of the federal poverty level. Medicaid is also moving away from fee for service into managed care.



A neurodevelopmental or DD center can have many different monitoring teams examining their individual program at different times of the year. Each monitoring team might have different oversight authority and use different criteria. One center experienced the following audits during the course of one year: an independent financial audit, both a county DD program and financial audit, a federal Chapter 1 audit, a regional Educational Service District audit for nonpublic school status, multiple school district audits since they contract with several districts, and the regional DD office's review for program compliance.

### Child Assessments and Duplication of Effort

A duplication problem also occurs in areas other than funding and monitoring. Screenings for developmental delays in children are done by different providers and for different programs. The study team found that when coordination does not occur, a child can have two different screenings and assessments. For example, in some cases, the use of Healthy Options to screen and assess Medicaid-eligible children is not closely tied to Part H efforts, and multiple screenings can occur.<sup>24</sup>

### Accountability for Childfind

Roles and responsibilities are also unclear for community childfind efforts. Part H requires an active childfind effort on the part of *all* involved parties.<sup>25</sup> "Childfind" is the term used to describe the efforts made to locate, identify, screen, and refer children who may be eligible for services. Families access early intervention services by referral from physicians or hospitals, public health clinics, word of mouth, and/or community advertising. A statewide toll-free hotline—Healthy Mothers, Healthy Kids—is available, which connects families with local resources.

The extent to which counties have active childfind programs varies. Some County ICCs have emphasized childfind activities and are actively pursuing coordinated screenings and promotional activities, while other counties are not focused on conducting childfind efforts. There are many reasons why childfind is not actively pursued in all regions, but one reason we found was that confusion existed about who was responsible. We were told in one county that school districts were responsible, while the districts disagreed and said it was the responsibility of those participating in Part H.

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<sup>24</sup> We also found that several counties have recognized this problem and are working on joint screening and assessment processes, but this is not yet universal.

<sup>25</sup> Participants include those receiving funds under Maternal and Child Health, Supplemental Security Income, Medicaid, Special Education, Developmental Disabilities, Headstart, and Native American programs.

## ***Service Equity***

Under Part H, the state has committed to making comprehensive services available to all eligible children whose families desire treatment. According to providers and agency program staff, geographic access to service is the primary determinant of whether a child can get early intervention services.<sup>26</sup> Our review of the distribution of providers in the state shows that few alternatives exist if there is no accessible DD or neurodevelopmental center in the region, and if the local school district is not involved in infant toddler services. The problem of access to providers is most acute in rural and remote regions of the state. (Providing a program is economically difficult in areas with small numbers of children with disabilities.) One successful way that has been used to solve this problem is to establish school district cooperatives.

Under Part H, waiting lists for early intervention services are not allowed, although in three out of five counties we visited there were waiting lists for services. The waiting lists were due to a lack of trained professionals in the area or insufficient space at the DD or neurodevelopmental center. Whether or not a local school district participates in birth to three services is also a factor. We found that centers will contract with school districts to serve infants and toddlers but will also provide service to children from districts that do not have contracts on a space available basis. If space becomes limited, however, only those children in districts with contracts will be taken. While this is an ethical dilemma for providers, these centers have a contract with only some of their school districts. Children from other districts might be turned away or put on a waiting list.

## **E. Conclusion**

This report concludes that continued participation in Part H of IDEA, at this time, would be in the interest of the state for the following reasons: 1) while research is limited, there is evidence that early intervention can have positive impacts, 2) there is little benefit to the state in withdrawing from the program since current services and funding demands will continue to exist, but without detailed requirements for coordination or federal financial support, and 3) although implementation has just begun, we observed some benefits attributable to the program.

However, we have identified some significant coordination problems that are reducing the value of the state's participation in Part H. There are also unanswered questions related to future program costs and the extent to which

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<sup>26</sup> In only one case out of dozens of interviews was there a barrier to service due to family income. In that community, some providers had limited the number of Medicaid clients they would serve. This did not appear to be a widespread practice.

the program can show measurable benefits resulting from Part H. As a result, actions to address the coordination issues, continued monitoring of the program, and deliberate consideration of continued participation and early intervention funding appear to be appropriate for legislative attention.

### ***Part H Regulations***

This study found that although there are policies and interagency agreements in place regarding agency participation in Part H, and seven years of interagency planning, there are still continued coordination problems. The most significant coordination problems for Part H implementation are those between DSHS, the lead agency for Part H, and OSPI, through which 80 percent of state spending on birth to three programs is channeled.

Joint rules defining agency roles and responsibilities under Part H appear to be a solution towards solving this long-standing coordination problem. A number of states have developed regulations for early intervention services that could serve as models. Therefore, our first recommendation appears below.

#### ***Recommendation 1***

The five participating state agencies: Department of Social and Health Services, Office of the Superintendent of Public Instruction, Department of Health, Department of Services for the Blind, and Department of Community, Trade and Economic Development should draft a common set of rules by September 1996 that will define agency and provider roles and responsibilities under Part H to improve consistency and clarity of birth to three early intervention services. The Department of Social and Health Services should take the lead in this effort.

### ***Integration of Early Intervention Funding***

The need for streamlining the complex system through which early intervention programs obtain funding has been recognized in other states. Integration of public funding sources is currently being tried by several states as a means of simplifying funding and to provide for more consistency with state policy. For Washington it is not clear whether combining funding sources would be worthwhile, but the option appears worth pursuing. Therefore, investigation of this option is recommended below.

#### ***Recommendation 2***

The State Interagency Coordinating Council for Part H should examine the possibility of integrating some or all of the funding sources currently

used to support services for infants and toddlers with disabilities and report back to the fiscal committees by September 1996.

### ***Future Evaluation of Part H***

This is the first year of Part H implementation. Through decisions made by the Executive branch of state government, Washington has chosen to participate in this optional federal program. By participating, Washington is required to provide a statewide system for early intervention services that includes making a comprehensive list of services available to all eligible children under age three. This study found that participation in Part H, at this time, is in the interest of the state; however, the decision to continue participation in the future should be deliberately made, and the legislature should be kept aware of the program's progress. Therefore, an evaluation of the Part H program is recommended.

Specific aspects of the program, including outcomes of children and their families, the effectiveness of interagency coordination, and the benefits of changing the lead agency for the program should be part of the evaluation.

### ***Recommendation 3***

The legislature should conduct an evaluation of the Part H program within five years. The Department of Social and Health Services and the State Interagency Coordinating Council should develop outcome measures for the Part H program by October 1996, and begin tracking the necessary data to document these measures.

## **Agency Response**

- Department of Social and Health Services  
Department of Community, Trade and Economic  
Development  
Department of Health  
Department of Services for the Blind
- Superintendent of Public Instruction



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

*Olympia, Washington 98504-0095*

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Legislative Auditor  
Office of Legislative Budget Committee  
Post Office Box 40910  
506 - 16th Avenue South East  
Olympia, Washington 98501-2323

Dear Ms. Broom:

Thank you for the opportunity to provide input on the Legislative Budget Committee's Birth to Three Years Study, Preliminary Report recommendations. The recommendations from the LBC report are provided below in their entirety. Following each recommendation is our joint response submitted by four participating state agencies (Department of Social and Health Services, Department of Community, Trade and Economic Development, Department of Health, and Department of Services for the Blind). The Office of the Superintendent of Public Instruction will be submitting a separate response.

**LBC Recommendation Number 1:** The five participating state agencies: Department of Social and Health Services, Office of the Superintendent of Public Instruction, Department of Health, Department of Services for the Blind, and Department of Community, Trade and Economic Development should draft a common set of rules by September 1996 that will define agency and provider roles and responsibilities under Part H to improve consistency and clarity of birth to three early intervention services. The Department of Social and Health Services should take the lead in this effort.

**Response:** The four agencies partially concur with the recommendation with the addition that legislation may be required.

We agree that all state agencies must play a role in and take responsibility for making Part H successful in Washington State. It is crucial for the agencies to work together to assure a coordinated system of early intervention service delivery and provide leadership at the state level.

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A common set of rules, adopted or cited, defining agency and provider roles and responsibilities will improve consistency and clarity of early intervention services to achieve the desired results. The current interagency agreement could be examined and, if needed, strengthened to more clearly define roles and responsibilities.

In addition, DSHS may not have authority to write Washington Administrative Codes except for the broad intent under RCW 70.195 and 71A. DSHS will consult with legal counsel regarding the authority under current statute. If needed, DSHS will request the Legislature to strengthen RCW 70.195.

**LBC Recommendation Number 2:** The State Interagency Coordinating Council for Part H should examine the possibility of integrating some or all of the funding sources currently used to support services for infants and toddlers with disabilities and report back to the fiscal committees by September 1996.

**Response:** The four state agencies concur with the need to explore the possibility of combined funding and agree as members to participate and support the State Interagency Coordinating Council in this effort.

We agree that integrating funding sources, including new ways of providing and paying for early intervention services, should be considered. The State Interagency Coordinating Council has already begun to look at different funding mechanisms.

**LBC Recommendation Number 3:** The Legislature should conduct an evaluation of the Part H program within five years. The Department of Social and Health Services and the State Interagency Coordinating Council should develop outcome measures for the Part H program by June 1996, and begin tracking the necessary data to document these measures.

**Response:** The four agencies partially concur with the recommendation.

Each of the four agencies agree with the development of outcome measures and the need to evaluate the Part H program. Although DSHS and the State Interagency Coordinating Council are assigned the responsibility for achieving this recommendation, all agencies will need to have significant involvement. The completion date for developing outcome measures and beginning to track necessary data is too short for agency contracting cycles and the Part H federal grant cycle and funding. Outcome measures and tracking additional data would need to be incorporated into future contracts.

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We hope our responses will be helpful to the Legislative Budget Committee in approving the Birth to Three Years Study, Preliminary Report. If additional information or clarification is needed, please contact me at (360)753-3903 or Sandy Loerch, Director, Infant Toddler Early Intervention Program at (360)586-8696.

Sincerely,

A handwritten signature in black ink, appearing to read "Norm Davis", with a stylized flourish at the end.

Norm Davis, Director  
Division of Developmental Disabilities

cc: Jean Soliz, Department of Social and Health Services  
Lyle Quasim, Department of Social and Health Services  
Tom Lockhart, Department of Community, Trade and Economic Development  
Maxine Hayes, Department of Health  
Shirley Smith, Department of Services for the Blind  
Doug Gill, Office of the Superintendent of Public Instruction  
Sandy Loerch, DDD, Infant Toddler Early Intervention Program  
Edie Harding, Washington State Institute for Public Policy  
Beth Keating, Legislative Budget Committee





# SUPERINTENDENT OF PUBLIC INSTRUCTION

JUDITH A. BILLINGS

OLD CAPITOL BUILDING • PO BOX 47200 • OLYMPIA WA 98504-7200

October 24, 1995

Cheryle A. Broom  
Legislative Auditor  
Office of Legislative Budget Committee  
P.O. Box 40910  
506 16th Avenue South East  
Olympia, Washington 98501-2323

Dear Ms. Broom:

Thank you for the opportunity to provide input on the Legislative Budget Committee's Birth to Three Years Study, Preliminary Report recommendations. The recommendations from the LBC report are provided and followed by our response.

LBC Recommendation Number 1. The five participating state agencies: Department of Social and Health Services, Office of the Superintendent of Public Instruction, Department of Health, Department of Services for the Blind, and Department of Community, Trade and Economic Development, should draft a common set of rules by September 1996 that will define agency and provider roles and responsibilities under Part H to improve consistency and clarity of birth to three early intervention services. The Department of Social and Health Services should take the lead in this effort.

Response: This agency concurs with the recommendation with the addition that legislation may be required.

We agree that all state agencies must play a role in and take responsibility for making Part H successful in Washington State. It is crucial for the agencies to work together to assure a coordinated system of early intervention service delivery and provide leadership at the state level. A strong set of rules, adopted or cited, and interagency agreements defining agency and provider roles and responsibilities will improve consistency and clarity of early intervention services to achieve the desired results.

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LBC Recommendation Number 2: The State Interagency Council for Part H should examine the possibility of integrating some or all of the funding sources currently used to support services for infants and toddlers with disabilities and report back to the fiscal committees by September 1996.

Response: This agency concurs with the need to explore the possibility of combined funding by the State Interagency Coordinating Council.

We agree that integrating funding sources including new ways of providing and paying for early intervention services should be considered. The State Interagency Coordinating Council has already begun to look at different funding mechanisms.

LBC Recommendation Number 3: The legislature should conduct an evaluation of the Part H program within five years. The Department of Social and Health Services and the State Interagency Coordinating Council should develop outcome measures for the Part H program by June 1996, and begin tracking the necessary data to document these measures.

Response: This agency concurs with the recommendation.

OSPI agrees with the development of outcome measures and the need to evaluate the Part H state system. The evaluation should measure the efficacy of the lead agency's role, State Interagency Coordination Council, County Interagency Coordination Councils and the effectiveness of direct services at the local level. OSPI will participate in the development of the outcome measures as members of the State Interagency Coordinating Council. The proposed timeline for developing outcome measures and beginning to track necessary data may be too short.

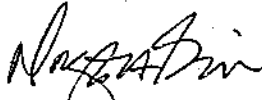
We hope our responses will be helpful to the Legislative Budget Committee in approving the Birth to Three Years Study, Preliminary Report. If additional

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information or clarification is needed, please contact Lou Colwell, Program Supervisor, Part H at (360) 753-6733, TDD (360) 586-0126.

Sincerely,

INSTRUCTIONAL PROGRAMS



Douglas H. Gill  
Director, Special Education

DHG:ra

cc: Lyle Quasim, Department of Social and Health Services  
Tom Lockhart, Department of Community, Trade and Economic  
Development  
Maxine Hays, Department of Health  
Shirley Smith, Department of Services for the Blind  
Sandy Loerch, DDD, Infant Toddler Early Intervention Program  
Edie Harding, Washington State Institute for Public Policy  
Beth Keating, Legislative Budget committee  
Norm Davis, Department of Social and Health Services