STATE OF CALIFORNIA

PART C
STATE PERFORMANCE PLAN CHANGES
FOR FFY 2006 (2006-2007)

Part C State Performance Plan Changes for FFY 2006

Table of Contents

		Page
Indicator 1	Services Provided In A Timely Manner	1
Indicator 3	Child Outcomes	4
Indicator 7	Evaluation and Assessment And Initial IFSP Meeting Conducted Within 45-Day Timeline	21
Indicator 8	Timely Transition Planning	24
Indicator 9	General Supervision System (Including Monitoring, Complaints, Hearings, Etc.) Identifies and Corrects Noncompliance As Soon As Possible But In No Case Later Than One Year from Identification	27
Indicator 11	Due Process Hearing Requests That Were Fully Adjudicated Within The Applicable Timeline	37
Indicator 13	Percent of Mediations Held that Resulted in Mediation Agreements	39

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Early Intervention Services In Natural Environments

Indicator 1: Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.

(20 USC 1416(a) (3) (A) and 1442)

Measurement:

Percent equals number of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner divided by the total number of infants and toddlers with IFSPs times 100.

States must account for untimely receipt of services.

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

In California, timely delivery of services is a primary goal of the Early Start Program. California defines *timeliness* as IFSP services beginning by 45 days after the IFSP date when the parent(s) has approved or accepted the service. Measurement used for this indicator is the provision of initial Part C services listed in the infant/toddler's initial IFSP no later than 45 days from the date of the IFSP. IFSP date used will be from the Early Start Report (ESR) form data on file with DDS. Early Start Reports are required for all eligible Early Start Program participants upon entering the program, upon exiting the program and at least annually between entrance and exit. Since processes, policies and procedures are the same for establishing IFSP services with EI Providers for families, timeliness will not differ significantly between services for Initial and subsequent IFSPs.

Commencement of IFSP services will be derived from electronic service provider claims data processed at the regional centers (the date the initial service was provided). Since these claims data include claims for non-required services which may be listed on a child's IFSP (e.g., day care or diapers), or administrative expenses (e.g., translation services or photocopying), such services will be excluded from the data used for this measure. Similar special care will be taken regarding claims for reimbursement of prior purchases and other transactions with unique relationships to actual dates of services.

For Annual Performance Reporting, DDS has designed and will run a data extraction query for its Uniform Fiscal System (UFS) and San Diego Information System (SANDIS), the State's major relational databases for transactions affecting not only Early Start but all other developmental disability programs as well, that will extract the dates of IFSPs from SANDIS for those infants/toddlers with Early Start Reports and the dates that services listed for the infant/toddler were first provided from the claim data from UFS that the regional centers (local programs) submit monthly to DDS. The time between the IFSP and service provision date will be calculated for each initial service authorized in the database for each infant/toddler, and the percentage of those receiving services in a timely manner (45 days), determined. A summary of the data and percentages will be reported.

The data extraction query will collect universal data on all infants and toddlers entering the program during the fiscal year reporting period whose services are billed by service event and will be run quarterly for monitoring purposes and annually for reporting to OSEP. This population will not include those infants and toddlers who receive services from a vendor that a local program has contracted with to provide services solely under contract for group services and that submits claims to the local program for group, rather than individual consumer billing. The number of infants and toddlers receiving group contracted services is small and the amount contracted varies by local program (refer to "Improvement Activities" below).

Status on meeting the requirement to provide services in a timely manner will be collected during compliance monitoring activities. Compliance monitoring activities consist of Site Monitoring Visits and ongoing Record Reviews. The Site Monitoring Visit is a comprehensive review of the local Early Start Program including assessment of the eligibility process, service coordination, interagency collaboration, service provision and family support. Samples of individual child records are reviewed to assess compliance with the procedural requirements. These samples are selected through a stratified random sampling process.

These comprehensive triennial reviews are conducted in each of the 21 regional center catchment areas by DDS in collaboration with CDE and a monitoring team that includes parents and an ICC representative. On a periodic basis, DDS liaisons revisit regional centers to conduct record reviews as follow-up activity to the Site Monitoring Visits. This provides an assessment of the local program's progress in resolving any compliance issues and identification of any new findings.

For compliance of this indicator DDS Liaisons will extract the IFSP date and services provision date data, for initial IFSP services only, that were provided to those infants/toddlers selected by random sampling, and will be incorporated as part of the State's new "Focused Monitoring" process when implemented. They will verify the IFSP dates and the types of services provided in the IFSP to the extracted data. Differences from IFSP dates and services data will be investigated and findings reported when appropriate.

Baseline Data for Federal Fiscal Year (FFY) 2004 (2004-2005):

California's data from 2004-2005 revealed that 96.54 percent of infants and toddlers served received timely services (measurement formula: 25,728 divided by 26,649, times 100 equals 96.54 percent). As noted in the Annual Performance Report (APR) submitted with this change, the source data was determined to be not as accurate as the method above to effectively measure the percent of infants and toddlers with IFSPs who receive early intervention services on their IFSPs in a timely manner. However, because many infants/toddlers enter the Early Start Program late and exit soon thereafter, the current baseline will be retained and target data for FFY 2005 (2005-2006) and FFY 2006 (2006-2007) collected once the new system query is designed for subsequent year reporting. This will ensure that IFSP records and vendor claim files are current and available at the regional centers for verification.

Discussion of Baseline Data:

The current baseline was calculated by measuring time from the IFSP completion date to when the purchase of service order is processed. This yields a statistical basis for setting a baseline and establishes methodology for continuous assessment of this measure. Refer to the current APR for California's discussion regarding the inadequacy of the data source for measurement of this indicator.

OSEP requires a target of 100 percent for this indicator.

Federal Fiscal Year (FFY)	Measurable and Rigorous Target
2005 (2005-2006)	100% of participants receive services in a timely manner.
2006 (2006-2007)	100% of participants receive services in a timely manner.
2007 (2007-2008)	100% of participants receive services in a timely manner.
2008	100% of participants receive services in a timely manner.

(2008-2009)	
2009 (2009-2010)	100% of participants receive services in a timely manner.
2010 (2010-2011)	100% of participants receive services in a timely manner.

Improvement Activities/Timelines/Resources:

DDS has designated Early Start liaisons that work collaboratively with local programs to improve their performance. The Early Start liaisons form a collegial relationship with the regional centers and provide frequent informal technical assistance on all Early Start issues. Focused training is also provided by the Early Start liaisons based on unique local needs and issues. California's Early Start also has a structured formal training and personnel development system. DDS maintains a contract with the WestEd Center for Prevention and Early Intervention to provide ongoing statewide training institutes for early intervention service providers and service coordinators. This comprehensive system of personnel development ensures that early intervention personnel are appropriately trained and also have knowledge of the regulatory requirements of Early Start. DDS will also be meeting with the ICC in January 2006, to identify additional improvement activities, timelines and resources for the SPP performance indicators.

Most frequently, services are delayed due to a shortage of qualified personnel, especially specialty therapists (occupational, speech and physical therapists). DDS has implemented a mechanism to allow regional centers to use an Early Start specialized therapeutic service code to purchase services in cases where application of existing reimbursement rates would result in any delays in the provision of early intervention services. The use of this service code allows the regional centers to compete fiscally in a competitive market for services and serves to improve the timeliness of both the evaluation/assessment and the provision of services.

Some local programs contract with vendors who provide services to infants and toddlers and submit claims to the regional center on a group basis. In these instances, the local programs have found that services have been provided more expeditiously. Contracted claims are billed to DDS as a group and not as individual billings for each infant and toddler. This billing procedure uses far fewer resources in comparison to the customary billing process of "fee-for-service", which is on a client-by-client basis.

Local programs that were identified as using the contract services model will be queried to determine the level (percentage) of contract services used for infants and toddlers and the responses obtained will be used to determine an adjusted percentage of timely services provided for the program. DDS piloted and tested the validity of this new method with one local program known to use cost-effective, contracting services by using a two-thirds random sample, in this case 25 of the 37 services provided that appeared to not meet the timeliness standard per new methodology. The results indicated that about three-fourths (18 of 25) of the infants and toddlers with at least one fee-for-service billing in the system, had received a substantial portion of their IFSP services via the expedited contract services model. Additionally, about one-third (8 of 25) received their full array of therapeutic services from three different infant development programs using the contract services model.

DDS intends to assess the use of contract services at each of these local programs through a self-assessment instrument. DDS will verify the accuracy of responses during "focused monitoring" at the local level when implemented. "Focused monitoring" is an improvement activity discussed under Indicator 9. Performance scores for the regional centers and the State will be adjusted where necessary and reported in subsequent APRs to OSEP.

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Early Intervention Services in Natural Environments

Indicator 3: Percent of infants and toddlers with IFSPs who demonstrate improved:

A. Positive social-emotional skills (including social relationships);

B. Acquisition and use of knowledge and skills (including early language/ communication); and

C. Use of appropriate behaviors to meet their needs.

(20 U.S.C. 1416(a)(3)(A) and 1442)

Measurement:

A. Positive social-emotional skills (including social relationships):

a. Percent of infants and toddlers who did not improve functioning = [(# of infants and toddlers who did not improve functioning) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers = [(# of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it = [(# of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it divided by (# of infants and toddlers with IFSPs assessed)] times 100.

d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers = [(# of infants and toddlers who improved functioning to reach a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers = [(# of infants and toddlers who maintained functioning at a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

If a + b + c + d + e does not sum to 100%, explain the difference**.**

B. Acquisition and use of knowledge and skills (including early language/communication and early literacy)

a. Percent of infants and toddlers who did not improve functioning = [(# of infants and toddlers who did not improve functioning) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers = [(# of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it = [(# of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it divided by (# of infants and toddlers with IFSPs assessed)] times 100.

d. Percent of infants and toddlers who improved functioning to reach a level comparable to

same-aged peers = [(# of infants and toddlers who improved functioning to reach a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers = [(# of infants and toddlers who maintained functioning at a level comparable to same-aged peers) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

If a + b + c + d + e does not sum to 100%, explain the difference**.**

C. Use of appropriate behaviors to meet their needs:

a. Percent of infants and toddlers who did not improve functioning = [(# of infants and toddlers who did not improve functioning) divided by (# of infants and toddlers with IFSPs assessed)] times 100.

b. Percent of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers = [(# of infants and toddlers who improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers) divided by the (# of infants and toddlers with IFSPs assessed)] times 100.

c. Percent of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it = [(# of infants and toddlers who improved functioning to a level nearer to same-aged peers but did not reach it divided by the (# of infants and toddlers with IFSPs assessed)] times 100.

d. Percent of infants and toddlers who improved functioning to reach a level comparable to same-aged peers = [(# of infants and toddlers who improved functioning to reach a level comparable to same-aged peers) divided by the (# of infants and toddlers with IFSPs assessed)] times 100.

e. Percent of infants and toddlers who maintained functioning at a level comparable to same-aged peers = [(# of infants and toddlers who maintained functioning at a level comparable to same-aged peers) divided by the (# of infants and toddlers with IFSPs assessed)] times 100.

If a + b + c + d + e does not sum to 100%, explain the difference**.**

CALIFORNIA'S RESPONSE:

Overview of Issue/Description of System or Process: Base on OSEP's determination letter and table dated June 15, 2007, California did not report the required entry data and activities submitted in the FFY 2005 SPP change because the sampling methods were not technically sound. From subsequent discussions, DDS and OSEP agreed on an appropriate strategy and methodology necessary for achieving the goal of baseline and targets establishment for FFY 2009. It is possible that California will have progress data prior to 2010 if the universal data system can easily capture entrance and exit data for children prior to the 2010 APR. This SPP change replaces Indicator 3 in the SPP submitted for FFY 2005.

1. **Revamping the California data collection system:** California is currently in a "development and phase-in" period of significant revision of the state's early intervention data system to

   a. Most accurately capture data per OSEP requirements;

   b. Implement universal reporting on OSEP designated child outcome measures; and

   c. Install necessary data elements which are necessary for detailed analysis of program performance.

   We believe that this new system will provide a capacity for data collection and program analysis that will be unparalleled in the country.

2. **Background: Existing infrastructure and current data capacity:** California has a longstanding infrastructure of region-based service agencies that purchase services, provide various family supports and provide service coordination. These 21 "regional centers" are nonprofit private

corporations that are under contract with the Department of Developmental Services to provide or coordinate services and supports for eligible individuals and their families. These activities focus not only on infants and toddlers in early intervention and their families, but also for children over 3 years and others throughout adolescence and adulthood who have developmental disabilities and who are substantially handicapped. Indeed, California is recognized as the only state that has a "civil rights act" for persons with developmental disabilities. This act constitutes an entitlement for services.

Because eligibility for California's regional center system consists of a lifetime entitlement for eligible children beyond age three, the regional centers have long conducted rigorous eligibility evaluations both at entrance to early intervention and also upon exit from early intervention services at age three. Therefore, the regional centers have decades of longitudinal data including specific diagnoses, co-occurring health conditions, functioning levels across the five key developmental areas upon entrance into the program, needs assessments, services received, and repeated measures of functioning levels at key points during the lifespan.

Unfortunately, this exceptionally rich developmental progress data has been confined, for the most part, to individual client records in hard copy documents. These data in the aggregate have been accessed on a statewide basis very intermittently and only in the context of independent research projects that are very labor intensive and costly. For example, in 2001, the University of California at Davis Medical Center reviewed numerous individual hard copy records in a physical collection of data in a statewide study at the request of the California State Legislature. This study was to investigate the significant increase in children with autism in California, focusing on the possibility of a "diagnostic shift" and/or to immigration into the state due to the multiple services available because of the state's legal mandate for services.

Certainly California has not been able to fully benefit from the extensive individual client data spanning many years (California operated an early intervention program prior to IDEA Part H/Part C). The amount of data available is substantial. In the early intervention program alone, California currently serves 32,000 children at any point in time and annually close to a total of 50,000 infants and toddlers. The current data system includes child outcomes on each of these children served in Early Start., albeit in hard copy only in each file at the local regional center office.

3. **Data system under development:** In a significant move to maximize our data capacity, California is now developing a data system for early intervention that will not only include the revised measures required by OSEP, but includes planning for **universal reporting.** This shift to universal reporting will capture key client measures, including functional outcomes, and will complement our existing comprehensive database of services and costs.

   California continues to maintain an extensive data base of specific types, amounts, and time intervals of various services for each child in early intervention. Indeed, this data has been essential to conduct retrospective studies for children who entered the regional center program after age three. However, full analysis of the efficacy of service types and amounts cannot be completed without additional data in early intervention.

   Further, the Early Start Data System will include all critical factors needed for a thorough analysis. Child outcomes will be analyzed in the context of key factors such as diagnosis, age at entry, length of time in the program, and the specific types of services received. It is only upon thorough analysis considering these key factors that California can determine the effectiveness of early intervention for different infants with specific conditions who received certain types and amounts of services. For example, consistent with scientific research, California has continued to emphasize early identification and intervention for children with autism. With the new data system, we will be able to describe for this and other diagnoses the average age at intake, amounts and types of services received, and the extent of improvement.

4. **Recent activity in the development of the data system:** In planning for this expansion of our data capacity and universal reporting, in our discussions with OSEP staff on October 25, 2007, it was mutually concluded that it would not be cost effective to immediately divert needed resources from the development of the new data system in order to conduct a one-time, statewide sampling

from hard copy records for the APR/SPP due February 2008. Accordingly, it was agreed that California's lead agency would continue with its data system improvement project and, for this next APR/SPP, instead focus our data improvement effort on one regional center to:

a. Demonstrate the comprehensiveness, accuracy and precision of existing data contained in client records at the regional centers;

b. Demonstrate that this data could be reasonably extracted and categorized into existing data sets as required by OSEP.

c. Utilize this data collection activity to inform us regarding how best to configure the data template for universal reporting.

The next step in the development of our expanded and universal data system involved targeting a regional center that parallels the statewide demographics including ethnicity and an urban/rural mix. That is, for this focused data activity to be considered an adequate field test of our data parameters, the regional center selected must be representative of the state in terms of urban/rural/remote/frontier but especially in terms of ethnicity of the population being served.

The regional center selected as representative was Valley Mountain Regional Center. This five county region includes urban areas (e.g. the city of Stockton, in San Joaquin County with over 300,000 people with 4,456 persons per square mile), rural areas (e.g. Stanislaus County with 342 persons per square mile) and also remote/frontier areas with as few as 2 persons per square mile (Amador County).

Per our joint planning with OSEP staff (Rhonda Spence and Larry Ringer), we agreed to pull a representative sample of at least 125 records. A stratified random sample was drawn from the three Valley Mountain Regional Center offices representing all five counties. Due to the unexpected number of families who had moved away with no contact information, we pulled 191 records to meet the sample criteria (6 months in the program, entrance and exit evaluations).

Interestingly, there were generally three reasons why the exit evaluation was missing in the sample:

a. The family was a Child Abuse Prevention and Treatment Act referral (i.e. from the county Child Protective Services program) and had minimal participation in the program.

b. The family was happy with their child's progress and abruptly terminated services, refusing the final exit evaluation as well as transition planning.

c. The family was fully cognizant of their child's serious delays, recognized that their child would be clearly eligible for ongoing regional center services at age 3, and "did not want to put their child through another evaluation."

Even with this relatively high attrition rate, the ethnicity distribution in the sample did parallel the distribution for California. Please refer to the ethnicity table in the data collection section.

5. **Policies and procedures to guide assessment and measurement practices:** There has been increased emphasis on the improved precision of the "informed clinical judgment " of each program's clinical team for its oversight of evaluation and assessment for eligibility and program implementation. Specifically, each regional center is charged with effective utilization of licensed clinical practitioners (physicians, psychologists, speech therapists, occupational therapists, physical therapists) and certificated practitioners for early intervention (developmental specialists, infant program specialists, and teachers). Accordingly, the regional centers set standards for licensure and certification, demonstrated expertise, and evaluation reports.

Regional centers monitor practitioners in the selection of instruments and practical evaluation processes as practitioners determine both the needs of the child as well as precise measures of each child's progress. Regional centers ensure that program standards by community practitioners include licensure and/or certification according to state laws and regulations regarding professional practice. These practitioners are also required to have demonstrated experience directly working with children with different diagnoses who are functioning at various levels. For example, prior to approving a practitioner to conduct evaluation for child outcomes, regional programs confirm

necessary training and expertise in formal assessment and evaluations, test and measurement theory, reporting/documentation protocol and, of course, appropriate professional licensure.

Further, there are professional meetings that include focused discussion on assessment and measurement practices. Early intervention managers from California's lead agency meet with the following specialty groups for the stated purposes:

a. Local early intervention managers, both Southern California and Northern California groups, convene locally as well as at statewide meetings to:

   1) Review updates on new methodologies and the use of various instruments on targeted populations

   2) Survey continuing professional education needs and training available for community practitioners.

   3) Problem solve on current challenges experienced in evaluation and assessments in specific regions, with certain populations, and with specific professional disciplines.

b. The Regional Centers Clinical Directors Group meets statewide as a group to:

   1) Review diagnostic and predictive precision in "Established risk" and "High risk" categories.

   2) Discuss methods to analyze cost effective utilization of community clinical resources for effective measurement practices for evaluation of progress.

   3) Promote local partnerships for training and technical assistance

c. The Association of Regional Center Agencies Early Intervention Committee meets quarterly to:

   1) Discuss roles and responsibilities of the lead agency as well as the regional centers.

   2) Promote participation by the regional centers in making necessary changes for federal compliance.

6. **Provision of training and technical assistance supports to administrators and service providers in outcome data collection, reporting and use:**

a. Formal training events included but were not limited to the following:

   1) "Accountability: Child and Family Outcomes, Part C State Performance Plan", Early Start Advanced Practice Institute, Burbank, May 21, 2007.

   2) "Fostering Family Involvement through Pivotal Response Training – Reducing Challenging Behaviors and Improving Long Term Outcomes", Early Start Advanced Practice Institute, Burbank, May 21, 2007.

   3) "What Your Partner is Doing: Desired Results Development Profile (DRDP)", Early Start Advanced Practice Institute, Burbank, May 21, 2007.

   4) "IFSP Basics/ Linking Evaluation and Assessment to Early Intervention Services", Core Institute III, San Diego, April 23, 2007.

   5) "Writing Outcomes", Service Coordination Institute: IFSP, Foster City, October, 2006

   6) "From Outcomes to Services – Child and Family Outcomes in Natural Environments", Service Coordination Institute: IFSP, Foster City, October, 2006

   7) "Child and Family Outcomes: Implications for Regional Centers"

   8) Early Start Managers Symposium, May 23, 2007

b. Record Reviews – on site reviews including technical assistance and discussions of child evaluations and child outcome measures

ACRC - Site Monitoring Visit, full scope conducted in 9/06
ELARC - Record Review conducted in 3/07
SARC - Record Review conducted in 6/07
FDLRC - Record Review conducted in 6/07
TCRC - Record Review conducted in 6/07

c. Target Child Outcome Data collection for the development of universal reporting for 1) data capacity, 2) data collection protocol; 3) Early look at longitudinal data

ELARC (3/07)
FNRC (5/07)
VMRC (5/07)

d. The lead agency routinely provided to regional centers the necessary overviews and progress reports in meeting outcomes requirements, solicited input from regional programs regarding required changes in data systems, and continued to convey the benefits of increased data capacity, including universal reporting.

7. **Quality assurance and monitoring procedures to ensure the accuracy and completeness of the outcome data:** The California lead agency commenced a total review of the monitoring and general supervision processes, including data and child outcome measures. These activities included:

   a. The convening of a regional center task force to review quality assurance, data collection and monitoring needs;

   b. An independent evaluation of the lead agency's performance criteria and monitoring processes;

   c. A convening of the Association of Regional Center Agencies (ARCA) Prevention and Early Intervention Committee to review the results of the task force and also the independent evaluation;

   d. Regular progress reports to the ARCA Committee on the progress made on the recommendations for improvement of performance standards, documentation, data reporting, and lead agency monitoring and technical assistance.

   Further, all site visits to regional programs for the purposes of technical assistance and/or monitoring include reviews of outcome data and improvement activities including among other topics service provider competencies, outcome data processes, timing of evaluations, and utilization of child evaluations in the IFSP process.

   Most importantly, California is preparing to implement universal reporting for child outcomes. In fact, California will be exceeding OSEP requirements for this indicator.

8. **Data system elements for outcome data input and maintenance and outcome data analysis:** California continues its data development project to:

   a. Revise current data elements to align with new OSEP requirements. Please refer to the draft of the new data input form, attached.

   b. Introduce necessary data elements to improve its capacity for thorough analysis of child outcomes, including but not limited to primary diagnosis and co-occurring conditions.

   c. Ensure local data collection and recording is valid, accurate, timely, and comprehensive.

Baseline (Progress) Data for Federal Fiscal Year (FFY) 2006 (2006-2007): DDS labels the following data as "progress data" and not "baseline data" as baseline and targets for this Indicator are not due until the FFY APR/SPP reporting period.

Progress Data

	Number of children	% of children
A. Positive social-emotional skills:		
a. Did not improve functioning	13	10.08%
b. Improved functioning but not sufficient to move nearer to functioning comparable to same-aged peers	26	20.16%
c. Improved functioning to a level nearer same-aged peers, but did not reach same-age level	13	10.08%
d. Improved functioning to reach a level comparable to same-aged peers	23	17.83%
e. Maintained functioning at a level comparable to same-aged peers	54	41.86%
Total	N = 129	100%
B. Acquisition and Use of knowledge & skills:	Number of children	% of children
a. Did not improve functioning	7	5.43%
b. Improved but did not move nearer comparable to same-aged peers	32	24.81%
c. Improved and moved nearer same-aged-peers, but did not reach same-age level	16	12.40%
d. Reached level of same-aged peers	28	21.71%
e. Maintained level of same-aged peers	38	29.46%
f. Insufficient Data	8	6.20%
Total	N = 129	100%
C. Use of appropriate behavior to meet needs:	Number of children	% of children
a. Did not improve functioning	13	10.08%
b. Improved but did not move nearer same-aged peers	26	20.16%
c. Improved and moved nearer same-aged-peers	6	4.65%
d. Reached level of same-aged peers	19	14.73%
e. Maintained level of same-aged peers	60	46.51%

f. Insufficient Data	5	3.88%
Total	N = 129	100%

Discussion of Baseline (Progress) Data

The 3 developmental areas designated by OSEP were measured at entrance to and exit from California's Early Start program for the targeted sample. Interestingly, the majority of children showed some improvement in each of the 3 indicator categories. That is, 55% showed improvement in "Positive social/emotional skills", 63 % in "Acquisition and use of knowledge & skills", and 51% in "Use of appropriate behavior to meet Needs". Generally, across the three developmental areas, the largest numbers of children were in the "Maintained level of same-aged peers" category. The smallest percentage of children in each category was in the "Did not improve" category.

1. In analyzing this preliminary data, the following questions emerge:
   a. What were the diagnoses of those children who did not improve? Were these profoundly involved graduates from the Neonatal Intensive Care Units? Were they children who entered the system late and who just met the 6 months in program criterion?
   b. What were the characteristics of those children who improved in one particular area yet maintained their skills in the other indicator categories?
2. What we have learned thus far:
   a. Restricting the age intervals in the outcomes sample biases the results. That is, confining the sample population to older children (via any stipulation that the children must have entered and exited within the past 24 months), typically restricts the sample to children with fewer disabilities (e.g. speech delays only).
   b. Often, the younger the child enters the program, more delayed the child is, and the less the improvement.
   c. Conversely, a predominantly developmentally delayed or disabled sample (D.D.) would be much more likely to enter the Early Start program as newborns, or at least within their first six months of life, especially those who exhibit dysmorphic anomalies.
   d. There is an attrition rate, as yet undetermined. From the records reviewed, these are families who moved away and left no contact information. Or, those families who recognize their child is eligible for ongoing regional center services at age 3 and want their child and them to be spared another rigorous evaluation.
3. Measurement strategies used to collect data:
   a. Who is included in the measurement, i.e. what population of children? The sample used for the development of the data system was a stratified random sample from a five county area that reflects the ethnic distribution of the state as a whole and includes urban, rural and frontier locations. The sample also reflected the various diagnoses served throughout California. The characteristics of the targeted sample are displayed in the following table:

ETHINICITY DISTRIBUTION FOR CALIFORNIA
FOR CHILDREN 0-3 YEARS OLD

<table>
<tr><th></th><th>California (Statewide)</th><th>Regional Center Ethnicity</th><th>Early Intervention Population</th><th>Sample</th></tr>
<tr><td>White</td><td>34.61%</td><td>30.94%</td><td>32.00%</td><td>32.0%</td></tr>
<tr><td>Black/African American</td><td>6.76%</td><td>5.86%</td><td>6.10%</td><td>6.4%</td></tr>
<tr><td>Hispanic</td><td>46.00%</td><td>43.12%</td><td>40.51%</td><td>40.8%</td></tr>
<tr><td>Native American</td><td>0.75%</td><td>0.39%</td><td>0.36%</td><td>0.8%</td></tr>
<tr><td>Other</td><td>N/A</td><td>3.99%</td><td rowspan="2">12.97% (includes those that are bi- or multi-racial, an ethnicity not listed, or chose not to report)</td><td rowspan="2">11.2% (includes those that are bi- or multi-racial, an ethnicity not listed, or chose not to report)</td></tr>
<tr><td>Unknown</td><td>N/A</td><td>12.13%</td></tr>
<tr><td>Polynesian/Pacific Islands</td><td rowspan="3">11.88%</td><td rowspan="3">8.00%</td><td>0.23%</td><td>0.8%</td></tr>
<tr><td>Filipino</td><td>1.32%</td><td>1.6%</td></tr>
<tr><td>Asian</td><td>6.51%</td><td>6.4%</td></tr>
<tr><td>Total</td><td>1, 653,968</td><td></td><td></td><td></td></tr>
</table>

b. What assessment/measurement tool(s) and/or other data sources were used? The various instruments used , often as part of a battery of test, include the Vineland Adaptive Behavior Scales, Receptive-Expressive Emergent Language Test (REEL), Peabody picture Vocabulary Test, Ages & Stages Questionnaire, and numerous others. Please see attached list of testing instruments used. The variety of instruments reflects the various diagnoses, developmental area being assessed, the age of the child, and any language/literacy barrier in the family.

c. Who conducted the assessments? The assessments were conducted by either regional center staff, intake coordinators or Early Start Service Coordinators, or licensed clinical practitioners who met vendor criteria and standards set by the regional center.

d. When did measurement occur? Entrance measurements typically occurred within 45 days of initial referral, unless complex conditions necessitated subsequent evaluations by specialists (e.g. speech therapist specializing in dysphagia for a child with a feeding disorder). Exit evaluations occurred between 30 and 36 months, unless the parents specifically requested early discharge (prior to age 36 months).

e. If multiple data sources were used, what method was used to summarize the data for each child? If a clinical practitioner used multiple evaluation instruments, and if the different instruments produced different functioning levels, the scores were averaged. Ultimate, by practice and state law, California relies on “informed clinical judgment” to determine a child’s functioning level.

f. What data was reported to the state, and how was the data transmitted? Not applicable for this report. As mentioned previously, the targeted sample was collected on a chart by chart, physical extraction approach conducted by the lead agency.

g. What data analysis methods were used to determine the progress categories? Generally, progress was determined by comparing entrance and exit functioning levels, focusing on the percentage of progress toward “same age” levels. That is, the functioning age in each developmental area was measured against the chronological age, or expected level of functioning. Because of the wide range of functioning considered in developmental research to fall within “normal development”, functioning levels were determined to be at “same age” levels if the functioning level was evaluated to be 80% or higher compared to chronological age. Specifically, the calculation formulas for each of the performance categories are as follows:

PERFORMANCE CATEGORY	PERFORMANCE CATEGORY FORMULAS
General success measure	“Functional quotient” = Quotient of functional age to chronological age, or, functional age/chronological age. In other words, the proportion of functioning in a particular developmental area compared to chronological age. That is, the level at which the child is performing compared to same age peers. For example, a .5 functional quotient means that, in a particular area, a child who is 12 months old is functioning at the 6 month level. If functional quotient is > or = to .8, then child is at “same age”. This allows for the tremendous range of individual differences with “normal” development. If functional age at entrance is within 20% of the chronological age at entrance, i.e., a functional quotient of .8 or greater, then the child is within “same age peers“ range at entry. (No improvement possible: only categories I or V can be entered with this exit condition) If functional age at exit is within 20% of the chronological age at exit, i.e. a functional quotient of .8 or greater, then the child is within “same age” range at exit. (Only performance categories IV or V can be entered with this exit condition). For “Acquisition and use of knowledge and skills” that combines communication and cognitive functioning, enter the category showing the least progress.
I = **Did not improve or no evidence of improvement**	If level of functioning in a particular area at exit is < or = to level of functioning in a particular area at entrance, THEN: **“I – *Did Not Improve*”**
II = **Improved but No Nearer Same-Age Peers**	If Exit FQ is < or = Entrance FQ, but exit functioning > entrance functioning, THEN: **“II – *Improved but No Nearer Same-Age Peers*”**
III = **Improved and Moved Nearer Same-Aged Peers**	If Exit FQ > Entrance FQ, but Exit FQ < .8, THEN **“III – *Improved and Moved Nearer Same-Aged Peers”***

IV = ***Improved and Reached Same-Aged Peers***	If Exit FQ > Entrance FQ, and entrance FQ is < .8, and Exit FQ > or =.8, THEN: **"IV *– Improved and Reached Same-Aged Peers"***
V = ***Maintained Level of Same-Aged Peers***	If entrance FQ is > or = .8 and exit FQ is > or = .8, THEN: **"V *– Maintained Level of Same-Aged Peers"***

Categories of Improvement were operationally defined as follows:

1. ***"Category I - Did not improve"*** is defined as <u>no change</u> in functional age at exit from that measured at entrance.
2. ***"Category II – Improved but No Nearer Same-Age Peers"*** is defined as improving in the specific functional areas, but with the functional level remaining at the same proportion of "same age" (expressed as FQ). The ratio of functional age to chronological age was calculated, both at entrance and exit. The ratio was used because using expressing the delay in terms of an absolute number of months would skew the comparison for young infants compared to toddlers. For example, a functional level at 6 months for a 12-month-old at entrance would be significant. However, a six month delay at exit at 36 months would be considered within the normal range. The calculated FQ in this example would be .5 at entrance (6 months to 12 months) and .83 at exit (30 months to 36 months).
3. ***"Category III – Improved and Moved Nearer Same-Aged Peers"*** is defined as improving in a specific functional area, but the functional level is now higher proportionately when compared to the chronological age.
4. **"*Category IV – Improved and Reached Same-Aged Peers"*** is defined as improving in a specific developmental area, reaching a ratio or proportion of functional level to chronological age of at least .8 (80%) at exit, when the entrance functional level was less than .8 (80%) of the chronological age.
5. ***"Category V - Maintained Level of Same-Aged Peers"*** is defined as having entered functioning at "same-age" equivalence (at least 80% or .8 of chronological age) and maintaining same-age equivalence functioning at exit.

The following are operational definitions of the indicators applied by DDS:

1. In determining a child's functioning level in various developmental areas, an emphasis was placed on "informed clinical judgment". Indeed, this concept is referenced in state law. This clinical judgment is often based on parent interviews, record review, direct observation, and a formal evaluation using standardized instruments. All Early Start entrance and exit data were based on normed and standardized instruments.
2. Premature infants were defined as those born prior to 37 weeks' gestation. Because standardized evaluation instruments vary significantly in adjusting for prematurity, including adjusting for prematurity up to a child's third birthday, we adjusted for prematurity regarding chronological age up to 36 months of age.
3. California believes that to accurately evaluate child outcomes, we must analyze the efficacy of services in light of an evaluation of the child across all developmental areas and in the context of the child's primary diagnosis (cerebral palsy, autism, level mental retardation, severe abuse and neglect, etc.). Therefore, we believe our families are best served by compiling the necessary data elements that are currently recorded by regional centers in the children's' records. Accordingly, our data on child functioning at entrance and exit include the following data elements:
    a. Diagnoses (medical, syndromes, co-occurring conditions, etc.)
    b. Developmental areas:

1) Social –emotional
2) Cognitive
3) Communication
   a.) Expressive
   b.) Receptive
4) Adaptive/self-help
5) Physical
   a.) Fine motor
   b.) Gross motor

4. For the purpose of federal reporting, it is necessary to match the standard developmental areas with OSEP measurement categories as follows:

   a. California's measure of social-emotional functioning was determined to be equivalent to the OSEP measure of "Positive Social-emotional skills."

   b. California's measures of cognitive abilities and receptive and expressive language skills were combined into the OSEP domain of "Acquisition and use of knowledge and skills." Scores for receptive and expressive language skills were averaged and compared to the cognitive ability score. For any cases where improvement in cognitive abilities was different from improvement measured in language skills, the lower improvement score was used, since OSEP's measure combines the two areas.

   c. California's Self-help/Adaptive functioning scores were used to measure "Use of appropriate behaviors to meet their needs." These tests typically combine a parent interview or parent-report questionnaire along with direct testing of the child for corroboration. Some of the self-help/adaptive tests also have a "Teacher" or "Clinician" corroboration component, consisting of having a teacher or clinician who is familiar with the infant or toddler complete an inventory of the child's functional abilities.

   d. Language/Communication was assessed in two distinct areas -- Receptive and Expressive Language skills. The two language areas were averaged into one functional age for the overall Language domain.

5. It is important to note that California continues to serve "High risk" children in the Part C program. These children are defined as those having the following characteristics: very low birth weight (1500 grams); born prior to 37 weeks—prematurity; metabolic problems i.e. hypoglycemia, hypocalcemia; CNS infection/abnormality; seizure activity during first week of life; serious biomedical insult, i.e., CNS bleeds; multiple congenital anomalies requiring special services; positive neonatal toxin screen/drug withdrawal; significantly SGA; prolonged hypoxemia; hyperbilirubinemia; prenatal exposure to teratogens; significant failure to thrive; infant born to DD parent; or persistent tonal problems. To qualify for admission to the Early Start program based on "high risk" factors alone, an infant or toddler must have two of the above-risk factors present.

Improvement Activities/Timelines/Resources

1. Completed and Ongoing Improvement Activities

   a. Professional development partnerships. Accurate and valid evaluations are key to any effort to assess child progress via child outcome measures. In this regard, the local practitioners conducting these evaluations must have the requisite expertise to evaluate infants and toddlers upon entrance and also at exit from early intervention services. DDS as the lead agency has an active partnership with each of the five University of California Medical Schools to assist in training local practitioners in formal continuing medical education sessions. Further, regional center psychologists, physicians and clinical directors meet

regularly in specialty groups including discussion of functional evaluation for developmental progress.

b. Training of hearing officers. DDS, as the lead agency, continues to work with the state Office of Administrative Hearings to plan and conduct annual training of the Administrative Law Judges who are responsible for hearing the due process hearings for Part C. Topics covered in the two June, 2007 trainings include: identifying valid formal assessment instruments, distinguishing among conflicting expert witnesses, evidenced–based practices, accepted criteria for developmental delay, and determining level of certainty for specific diagnoses.

2. Planned Improvement Activities

a. Revision of California's early intervention data form. California has continued development of our system for child outcome measures per feedback from the previous APR/SPP and ongoing discussion with OSEP. Specifically we have revised the State's Early Start Report form for universal reporting of child functioning levels at entrance and upon exit from the early intervention program (refer to draft form attached). We are expanding the form to include more compliance and program evaluation data elements in accordance with the increased OSEP reporting requirements. DDS as the lead agency will collaborate with representatives from the regional centers to ensure data completeness, utility, and expediency. This collaboration process with also promote the productive partnership with a focus on program improvement.

b. DDS has commenced discussions with the University of Southern California graduate psychology program to review and improve evaluation methodology in the various developmental areas.

EARLY START REPORT – DRAFT

1. Report date:

M M D D Y Y Y Y

2. Early Start Report reason [ ]

1 - Initial Report
2 - Annual Review
3 - Periodic Review
4 - Early Exit Final Report
5 – Initial Transition Plan Report (e.g. 30 mos.)
5 - Final Transition (usually 36 months)

3. Primary Service Coordinator
Regional Center:

4. Unique Client Identifier

5. Birth date

M M D D Y Y Y Y

6. Sex:

7. Date of Initial Referral

M M D D Y Y Y Y

8. Initial Referral Source

(If not Regional Center, use codes below)

001- Parent 002 - Physician/Health Plan
003 - County Health Dept. 004 - County Mental Health
005 - DPSS/County Welfare 006 - CA Children Services
007 - CHDP 008 - Local Education Agency
009 - Private Service Agency 010 - Child Care Provider
011 - MCH Contract Project 012 - Child Protective Agency
013 - Hospital 014 - Family Resource Center
015 - Other

9. IFSP Last date

M M D D Y Y Y Y

10. Mother's Disability [ ] [ ] [ ]

1 - None
2 - Developmental Disability
3 - Physical Disability
4 - Mental Disorders
5 - Disability Exists, Type Unknown
6 - Mother's History Unknown

11. Father's Disability [ ] [ ] [ ]

1 - None
2 - Developmental Disability
3 - Physical Disability
4 - Mental Disorders
5 - Disability Exists, Type Unknown
6 - Father's History Unknown

12. Mother's maiden name:

13. HIGH RISK FACTORS (Mark an "X" in all factors that apply)

(a) Medical

[ ] Very low birth weight (1500 grams)

[ ] Prematurity (<32 weeks) number of weeks premature: [ ][ ]

[ ] Metabolic problem, i.e., Hypoglycemia, hypocalcemia

[ ] CNS infection/abnormality

[ ] Non-febrile seizure activity during first week of life

[ ] Serious biomedical insult, i.e., CNS bleeds

[ ] Multiple congenital anomalies or genetic disorders req. spec. srvcs.

[ ] Positive neonatal tox screen/drug withdrawal

[ ] Significantly SGA

[ ] Prolonged Hypoxemia and/or assisted ventilation for 48 hrs or more during 1st month of life

[ ] Hyperbilirubinemia

[ ] Prenatal exposure to terratogens

[ ] Significant failure to thrive

[ ] Persistent tonal problems

(b) Clinical/Behavioral Factors

[ ]Infant born to DD parent

14. Developmental Delay
(Mark an "X" in all that apply)

[ ] Cognitive (acquisition and use of knowledge and skills)
[ ] Physical
[ ] Communication
[ ] Social/Emotional
[ ] Adaptive/Self-Help Skills (Use of appropriate behaviors to meet their needs)

15. Type of Developmental Disability (Mark an "X" in all that apply)

[ ] Mental Retardation [ ] Epilepsy
[ ] Cerebral Palsy [ ] Autism
[ ] Other Developmental Disability

16. Established Risk Condition(s) and Diagnosed Condition(s)

List below conditions and major medical problems that will impact developmental growth or service provision.

ICD-9-CM Code	Condition Type(s)/Specify
[ ][ ][ ] . [ ][ ]	
[ ][ ][ ] . [ ][ ]	
[ ][ ][ ] . [ ][ ]	

17. Vision Status [ ]

0 - No vision loss
1 - Near normal
2 - Moderate impairment
3 - Severe impairment (legally blind)
4 - Total blindness (no light perception)
5 - Vision loss, one eye
6 - Vision loss diagnosed, severity undetermined
7 - Vision loss suspected, not diagnosed
8 - Not tested

18. Hearing Status [ ]

0 - Hearing within normal limits
1 - Mild to moderate hearing loss
2 - Severe hearing loss
3 - Profound hearing loss
4 - Hearing loss - one ear
5 - Hearing loss diagnosed, severity undetermined
6 - Hearing loss suspected, not diagnosed
7 - Not tested

19. Ambulation [ ]

1 – Newborn
2 - Has head control
3 - Sits with support
4 - Stands with support
5 - Walks with support (i.e.,hand holding, normal development)
6 - Walks without support
7 - Walks well
8 - Unknown

20. Special Aids or Equipment (Mark an "X" in all that apply)

[ ] None [ ] Apnea Monitor [ ] Splints, casts, braces [ ] Feeding Tube (N.G.)
[ ] Oxygen equipment [ ] Gastrostomey Tube [ ] Feeding devices [ ] Tracheostomy equipment
[ ] Positioning equipment [ ] Other assistive devices [ ] Other Ostomy Equipment

21. TYPE OF SERVICE (Mark an "X" in the appropriate boxes in column 1)

[ ] Medical Assessment/Consultation
[ ] Nutrition Assessment/Consultation
[ ] Nursing Assessment/Intervention
[ ] Developmental/Psychological Assessment
[ ] Social Work Services
[ ] Family Training and Counseling
[ ] Occupational Therapy
[ ] Physical Therapy
[ ] Language/Speech Services
[ ] Audiology
[ ] Vision Services
[ ] Assistive Technology Services
[ ] Respite Care
[ ] Infant Development Program
[ ] Service Coordination/Case Management
[ ] Transportation
[ ] Health Service/Intervention
[ ] Behavior Intervention

22. LOCATION: Location of Primary Service(s) or Program(s): (Mark an "X" in the boxes that apply)

[ ] Early Intervention classroom/program/center
[ ] Hospital, Inpatient
[ ] Residential Facility
[ ] Family child care
[ ] Outpatient Service Facility
[ ] Other Setting
[ ] Home
[ ] Regular Nursery School/Child Care Center

[ ] Justification documented in family record for all settings not considered a "natural environment".

<u>**Transition Planning**</u>

23. Parent Notification date:

M	M	D	D	Y	Y	Y	Y

24. LEA notification date:

M	M	D	D	Y	Y	Y	Y

25. First Transition Meeting:

M	M	D	D	Y	Y	Y	Y

26. Last Transition Meeting:

M	M	D	D	Y	Y	Y	Y

27. Referral to: Mark an x in the boxes that apply

[ ] School program
[ ] Private Agency
[ ] Family Resource Center
[ ] Regional Center Services
[ ] None required
[ ] Parent refusal

Referral Date (if applicable):

M	M	D	D	Y	Y	Y	Y

28. Child Outcomes Record all ages in months

Developmental Areas	**ENTRANCE** Eval Date: [ ] same date for all areas Instruments Used- list primary first	Functional Age [FA1] (in months)		**ENTRANCE** Eval Date: [ ] same date for all areas Instruments Used- list primary first	Functional Age [FA2] (in months)
Social-Emotional	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Cognitive (acquisition and use of knowledge and skills	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Communication (Expressive)	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Communication (Receptive)	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Self-Help (Use of appropriate behaviors to meet their needs)	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Physical (Fine Motor)	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]
Physical (Gross Motor)	M M D D Y Y Y Y	[ ][ ]		M M D D Y Y Y Y	[ ][ ]

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Effective General Supervision Part C / Child Find

Indicator 7: Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

(20 USC 1416(a) (3) (B) and 1442)

Measurement:

Percent equals number of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting was conducted within Part C's 45-day timeline divided by number of eligible infants and toddlers evaluated and assessed times 100.

States must also account for untimely evaluations.

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

Evaluation and assessment requirements and initial IFSP meeting timelines are compliance items monitored by ongoing record reviews and triennial site monitoring visits. Regional centers are credited with this item based on timeliness and completeness of evaluations and assessments. IFSPs that are based on incomplete data are not credited. To correct this, regional centers have technical assistance provided by DDS staff aimed at marshalling the resources to come into compliance within one year of the non-compliance finding.

In OSEP's September 30, 2005 letter to DDS, California was directed to address plans to improve performance in this area in the SPP. The OSEP letter was in response to the State's April 19, 2005 submission of the Federal Fiscal Year 2003 Annual Performance Report. Specifically, the State was directed to ensure compliance with the requirement that initial evaluations and assessments are completed, and an initial IFSP meeting is convened with 45 days from referral. California must also ensure that IFSPs include a statement of the child's present level of development in five areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development.

Baseline Data for FFY 2004 (2004-2005):

Baseline data from 2004-05 indicates that 72.38 percent of children have their evaluation and assessment completed and have an initial IFSP meeting held within 45 days of referral (422 divided by 583, times 100 equals 72.38 percent.)

Discussion of Baseline Data:

This 72.38 percent represents slippage from the prior reporting years (87.66 percent and 84.5percent respectively). Often during the first IFSP meeting, it is determined that additional assessments in specific areas are needed to determine additional service needs. When this requires the services of specialty therapists (speech, occupational, physical and/or sensory integration therapists) or personnel experienced in early childhood vision and/or hearing impairments, there can be delays in obtaining the assessments. Further, regional centers have been held to the standard of having completed both initial evaluations and also more comprehensive evaluations in the same specialty areas if the initial evaluation indicates a need for a more comprehensive evaluation. California will continue to dialogue with OSEP regarding the evaluations and assessments required within the first 45 days, as it is likely that California is much closer to the required standard than our reported percent for this indicator.

Finally, the State continues to experience shortages of these qualified professionals required to conduct the evaluations in the different specialty areas.

OSEP requires a target of 100 percent for this indicator.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	100% of children have evaluation, assessment and IFSP meeting within 45 days.
2006 (2006-2007)	100% of children have evaluation, assessment and IFSP meeting within 45 days.
2007 (2007-2008)	100% of children have evaluation, assessment and IFSP meeting within 45 days.
2008 (2008-2009)	100% of children have evaluation, assessment and IFSP meeting within 45 days.
2009 (2009-2010)	100% of children have evaluation, assessment and IFSP meeting within 45 days.
2010 (2010-2011)	100% of children have evaluation, assessment and IFSP meeting within 45 days.

Improvement Activities/Timelines/Resources:

For an overview of California's improvement approach, see page 4, Improvement Activities/Timelines/Resources for Indicator 1, paragraph one.

In major urban areas the private sector is able to out bid the regional centers for the scarce therapists available. DDS has implemented a mechanism to allow regional centers to use an Early Start specialized therapeutic service code to purchase services in cases where application of existing rates would result in any delays in the provision of early intervention services. The use of this service code continues to improve the timeliness of both the evaluation and assessment and the provision of services. DDS will also be working with the ICC to identify improvement activities to focus on creating a greater supply of providers in high demand occupations. Finally, DDS will continue to partner with the University of California Medical Schools to improve the professional expertise of community clinicians to promote increased access to quality services.

Local programs are encouraged to initiate services in a timely manner for all services determined at the initial IFSP meeting. Additional service needs identified in subsequent assessments will be initiated as soon as possible. The annual goals for improvement in this area of performance will be shared with the regional center programs and their progress toward the goal will be made part of Early Start Statistics Report. This report lists key performance indicators and is shared with the centers and the ICC. DDS is also collaborating with CDE to develop strategies such as joint training of LEAs, collaborative local technical assistance, state level planning meetings, and co-sponsorship of local pilot projects to improve the performance of LEAs in meeting this target.

For FFY 2006, DDS has drafted changes to its Early Start Report form and is in the process of submitting it to stakeholders for review and feedback. This form resides in the San Diego Information System (SANDIS) and is the data tracking tool used for all Early Start participants. The State has added the C*hild's Referral Date* to the list of data elements on the form. With the IFSP date that is already reported

on the form, California will be able to universally report for this Indicator when completed. Use of the data in the form will not be available for reporting purposes until at least the FFY 2009-2010 reporting period.

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Effective General Supervision Part C / Effective Transition

Indicator 8: Percent of all children exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:

A. IFSPs with transition steps and services
B. Notification to LEA, if child potentially eligible for Part B: and
C. Transition conference, if child potentially eligible for Part B.

(20 USC 1416(a) (3) (B) and 1442)

Measurement:

A. Percent equals number of children exiting Part C who have an IFSP with transition steps and services divided by number of children exiting Part C times 100.

B. Percent equals number of children exiting Part C and potentially eligible for Part B where notification to the LEA occurred divided by the number of children exiting Part C who were potentially eligible for Part B times 100

C. Percent equals number of children exiting Part C and potentially eligible for Part B where the transition conference occurred divided by the number of children exiting Part C who were potentially eligible for Part B times 100.

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

This item is measured by reviewing the data found in the clinical record during periodic record reviews. The sampling is organized in such a way as to insure that some transition children are included in each record review.

Baseline Data for FFY 2004 (2004-2005):

Transition Steps: 90.24 percent (34 divided by 41, times 100 equals 90.24 percent)

LEA Notification: 91.89 percent (34 divided by 37, times 100 equals 91.89 percent)

Transition Conference with LEA: 88.37 percent (39 divided by 43, times 100 equals 88.37 percent).

Discussion of Baseline Data:

Each regional center works with many LEAs. The extent of the communication and cooperation between them varies.

OSEP requires a target of 100 percent for this indicator.

FFY	Measurable and Rigorous Target		
	Transition Steps	**LEA Notification**	**Transition Conference**
2005 (2005-2006)	100%	100%	100%

FFY	Measurable and Rigorous Target		
	Transition Steps	**LEA Notification**	**Transition Conference**
2006 (2006-2007)	100%	100%	100%
2007 (2007-2008)	100%	100%	100%
2008 (2008-2009)	100%	100%	100%
2009 (2009-2010)	100%	100%	100%
2010 (2010-2011)	100%	100%	100%

Improvement Activities/Timelines/Resources:

For an overview of California's improvement approach, see page 4, Improvement Activities/Timelines/Resources for Indicator 1, paragraph one.

The improvement strategy for this item will involve improvement in key components of the special education system. In FFY 2005 (2005-2006), Early Start and CDE began conducting Transition Workshops in locations across the state. These workshops communicate the requirements and importance of interagency communication at the point of transition for Early Start families and children.

Through training efforts, Early Start will share with regional centers the models that have been successful in many communities, such as identified agency contacts for the transition issues. This model identifies an LEA contact person to work with each Early Start office or service coordinator. This contact is available on a year around basis to facilitate the transition of Early Start referrals.

The SPPs for both DDS and CDE (Part B of IDEA) include indicators measuring the completion of transition from Part C to Part B by the child's third birthday. DDS and CDE will continue to foster collaboration between the regional centers and LEAs to achieve this goal. Further, DDS and CDE continue to improve their collaborative partnership with joint planning sessions, joint trainings of regional centers and LEAs, and also local pilot projects to field test service models focusing on outcome evaluation.

In FFY 2006, DDS drafted changes to its Early Start Report (ESR) form and is now in the process of submitting it to stakeholders for review and feedback. This form resides in the San Diego Information System (SANDIS) and is the data tracking tool used for all Early Start participants. Revisions to the existing system to universally report on transition planning were made in collaboration with CDE to better address the national transition issue. Changes to the ESR form that DDS is proposing to stakeholders include not only adding a Part B Referral Date data field, but date data fields for Parent Notification, LEA Notification, First Transition Meeting, and Last Transition Meeting as well. CDE is adding separate referral and evaluation data fields to its CASEMIS system. With the changes made to both agencies' systems, DDS and CDE are planning to target correction of noncompliance in a more appropriately and more effective manner. Use of the data in the ESR form will not be available for reporting purposes until at least the FFY 2009-2010 reporting period. (Refer to Indicator 9 for complete description).

In FFY 2006, both DDS and CDE committed to participate in the National Early Childhood Transition Initiative through the Western Regional Resource Center, in order to improve transition outcomes in California. This is a long term project that has not yet moved beyond initial discussions but is expected to assist in the development of State and local area policies and procedures.

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 9: General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification:
   a. number of findings of noncompliance made related to priority areas.
   b. number of corrections completed as soon as possible but in no case later than one year from identification.

   Percent equals b divided by a times 100. See table entitled Monitoring Priorities for items not in compliance. For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

B. Percent of noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification:
   a. number of findings of noncompliance made related to such areas.
   b. number of corrections completed as soon as possible but in no case later than one year from identification.

   Percent equals b divided by a times 100. For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification:
   a. number of EIS programs in which noncompliance was identified through other mechanisms.
   b. number of findings of noncompliance made.
   c. number of corrections completed as soon as possible but in no case later than one year from identification.

   Percent equals c divided by b times 100. For any noncompliance not corrected within one year of identification, describe what actions, including technical assistance and/or enforcement that the State has taken.

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

For this performance indicator, California has restructured its General Supervision System database and for baseline development, used a variation of the OSEP document submitted for the FFY 2005 APR. This document is re-entitled "*Aggregated Baseline Data for 2005-2010 SP*" (Attachment 2). Refer to Tables 9A, 9B, and 9C for data collected. Data for measurement of Indicators A and B were retrieved from performance data during regional center record reviews. For measurement C above, these data are drawn from the DDS Office of Human Rights and Advocacy Services (complaints) and the Office of Administrative Hearings (OAH) database (mediations and due process hearings).

Beginning with FFY 2006, findings are now categorized for reporting purposes and are not considered a finding unless the number of occurrences for a specific category of a specific local program falls under 85

percent. This includes findings obtained from both site monitoring visits and review/analysis of data for critical indicators but does not include findings for the performance indicators that do not have targets of 100 percents. Complaints or due process findings associated with the various SPP indicators that are reported are also not included.

Baseline Data for FFY 2004 (2004-2005):

The measurement formula for the overall performance rate for this indicator is (number of potential findings, less number of findings, plus number of timely corrections) divided by number of potential findings. For FFY 2004, the overall performance rate is 96.27 percent ((28,474 plus 1,128 less 66) / 28,474 equals 96.27 percent). The measurement formula for the overall correction rate is number of timely corrections divided by the number of findings. For FFY 2004, the overall correction rate is 5.85 percent (66 divided by 1,128 times 100 equals 5.85 percent). As reported in the FFY 2005 Annual Performance Report, the majority of findings is perhaps due to DDS's treatment of findings from FFY to FFY and because timely corrective action to take was not appropriately stipulated in finding letters to the regional centers.

Table 9A

This table is comprised of indicators specified in OSEP's document (Attachment 2). For FFY 2004 (200402005), DDS is unable to report on Indicator 1 (Refer to Indicator 1 for clarification). Indicator 3 data reported is a preliminary baseline (Refer to Indicator 3 for clarification). With the exception of Indicators 2, 5, and 6, all measurements are based on record reviews conducted at ten of the 21 regional centers (local level). Indicators 5 and 6 were measured from available data. Indicator 2 is also measured from available data but as discussed in California's FFY 2005 APR, target data for it has been adjusted because of the new data collection methodology being applied.

Indicator	Potential Findings	Findings	Number Verified Corrected	% Corrected in Timelines	Overall Performance Rate
Services Are Provided in a Timely Manner	26,649	921	0	0.00%	96.54%
Services Are Provided in Natural Environment	195	4	0	2.05%	97.95%
IFSPs Are Established Within the 45-Day Timeline	195	43	6	13.95%	86.05%
Timely Transition Planning Part C to Part B	59	6	5	83.33%	98.31%
Total	27,098	974	11	1.13%%	96.45%

Table 9B

This table is comprised of six indicators that California will monitor because of their association with the priority indicators in Table A, importance to the provision of timely services to the infants/toddlers and their families, and because of both federal and state mandated requirements. All measurements for these specific indicators are based on record reviews conducted at ten of the 21 regional centers (local level).

Indicator	Potential Findings	Findings	Number Verified Corrected	% Corrected in Timelines	Overall Performance Rate
IFSP Contains 5 Domains	195	45	19	42.22%	86.67%

IFSP Meeting Notice Provided to Family	195	26	12	46.15%	92.82%
Outcomes Contain Procedures, Criteria, Timelines	195	15	9	60.0%	96.92%
Services Contain Method, Frequency, Intensity, Duration	195	7	3	42.86%	97.95%
IFSP Contains Family Concerns, Priorities, Resources	195	3	1	33.33%	98.97%
Evaluations Are Conducted in Timely Manner	195	53	6	11.32%	75.90%
Total	1,170	149	50	33.56%	91.54%

Table 9C

This table is comprised of the data in the "*SPP/APR Attachment 1 (Form)*" on page 46 of this report.

Indicator	Potential Findings	Findings	Number Corrected	% Corrected in Timelines	Overall Performance Rate
Agencies in Which Noncompliance Was Identified (Two Agencies)	173	0	0	100%	100%

Discussion of Baseline Data:

Table 9A

Although the reporting requirement only demonstrates a "noncompliance rate" based on the number of findings and the findings that were verified as corrected within one year, further analysis of the data indicates that California's overall performance regarding the indicators measured is high. There were 195 records reviewed at ten regional centers for this table. With the addition of the electronic data for timely services, there was a potential for 27,098 findings. Even though results yielded 974 findings that were not verified as corrected in a timely fashion, 96.45 percent (27,098 less 974 plus 11) divided by 27,098 times 100 equals 96.45 percent) of all other record elements examined were satisfactory.

Table 9B

Analysis of the data for Table 9B demonstrates that California's overall performance regarding the indicators measured is high. There were 195 records reviewed at ten regional centers for this table and across all indicators, a potential for 1,170 findings. While results yielded 149 findings that were not verified as being corrected in a timely fashion, 91.54 percent ((1,170 less 149 plus 50) divided by 1,170 times 100 equals 91.54 percent) of all other record elements examined were satisfactory.

The indicator "Evaluations Are Conducted in Timely Manner" is not associated with the initial evaluations/assessments and establishment of an infant/toddler's IFSP within 45 days, but is the higher measurement standard California has mandated for professional evaluation at the regional centers. These findings are related to the lack of access to professional services for evaluations of hearing and vision, which is elaborated upon in Indicator 7, and continues to be addressed by DDS through the use of the specialized therapeutic service code and waivers to state requirements that allow the use of speech and language assistants.

Table 9C

California's overall performance rate for this indicator was 100 percent, with no findings to for this indicator.

California's complaint/resolution process involves procedures that are distinct from the system for resolving disagreements under due process (Refer to Indicators 10, 11, and 13). The two agencies/entities that provide data for the measurement of this indicator are the Lead Agency's Office of Human Rights and Advocacy (OHRAS) and an independent contractor for the Lead Agency, the Office of Administrative Hearings (OAH). Violations of statute or regulations are investigated by OHRAS, where as due process filings are resolved by OAH. If a complaint is received by OHRAS that addresses a disagreement regarding the denial or change in eligibility or services, it is referred to the OAH for adjudication. Informal local resolution is encouraged but not required. Many issues are resolved in this informal, local manner.

OSEP requires a target of 100 percent for this indicator.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	100% of noncompliance findings are corrected within one year of identification
2006 (2006-2007)	100% of noncompliance findings are corrected within one year of identification
2007 (2007-2008)	100% of noncompliance findings are corrected within one year of identification
2008 (2008-2009)	100% of noncompliance findings are corrected within one year of identification
2009 (2009-2010)	100% of noncompliance findings are corrected within one year of identification
2010 (2010-2011)	100% of noncompliance findings are corrected within one year of identification

Improvement Activities/Timelines/Resources:

1. Following site monitoring visits, results of findings will be sent to regional centers requesting that corrective action be taken and that findings are to be corrected by no later than one year from the date of the transmittal letter. Additionally, DDS will prescribe actions that a regional center can take to be considered appropriate corrective action. Included will be a request to notify DDS in writing that corrective action has been completed and what specific actions were performed. Upon receipt of the regional center's letter of completed corrective action, DDS will verify where possible and consider the findings as having been corrected.
2. DDS will continue to analyze and reconfigure its database to effectively track and monitor timeliness for correction of identified non-compliance and for use in identifying potential statewide/regional center-specific systemic issues that might require targeted technical assistance.
3. For regional centers that are identified as not appropriately correcting non-compliance in a timely manner, DDS will review the case and consider the following actions to take:
    a. Technical assistance only
    b. Additional site monitoring visits focusing on areas of non-compliance
    c. Combined additional site monitoring visits with technical assistance

d. Training
e. Combined Training with technical assistance.
f. Letter from the Director of DDS to the Executive Director of the Regional Center
g. Performance contract language for improvement

4. Beginning in FFY 2006, DDS will explore the potential of general supervision through focused monitoring and will convene a stakeholder workgroup with the intent of re-designing its current general supervision system. The current general supervision system consists of reviewing/analyzing data extracted from SANDIS/UFS, conducting triennial Site Monitoring Visits, and conducting periodic on-site record reviews of individual infants and toddlers as a follow up activity to the more comprehensive Site Monitoring Visits. From these activities, DDS determines the status of local programs in meeting indicator targets, identifies statewide and local program strengths and weaknesses, plans improvement activities and takes enforcement actions where needed, and reports to OSEP each year.

   The stakeholder workgroup will have the long term goal of completing the State's new general supervision through focused monitoring system projected for completion in FFY 2009. The concept behind the new system will be to identify and use all available data and information (statewide and local) in the planning and implementation of on-site visits to local programs given available resources and create new sources or acquisition methodologies if needed. Visits will be planned using a desk audit to focus on specific aspects of programs, policies, and/or procedures designed to yield results for local program improvement, APR indicator reporting, and corrective action planning. The status of this activity will be updated in next year's APR.

Part C – SPP /APR Attachment 1 (Form)

Report of Dispute Resolution Under Part C of the Individuals with Disabilities Education Act Complaints, Mediations, Resolution Sessions, and Due Process Hearings

SECTION A: Signed, written complaints	
(1) Signed, written complaints total	
(1.1) Complaints with reports issued	6
(a) Reports with findings	6
(b) Reports within timeline	5
(c) Reports within extended timelines	1
(1.2) Complaints withdrawn or dismissed	0
(1.3) Complaints pending	0
(a) Complaints pending a due process hearing	0

SECTION B: Mediation requests	
(2) Mediation requests total	63
(2.1) Mediations	
(a) Mediations related to due process	33
(i) Mediation agreements	17
(b) Mediations not related to due process	0
(i) Mediation agreements	0
(2.2) Mediations not held (including pending)	30*

SECTION C: Hearing requests	
(3) Hearing requests total	167
(3.1) Resolution sessions	Not applicable
(a) Settlement agreements	Not applicable
(3.2) Hearings (fully adjudicated)	16
(a) Decisions within timeline **SELECT** timeline used {30 day/Part C 45 day/Part B 45 day}	16
(b) Decisions within extended timeline	0
(3.3) Resolved without a hearing	121

* = Pending but within timeline

Attachment 2

Aggregated Baseline Data for 2005-2010 SPP

Indicator 9:

	# of findings of noncompliance	# of corrections verified within one year	Percent corrected
A. Monitoring Priorities	974	11	1.13%
B. Other	149	50	33.56%
C. Other mechanisms	5	5	100.00%
TOTAL	1,128	66	1,128/66 = 5.85%

Table for #9A

Monitoring Priority: Effective General Supervision Part C		
Indicator	Measurement Calculation	Explanation
9. General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification. A. Percent of noncompliance related to monitoring priority areas and indicators corrected within one year of identification: a. # of findings of noncompliance made related to monitoring priority areas and indicators. b. # of corrections completed as soon as possible but in no case later than one year from identification. Percent = b divided by a times 100.	See attached Calculation Chart for specifications of data included here a = 974 b = 11 b/a - 11/974 = 0.0113 X 100 = 1.13%	An on-site review was conducted for only 6 of the 21 regional center programs. There was the potential for 244 findings for this table, which demonstrates that overall, there was only a 5.74% noncompliance rate and a 94.26% compliance rate.

Compilation Table

Indicator	Monitoring Method	# Reviewed	# with Findings	a. # of Findings	b. # Verified Corrected w/in 1 yr	% Corrected w/in 1 yr
1. Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner ***(Refer to Indicator 1 for discussion)***	Self-Review	NA				NA
	On-site Visit	NA				NA
	Data Review	26,649	921	921	0	0.00%
	Other: Specify	NA				NA
2. Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the	Self-Review	NA				NA
	On-site Visit	195	4	4	0	0%
	Data Review	NA				NA

Indicator	Monitoring Method	# Reviewed	# with Findings	a. # of Findings	b. # Verified Corrected w/in 1 yr	% Corrected w/in 1 yr
home or programs for typically developing children.	Other: Specify	NA				NA
3. Percent of infants and toddlers with IFSPs who demonstrate improved: positive social-emotional skills, acquisition and use of knowledge and skills; use of appropriate behaviors to meet their needs. **NEW INDICATOR NO DATA 2004-05**	Self-Review					
	On-site Visit					
	Data Review					
	Other: Specify					
4. Percent of families participating in Part C who report that early intervention services helped the family: know their rights; effectively communicate their children's needs; and help their children develop and learn. **NEW INDICATOR NO DATA 2004-05**	Self-Review					
	On-site Visit					
	Data Review					
	Other:					
5. Percent of infants and toddlers birth to 1 with IFSPs.	Self-Review	NA				NA
	On-site Visit	NA				NA
	Data Review	5,643	NA	NA	NA	NA
	Other: Specify	NA				NA
6. Percent of infants and toddlers birth to 3 with IFSPs.	Self-Review	NA				NA
	On-site Visit	NA				NA
	Data Review	28,781	NA	NA	NA	NA
	Other: Specify	NA				NA
7. Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45 day timeline.	Self-Review					NA
	On-site Visit	195	43	43	6	13.95%
	Data Review	NA				NA
	Other: Specify	NA				NA
8. Percent of all children	Self-Review	NA				NA

Indicator	Monitoring Method	# Reviewed	# with Findings	a. # of Findings	b. # Verified Corrected w/in 1 yr	% Corrected w/in 1 yr
exiting Part C who received timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday.	On-site Visit	59	6	6	5	83.33%
	Data Review	NA				NA
	Other: Specify	NA				NA
TOTALS	SUM COLUMNS A AND B			974	0	

Table for #9B

Monitoring Priority: Effective General Supervision Part C		
Indicator	Measurement Calculation	Explanation
9. General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification. B. Percent of noncompliance related to areas not included in the above monitoring priority areas and indicators corrected within one year of identification: a. # of findings of noncompliance made related to such areas. b. # of corrections completed as soon as possible but in no case later than one year from identification. Percent = b divided by a times 100.	a = 149 b = 50 b/a - 50/149 = 0.3356 X 100 = 33.56%	An on-site review was conducted for only 6 of the 21 regional center programs. There was the potential for 690 findings for this table, which demonstrates that overall, there was only a 7.83% noncompliance rate and a 92.17% compliance rate.

Table for Indicator #9C

Monitoring Priority: Effective General Supervision Part C		
Indicator	Measurement Calculation	Explanation
9. General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification. C. Percent of noncompliance identified through other mechanisms (complaints, due process hearings, mediations, etc.) corrected within one year of identification: a. # of agencies in which noncompliance was identified through other mechanisms. b. # of findings of noncompliance made. c. # of corrections completed as soon as possible but in no case later than one year from identification. Percent = c divided by b times 100.	a = 2 b = 5 c = 5 c/b - 5/5 x 100 = 1 x 100 = 100%	A data review was conducted for all 21 regional center programs.

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 11: Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent equals (3.2)(a) plus (3.2)(b) divided by (3.2) times 100.

(Percent equals (number of decisions within timeline {30 day/Part C 45 day/Part B 45 day} plus number of decisions within extended timeline) divided by total number of hearings (fully adjudicated) times 100)

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

All participants in the Early Start Program are informed of their right to undertake a due process proceeding if they are unable to reach agreement with the regional center or LEA about the substance of the family's program. DDS contracts with the OAH to provide an impartial adjudication of these issues. OAH provides DDS with the results of the hearings and formal mediation agreements and data on the numbers cases pending, resolved and dismissed.

Baseline Data for FFY 2004 (2004-2005):

The current data indicates that due process hearing requests are adjudicated within the 30 day timeline 100 percent of the time (measurement formula: 16 plus 0, divided by 16 times 100 equals 100 percent.)

Discussion of Baseline Data:

DDS has an excellent working arrangement with OAH and the performance of the requirements of this process has been excellent. A high level of quality and performance can be expected in the future.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	100% of cases will be adjudicated within the 30-day timeline.
2006 (2006-2007)	100% of cases will be adjudicated within the 30-day timeline.
2007 (2007-2008)	100% of cases will be adjudicated within the 30-day timeline.
2008 (2008-2009)	100% of cases will be adjudicated within the 30-day timeline.

FFY	Measurable and Rigorous Target
2009 (2009-2010)	100% of cases will be adjudicated within the 30-day timeline.
2010 (2010-2011)	100% of cases will be adjudicated within the 30-day timeline.

Improvement Activities/Timelines/Resources:

In OSEP's September 30, 2005, letter to DDS, California was directed to address plans in the SPP to improve performance in this area. The OSEP letter was in response to the State's April 19, 2005, submission of the Federal Fiscal Year 2003 Annual Performance Report. Specifically, the State was directed to ensure compliance with the requirement that not later than 30 days after the receipt of a parent's complaint, the impartial proceeding required under this subpart is completed and a written decision mailed to each of the parties.

When the OAH receives a parent's complaint/filing for due process hearing, a mediation session and due process hearing are scheduled to be held within the 30 day timeline. Participation in the mediation is voluntary for parents. OAH may allow an extension to the 30 day timeline only when the justification for the extension is due to exceptional circumstances. Exceptional circumstances may include family illness, the family's absence from the geographical area or the family's request to secure evidence pertaining to the complaint. Exceptional circumstances do not include administrative delays by the regional center/LEA.

As of FFY 2006, DDS is conducting contract negotiations with the OAH in order to add and/or clarify information/data in its submissions of reports to DDS. Negotiations include the general streamlining of information/data and language regarding the mailing of settlements and decisions, and the legal implications and impact of changing the current definition of "exceptional family circumstances". Early Start will also continuously monitor the OAH contract to ensure that this current level of performance is maintained.

Part C State Performance Plan (SPP) for 2005-2010

Overview of the State Performance Plan Development:

Please refer to overview of SPP development on page 1.

Monitoring Priority: Effective General Supervision Part C / General Supervision

Indicator 13: Percent of mediations held that resulted in mediation agreements.

(20 U.S.C. 1416(a) (3) (B) and 1442)

Measurement:

Percent equals (2.1)(a) (i) plus (2.1)(b) (i)) divided by (2.1)(a) times 100.

(Percent equals (number of mediations not related to due process plus number of mediation agreements) Divided by total number of mediations times 100)

CALIFORNIA'S RESPONSE

Overview of Issue/Description of System or Process:

See Indicator 11 above, for the description of the process.

Baseline Data for FFY 2004 (2004-2005):

Baseline data indicates that 51.52 percent of mediations that were held resulted in an agreement (measurement formula: 17 plus 0, plus 0 divided by 33 times 100 percent equals 51.52 percent.)

Discussion of Baseline Data:

Of the 167 due process filings for this period, 104 were withdrawn subsequent to informal processes. The parties agreed prior to the scheduled formal mediation or due process hearing. Therefore, mediation was offered to the remaining 33 cases. Of these, 17 had formal mediation agreements and the remaining 16 were fully adjudicated in a due process hearing.

The ICC recommended setting the measurement for this indicator at 50 percent with the understanding that the lead agency will explore ways to probe individual cases to determine the reasons why a family withdraws their request for mediation/due process hearing in the majority of filings. With the baseline percentage of 51.52 percent, and considering the ICC's recommendation, DDS established a target of 55 percent for mediations held that resulted in mediation agreements.

FFY	Measurable and Rigorous Target
2005 (2005-2006)	55% of mediations will result in agreements.
2006 (2006-2007)	55% of mediations will result in agreements.
2007 (2007-2008)	55% of mediations will result in agreements.
2008 (2008-2009)	55% of mediations will result in agreements.

FFY	Measurable and Rigorous Target
2009 (2009-2010)	55% of mediations will result in agreements.
2010 (2010-2011)	55% of mediations will result in agreements.

Improvement Activities/Timelines/Resources:

The Quality Service Delivery System Committee of the ICC in collaboration with DDS will monitor this indicator and continue to make recommendations to improve the state's performance on this item, if needed. Every six months, DDS will present a data report to this group and include the progress towards the goal. When improvements are needed, the ICC will make recommendations to DDS for actions to improve performance on this indicator.