

**Early On® Redesign  
Public Comment on  
Recommendations from the Eligible Population Task Force**

*(NOTE: This document includes public comment received via e-mail through 4/20/06. Comment has been organized by Activity, but has not been otherwise edited or modified.)*

**Activity C. Clarify current eligibility criteria**

**RECOMMENDATIONS**

- Adopt the revised and updated Established Conditions document.
- Adopt the following criteria for children eligible for *Early On* due to developmental delay:

Age	Percent delay	Methodology
Up to 2 months old*  <i>*Corrected age</i>	<ul style="list-style-type: none"> <li>• Any delay</li> </ul>	<ul style="list-style-type: none"> <li>• Informed Clinical Opinion</li> <li>• Must re-determine eligibility at or before 6 month IFSP review using a recommended Developmental Evaluation Tool</li> </ul>
2-36 months old	<ul style="list-style-type: none"> <li>• 25% delay in 1 area of development (<i>or equivalent Standard Deviation delay score</i>)</li> <li>• 20% delay in 2 or more areas of development (<i>or equivalent Standard Deviation delay score</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Developmental Evaluation Tool (primary)</li> <li>• Informed Clinical Opinion (secondary)</li> </ul>

- Adopt the proposed document on Informed Clinical Opinion for *Early On* to complement the recommendations regarding tools.
- Clarify how long to correct for prematurity when doing developmental evaluations.
- During the first year of implementation of new eligibility criteria, monitor Child Find/enrollment data to understand the impact of the change.
- Consider setting up a 'tracking' system for children who do not qualify under the new eligibility definitions.

**Public Comments Received:**

- My concern, which has been expressed by many others in our U.P Early On network, is that [placing a percentage of delay criteria for developmental delay will exclude children from services who may be helped at the earliest point of concern](#), causing them to wait longer for eligibility and thereby delaying appropriate services which would minimize the child's needs over the long term. It is also important that informed clinical opinion remain as an important determinant in eligibility as relying solely on data and percentages stands to limit the access of children whose families need education and guidance in developmental areas to insure that the children

receive needed stimulation. If a delay shows up, however small, attending to the need promptly is the most efficient, cost effective and practical way to insure that the child catches up. Waiting only serves to widen gaps in development and it is more difficult to facilitate the needed changes when needs are greater and methods of child-rearing/teaching have become ingrained. Early On has always stood for these concepts of creating change and changing them will be a definite step backwards for early intervention practice.

- I believe that if we are switching to a percentage delay then it should be the same percentage across the board. It will be difficult enough to get service coordinators to determine if a delay is 25% and there is a chart that can be used with the IDA. To ask them to calculate a 20% delay is asking too much and will just confuse them.
- I am concerned about the latest proposal for an established % delay in order to qualify for services through Early On. I have been involved with EO for the last 15 years and been very proud of the work we've done with children with the beginnings of a delay, particularly in speech development. Because we qualified children for services with anything below 100% and our informed, clinical opinion that something isn't quite right, we've been able to support children before there are major delays. Now I feel you have decided to take a giant step backward toward the model we had before EO existed, namely Special Ed. It was so frustrating back then to know children would need services but be prevented from offering any until they really failed. I would appreciate understanding the reasoning (I always assume it's tied to money these days!) behind this decision. I would even more appreciate you changing the % to read "10% delay needs to be established" or possibly "at least a 15% delay in 1 area and 10% in 2 or more areas." This would allow us to continue supporting children and families in the best possible way to prevent the need for special ed.
- This information appears to be an appropriate way to identify and serve those needing Early On services.
- Hello, I am new to the Early On program and new to the special education field, previously I have been a lower elementary teacher. I recently found out about the possible restructure of Early On and how to qualify a child for part c. I am very sad to hear that it would require a 25% delay in one area of the IDA or a 20% delay in two or more areas of the IDA. I would strongly urge to keep the recommendations for part c how they are right now. There are so many children that greatly benefit from the part c early on early intervention program. If the changes are made, I bet there will be more problems down the road as the kids that could have received services are no longer eligible.
- I am responding on behalf of the Early On Coordinators from the Upper Peninsula. The following are some of the concerns that we have. Eligible Populations: 1. The Percent Delay is very concerning to us as a group. It seems to be pushing Early On to become more like Special Ed and we feel that many children would "fall through the cracks" under this plan. This would also cause concern for children with suspected disorders or conditions that cannot be diagnosed before a child's third birthday. Early On should remain broad so that children with "smaller" amounts of delay can receive services before it becomes a bigger problem and these children then require even more services once they enter school. 2. There is still no mention of prematurity as an established condition. With the rise in referrals for micro preemies, this is a big concern. We need a way to make these children eligible so,

once again, any problems can be dealt with right away. 3. Informed Clinical Opinion: If informed clinical opinion cannot be used for eligibility, what is it for? This is how we capture children who may score OK when tested but something is unusual or out of the ordinary and needs treatment, this was how we could qualify a child based on quality of performance instead of just number of items passed on a test.

- I support the "any delay" for children up to 2 months old adjusted age. This certainly will help with premature infants. Placing a 25% delay in 1 area, or 20% delay in 2 or more areas, requirement for eligibility will (at least initially) result in less children qualifying for services. Given that the State is below the 2% unofficial benchmark of OSEP (and that is using a broad eligibility) it would be apparent that if all things remain equal, we will serve less children. Personally, I think we need to serve more, not less. This is especially true when the issue of informed clinical opinion plays such a major role in assessing and evaluating infants and toddlers. Much of our work locally targets specific populations i.e. teen parents, low income families, prenatally exposed infants and children who are in families referred to CPS. We know the potential negative aspect of the environmental impact on a child's development. By placing arbitrary cut off scores on standardized assessment tools limits the opportunities to work with the families of these children. I am afraid that we will start seeing more of these children in the 3 - 5 year old special education programs and classrooms. A "tracking" system is available through EETRK. The additional time and effort necessary to enter the number of children who you wish to track is an obstacle that would have to be addressed.
- I concur with all of the recommendations included in the task force documents. Would like to add the following to be considered. The Informed Clinical Opinion Document: More specificity related to issues that come up frequently would be helpful. One example is in the case of children in foster care, where our existing tools do not show delay. In this case, the content of clinical interviews with parents/foster parents; observation of parent-infant interaction, evaluation of the child at play, etc. becomes extremely relevant. Service providers need much more guidance as to what should be included in these aspects of evaluation, and if service areas must use specific professionals to do these evaluations, (e.g. social work or psychology), then our local ICC's must have that expectation made clearly, so communities can plan better in a cross-agency way. I didn't note any changes to the established condition list other than comments on page 2 referring to where to get more detailed info about less common conditions and contact persons...did I miss something?
- Under the Established Conditions document, you listed LOW VISION as 20/700, it should read 20/70 corrected (if we want to align with special education) or 20/200 corrected (if you want to use the state/federal definition of legal blindness). I remember this conversation, but can't recall what we had settled on. I just know it wasn't 20/700.
- On first reading, the established conditions look about right to me. I would add under cerebral palsy the diagnosis of hypertonia or hypotonia. We find that babies who to us sure look like they have CP have doctors that are unwilling to give that diagnosis so young. Also, if you are adding diagnosis to the list septo-optic defect (SOD) could go under vision issues. I continue to be confused about Informed Clinical Opinion. I am thinking about how to use this for kids and moms who are

being referred to Early On due to attachment or other emotional concerns. How would I get a developmental delay of 25% when "it cannot be captured through traditional eligibility tools"? I think this is going to need much more clarification.

- *First bullet point.* Re the Established Conditions document ("Proposed Changes to Early On Established Conditions" Draft 7). Before presenting this document to others for review, I suggest that the changes be highlighted so that a reader can more easily identify them. I believe that the addition of very low birth weight, small for gestational age, intrauterine growth retardation, and chronic asthma are the only additions, and I find those additions acceptable. *Second bullet point-* Developmental delay criteria. The rationale for making a change and the benefits that the workgroup feels would be gained by changing the developmental delay criteria are not described. Knowing these would be helpful in considering the recommendations. I recommend that Early On retain "any delay" as our criterion, since it allows us to serve more children, gives us the greatest flexibility in serving children and families, is a simpler and more user-friendly determination for the family members, and most emphasizes the "early" in early intervention. Our LICC recommends the same, as has been communicated with redesign earlier. If we have been required by OSEP or some other source to set a standard other than "any," I recommend "20% in one developmental area, or any delay in two areas." *Third bullet point-* re the proposed document on informed clinical opinion. This document's interpretation of informed clinical opinion (ICO) is inconsistent in several ways with IDEA and the NECTAC article that it uses as a reference. The proposed ICO document treats informed clinical opinion as a separate element of evaluation, that would be used only some times and in some instances, when ICO is an integral part of every evaluation. Tries I think to include too much, which makes the ICO concept much more complex. For instance, the points mentioned as to "who can take part" and "what would be included" are in general the case for all evaluations for Early On. They are described as if they are new, or particular to only certain instances. Adds elements under ICO that are not part of the evaluation (family aspects, and IFSP considerations). These will of course be considered later, but not in the eligibility determination, which is based on the child. A description of ICO can be much simpler. It has always been true that informed clinical opinion will in some cases determine that a child is eligible, even if a standardized evaluation instrument does not show developmental delay and there is no diagnosis to determine that an established condition exists. I recommend that the document be revised so the wording is more clearly consistent with IDEA. Finally, making this a "Guideline" and wording such as "will be used," "can be used," "must be included" suggests that this document may become a set of requirements. Informed clinical opinion is already described in IDEA and regulation. Creating a further and differing set of requirements will only create confusion and problems. A discussion of ICO and IDEA, or reminder—but not a set of requirements. *The fourth and further bullets* are further tasks remaining to be done, and I agree that they are valuable to consider. The field and public must comment on these further once a product has been generated to which to respond. I have following comments: Re: Clarify how long to correct for prematurity. We are taught to do so until the child is two years old. Is this to be changed? Re: Tracking. Under our existing eligibility criteria, a child with slight delays would be found eligible, then per their IFSP provided a low intensity of services (occasional professional service visits

and of course the actions of the family)-- essentially "tracked" to see how his/her development progressed with that degree of intervention. The idea that we change our eligibility, find such a child not eligible, but still track them (perhaps in almost the same fashion) does not seem to offer any advantage to either the child/family or the providers. Also, EETRK has had a "tracking" status that is currently not used; that could perhaps be helpful. Finally, "tracking" is a form of service (or activity) requiring time and resources. If local Early On is to track children who are not eligible,

resources will be needed. Added recommendation for further consideration If eligibility criteria are to be changed such that more children evaluated will be found not eligible, this change creates a systemic issue. Children receiving an evaluation but not eligible will otherwise be an un-funded obligation (in time and resources) to the local area. This is already a concern. Likewise, "tracking" will require time and resources. We should consider a revision of the funding formula for local Early On to include support for children evaluated but not eligible, and for children "tracked." I suggest that our eligibility task force and fiscal study look at these relationships. Also, if criteria are changed so that eligibility is less likely, we should also consider establishing a means to allow children who obviously will not be eligible to be determined quickly to save them and their parents the time of a lengthy evaluation.

- The suggested revision of the document endeavors to show ICO as an integral part of eligibility determination process and IFSP. New text is in italic (sorry, this email does not show italic). Notes or comments are [in brackets]. Description of Informed Clinical Opinion in Michigan Early On: Informed Clinical Opinion is part of every eligibility determination for Part C, included in all evaluation and assessment and in determining existence of an established condition. Informed Clinical Opinion includes sensitive, informed use of qualitative and quantitative information, synthesizing and integrating the impressions and observations of multidisciplinary team members. It may go beyond reporting of test scores and diagnoses and may establish eligibility in instances where standardized measures of development do not clearly show developmental delay, and medical/health records do not clearly indicate an established opinion. Informed Clinical Opinion should: reflect a meaningful assessment of the individual child's development; address the functional impact and the implications of noted delays or differences in development; suggest areas that may require further evaluation [*Note these listed above are related to evaluation and eligibility determination, while the two items listed below are not*] *The Informed Clinical Opinion is also beneficial in helping to*: reflect a meaningful assessment of the family resources, priorities, and concerns; Identify areas in which the family's knowledge, skills, and ability to enhance their child's development can be supported; suggest areas to address on the IFSP [*Note these are related to service planning*] Informed Clinical Opinion is NOT a means to circumvent the eligibility criteria for Early On. The ICO will need to document that a delay that meets eligibility criteria likely exists (*as currently defined*). Informed Clinical Opinion is a way to capture information about a delay relating to the child's condition/development/behavior that is not or cannot be fully captured through traditional eligibility tools, that is *Informed Clinical Opinion may determine a child eligible in cases where eligibility is not shown by review of the health/ medical records and the evaluation of*

*functioning in developmental areas. ICO is particularly likely to be helpful in situations such as:* To determine eligibility based on developmental delay for children whose age is under 2 months (corrected) at entry to *Early On*; To determine eligibility based on developmental delay for children older than 2 months (corrected) at entry to *Early On*, when delay is suspected but traditional eligibility tools do not show the delay. Who can contribute to the Informed Clinical Opinion? Professionals meeting *Early On* personnel qualifications, the child's parents. WHAT is included? As part of eligibility determination, to reach an Informed Clinical Opinion about the eligibility of a particular infant or toddler, a multi-disciplinary team will synthesize and interpret information from two or more of the following types of sources: Clinical interviews with parents [PLEASE DEFINE CLINICAL] ; Information from other caregivers who spend significant time with the child; Evaluation of the child at play [or usual activity]; Observation of parent-child interaction \*; Neurodevelopmental or other physical examinations [PLEASE DEFINE]; Additional psychometric and diagnostic data [DEFINE TERMS] *Developmental history* \* As part of an evaluation for the IFSP, the Informed Clinical Opinion will: Be included in the IFSP document; Identify sources of information used (documents, tests, etc.); Identify persons who provided information (their discipline/qualifications) [NAMES?]; Identify the estimated % of delay [*This might be problematic, since in some cases the "objective" measurements didn't sufficiently capture delay. But if "estimated" is the operative word, ok.*]; [add:] Identify the conclusion reached, i.e. "*Child is determined eligible for Early On due to ... and ... qualitative concerns that lead us to determine that child is eligible.*" *The statement of Informed Clinical Opinion may also:* Contain recommendations related to the IFSP and services that are likely to be helpful to the child. How will it link to evaluation, ongoing assessment, and progress toward child outcomes? *As noted above,* Informed Clinical Opinion developed at the time of eligibility determination to *Early On* identifies *an estimated % delay*, comparing the child's developmental skills with those of their same aged *typically developing peers*. Informed Clinical Opinion may be used to indicate the child's degree of progress during their time in *Early On*, as is done at each review and annual IFSP. I hope this is helpful.

- The Established conditions document has my heart all a flutter. Can we really get all of these children into early intervention? I would love to see this happen. Obviously I am happy with the diagnoses. However, if early intervention is from 0-3 years why are the established conditions for those 0-2 years old? I am hoping that this means children who were in the NICU and <1500 grams will not have to wait until they are 4 months corrected age to be evaluated, if they get evaluated at all. Correcting for prematurity is usually done through 24 months of age. Tracking system would be great!!
- Recommend the following be added to established conditions:
  - a. Under A. Definitions section – add 10. Mental Health Conditions
  - b. Mental Health Conditions
    - Reactive Attachment Disorder
    - Post Traumatic Stress Disorder
    - Deprivation/Maltreatment

- Disorders of Affect
  - Depression of infancy and early childhood
  - Mixed disorders of emotional expressiveness
  - Adjustment Disorders
  - Regulatory Disorders
- c. Move "Failure to Thrive" to Chronic Medical Illnesses category
- d. Eliminate Infantile Schizophrenia
- e. Leave Pervasive Developmental Disorder (PDD) and Autistic Spectrum Disorder under #6. Development Disorders. Remove the word "atypical."  
Rationale: The category of established conditions for Atypical Developmental Disorders in the proposed definition contains certain conditions that would be considered mental health conditions ( Reactive Attachment Disorder and Regulatory Disorders) rather than developmental disorders. Other mental health conditions that would have a high probability of resulting in developmental delay were omitted. Infantile Schizophrenia is no longer a diagnosis that is used.
- 2) Recommend that maternal depression be included under the Mental Health Conditions category as a condition that has a high probability of resulting in developmental delay.

Rationale: Literature and research shows that maternal depression, trauma, and abuse and neglect have a high probability of having a negative impact on child development if left untreated.

According to Child Trends Databank, Eighteen percent of parents living in households receiving welfare showed symptoms of depression in the year 2003, compared with 4 percent of parents in families that did not receive welfare.

Children of depressed mothers are more likely than other children to have behavior problems, academic difficulties, and health problems.<sup>1</sup> Among families receiving welfare, children of depressed mothers have, on average, lower scores than other children on math achievement tests.<sup>2</sup> Depression among mothers has also been linked to delays in cognitive and motor development among children ages 28 to 50 months.<sup>3</sup> Long-term, severe maternal depression has been found to have especially adverse consequences for child development and behavior.<sup>4,5</sup> Among five-year old children of depressed mothers, for example, those whose mothers experienced frequent and/or severe depression were more likely than others to have behavioral problems and lower vocabulary scores.<sup>6</sup>

Furthermore, the National Institute for Public Health put out a news release regarding a study published in the September issue of *Developmental Psychology*, that found, children of depressed mothers performed more poorly on measures of school readiness, verbal comprehension, and expressive language skills at 36 months of age than children of mothers who never reported depression. In addition, children of depressed mothers were

reported to be less cooperative and to have more problem behaviors at 36 months.

<sup>7</sup>"This study examines the role of maternal depression in children's development," said Duane Alexander, M.D., Director of the National Institute of Child Health and Human Development (NICHD). ***"It demonstrates that depression does not just affect the mother, but that it is also linked with the well-being of her child."***

<sup>1</sup> Ahluwalia, S.K., McGroder, S.M., Zaslow, M., and Hair, E.C. (2001). Symptoms of depression among welfare recipients: A concern for two generations. *Child Trends Research Brief, December 2001*. Child Trends: Washington, D.C. Available at: [http://www.childtrends.org/Files/Research\\_\\_Brief\\_Depression.pdf](http://www.childtrends.org/Files/Research__Brief_Depression.pdf).

<sup>2</sup>Hair, E.C., McGroder, S.M., Zaslow, M., Ahluwalia, Surjeet, and Moore, K.A. (2002) How do maternal risk factors affect children in low-income families? Further evidence of two-generational implications. Co-published simultaneously in *Journal of Prevention and Intervention in the Community*, Vol. 23, No.12, 2002, pp. 65-94 and *The Transition from Welfare to Work: Processes, Challenges, and Outcomes* (ed: Sharon Telleen, and Judith V. Sayad) The Haworth Press, Inc., 2002, pp. 65-94.

<sup>3</sup>Petterson, S.M. and Albers, A.B. (2001) Effects of poverty and maternal depression on early child development. *Child Development*, November/December 2001, Vol. 72, Number 6, pp 1794-1813. Society for Research in Child Development, Inc. Access to issue available for purchase online at: <http://www.srkd.org/subinfo.html>.

<sup>4</sup>Ibid.

<sup>5</sup>Brennan, P.A., Andersen, M.J. Najman. J.M., Williams, G.M., Hammen, C., and Bor, W. (2000). Chronicity, severity, and timing of maternal depressive symptoms: relationships with child outcomes at age 5. *Developmental Psychology*, 36(6): 759-766. American Psychological Association.

<sup>6</sup>Ibid.

<sup>7</sup>Hops, H. (1995). Age- and gender-specific effects of parental depression: A commentary. *Developmental Psychology*, 31(3): 428-431.

- 3) Recommend that an ASQ S/E (screen) be done for all children referred to Early On. For those who red flag up on the screen– refer for mental health assessment.

Rationale: "...the use of systematic screening tools may increase the identification of children at-risk who could benefit from an intervention, but do not yet demonstrate any of the signs and symptoms of a full fledged developmental problem or mental health diagnosis." ("Developmental Problems: Issues, Obstacles and and Opportunities for Change," Bergman August 2004, The Commonwealth Fund.)

- Established Conditions document: Addition of Abuse/Neglect as diagnosed by a qualified health professional (page 6). **While A/N is an ICD-9 code, treatment by current Early On staff for abuse and neglect remains problematic. This issue could be addressed with a collaborative commitment by the Department of Community Health for provision of treatment by infant mental health specialists in the upcoming Memorandum of Understanding.** Change in criteria for eligibility for developmental delay to a 25% delay in 1 area, or a 20% delay in 2 or more areas: **One concern is that no data was collected to estimate the effect of the criteria changes on the number of children who would not be eligible for Early On compared with the current criteria of "a delay". Another concern is the difficulty in measuring the difference between a 25% delay and a 20% delay and whether it is even statistically significant. Also, many of our LICC members worried about children not qualifying for Early On with mild delays globally, who may later receive a diagnosis such as autism, which could have been treated at an earlier age. Changing the delay in 2 or more areas to "a delay" or a 10% delay, rather than a 20% delay would prevent those children from slipping through the cracks. Consider setting up a "tracking" system for children who do not qualify under the new eligibility definitions: Any new "system" should first be piloted in diverse geographical and demographical regions. A fiscal analysis documenting increased expenses in time, training, supplies, etc. must be done and a commensurate increase in local funding must accompany any new requirements.**
- I can understand the proposed changes for putting a % of delay on a child in order to qualify ... and I appreciate all of the support to allow for informed clinical opinion. But depending on the "tools" used .. a child can be "delayed" but still not qualify with the "tool" we are using... for example ... I have been able to qualify children for speech because of articulation issues ... the IDA does not really address articulation skills. 1a. The other concern on that same issue is that the recommendation would be to hook the family up to "Other area early childhood resources" if they do not qualify for EO. I am not sure that every county has additional resources. I know in our area there is a very little as far as early childhood services or even opportunities to engage in any kind of early childhood activity. 2. It seemed as though I read somewhere that there was the possibility of qualifying babies born at 26 weeks or earlier would be an automatic qualifier also ... I would agree with that. UNLESS the new categories of Medically Fragile and brain hemorrhage are to address that population. 2a. I would be "unclear" as to what "children with complex health care needs" would mean? under medically fragile? It seems ticky tacky ... but it does seem sort of vague when everything else is seeming to be more succinct.

## Activity D. Review current eligibility determination process

*Documents to review: Eligibility Determination Process Chart*

*Recommended Tools Chart*

### RECOMMENDATIONS

- Adopt the revised Eligibility Determination Process and its components as described in the Eligibility Determination Process chart.
- Adopted eligibility re-determination procedures as described in the Eligibility Determination Process chart.
- Adopt the list of tools reviewed and recommended by the Tools Workgroup.
- Review the list of recommended Child Outcomes measurement tools again once *Early On* decides how the system will be measuring child outcomes. This current list only reflects which tools we believe will capture incremental progress across all domains of development (the minimum that would be needed to respond to SPP requirements).
- For tools recommended for eligibility determination, develop training & guidance materials to help local service area personnel to know how to reliably and consistently calculate % delay or SD delay scores/information.
- Prior to implementation of these recommendations, reexamine the recommended eligibility determination tools to understand whether they can successfully differentiate slight differences in % delay, like 20% vs. 25% (which has been proposed for eligibility criteria).
- Clearly identify the characteristics of "existing documentation" that may be used to determine eligibility based on developmental delay as this may be a point of confusion for the field given that they are receiving a list of approved tools (e.g. documentation must yield a % delay score or SD delay score; must be appropriate for ages 0-3; and any other requirements related to validity or reliability of acceptable documentation).
- Define the minimal personnel requirements (prerequisites) to be able to use any of the recommended tools (for eligibility, IFSP development, or child outcomes) – e.g. training in child development, interviewing skills, etc.
- Connect the *Early On* CAPTA workgroup with the children's mental health committee that is identifying eligibility tools for children's mental health to share information and research. This may prove useful related to Informed Clinical Opinion methodology for *Early On*.

### Public Comments Received:

- I concur with the suggestion that "existing documentation" must be clarified.
- Have we always had the obligation of "acknowledgement of referral in writing or by phone to primary referral source"? What if it is a family member or neighbor? I would like to suggest a wording change for a section under Orientation and Intake. Currently it is stated "Develop composition of multidisciplinary team (two different disciplines) for eligibility determination . . ." Could you change it to "Develop composition of multidisciplinary team (at least two different disciplines)" By saying two different disciplines it almost sounds like it can't be more than two. I love our multidisciplinary evaluations using a full team and wouldn't want that type of evaluation to be discounted.

- First bullet* re the recommendation to adopt the Eligibility Determination Process as described in the chart. The process as described in the chart is a fair description of typical steps in determining eligibility; thank you for showing that a lot goes into this process. I would add that many variables can affect the process, so to be sensitive to the family and flexible to their needs the experience for a particular family may differ from the chart at points. Also, the chart includes actions that are good practice but peripheral. However, such a step by step process should not be created as a requirement. The requirements for determining eligibility are found in IDEA and in the regulations that will follow.

Creating a parallel document such as the chart may be helpful as a reference, example, or training tool, but no more. If it is treated as an additional requirement, it will only add to complexity and potentially to confusion. It also increases the likelihood that we are asking families to fit into unnecessarily detailed requirements (jumping through hoops) in ways that are not family- centered or family friendly.

*Second bullet point.* Same comment *Third and further bullet points* are unfinished tasks that are being encouraged. They are important tasks. The field and public must comment on these further once a product has been generated. Note: The fourth bullet point refers to "Child Outcomes measurement" for SPP requirement. This has been repeatedly stated as distinct from IFSP outcomes. There may be some similar language and other parallels, and the same measurement tools might even be used in both, but the two are distinct and different. So if we are to mention this in a document about eligibility evaluation, I believe that we need to be clear that the eligibility process for a child is distinct from the outcome measurement process that will be used for statewide evaluation of the system per SPP.
- Should it really take 45 days to get a child with one of the eligible condition into services? Could there not be some way that they are getting into services within a month. I think of many of the NICU children who are in the units for months. It seems silly not to be able to get the child and family connected so that services can begin shortly after discharge. We have so many children who end up readmitted to the hospital for one reason or another. maybe with earlier intervention this wouldn't happen as often. Many times I see children back after discharge from the hospital in 4-6 weeks and they have had no contact. This is a lot of time in the life of an infant. The tools are good. Define the minimal personnel requirements to administer tools: This needs to be consistent and needs to be Early On staff. It does not make sense to many therapists and medical personnel that a social worker be the one to determine if a child is delayed or not and whether they are getting appropriate intervention. It doesn't make sense to the social workers I know either. We should have our most experienced people doing these assessments. There already has been a concern raised in many cases by someone who has some experience in child development. The evaluation should be with more experienced individuals. The other thing we hear from parents and Early On is that the home health nurse, or the MOMs program worker, public health department nurse is the early intervention worker. If this is the case then most of them don't know it. Many times that is not what they were sent out to follow. Consistency is lacking.
- Eligibility Determination Process chart: **There are many steps that have been added to the process that will increase work for Early On Coordinators, service coordinators and secretarial help. All additions to current procedures must be funded. These include:**

- "Acknowledgement of referral in writing or by phone to primary referral source." **Will this be accompanied by additional paperwork that documents compliance?**
- "Assist family in completion of applications for public programs they may be eligible for" **Who is responsible for doing this?**
- "Schedule and plan IFSP development meeting, notify all participants in writing" **Does it say in the regulations that all participants must be notified in writing? Who would mail out the invitations? The service coordinator? EOC? Secretary? Arrangements are often made by phone and the meeting is scheduled before written invitations would be received. Documentation needed for compliance?**
- "Notify referral source of results of the eligibility determination process and IFSP development with parental consent" **This is best practice, but must it become a new standard? Documentation needed for compliance?**
- "Annual re-determination of eligibility" **This is a huge addition to workload. What is entailed in the re-determination? Does the evaluation have to again be administered by two professionals? Is another vision and hearing screening done? Are medical records requested again?**

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## Broad Recommendations across Activities A-D

### RECOMMENDATIONS

- Use the Eligible Population Task Force work to help describe and inform other decisions related to *Early On* Redesign. Include some participants from the Fiscal Task Force and the Eligible Population Task Force to be a part of the review and synthesis of the work of each group in order to inform any policy recommendations.
- Link the results of the Eligible Population Task Force with the larger early childhood system efforts. Define who should be served by *Early On* and who should be served by the rest of the early childhood system.
- The results of the Eligible Population Task Force should be reported to the Children's Cabinet and the ECIC. It would help show that the state needs to make a case for this population.

### Public Comments Received:

- First of all I wish to commend the task force on its work in this section of the redesign process. It is obvious that a great deal of thought and effort went into the recommendations. For this I wish to thank the participants. Based on the recommendations, I have the following comments/questions:  
Activity A - Establish membership of the Task Force. I would have liked to see the membership roster, specifically what was the breakdown between State and local representatives, Part C staff and partner agencies, etc.  
Activity B - Estimate prevalence rates. What a nice report up to the point of conclusions. Three different models for prevalence was discussed but I did not see if one (or any) was determined to be the chosen model for Michigan. Was there ever any prevalence numbers ever released and or adopted as a target for the State, and better yet as a target for local communities based on the three models suggested?
- It sounds like the percentage of the birth cohort that should be identified will still take some work. I do like the idea of looking at risk factors for the communities to determine how many kids should be found.
- The overall purpose for possibly changing Early On eligibility has not yet been clearly defined. Is it to serve more children, fewer children, focus on children with greater need, change our 'target' number of children to be served? Has a change been required or suggested by OSEP? A definition or goal would be helpful in guiding these considerations. Activity A. Establish membership. No comment Activity B. Establish prevalence rates. No information about the Michigan Prevalence study is available at this time. My comment is that since this information is a foundation piece of the discussion about Early On's eligible population, we should not make any final decisions about eligibility until we are able to consider the Prevalence Study. It will hopefully tell us things such as more precisely how many children are potentially eligible under the current criteria, how many would likely be eligible under several other criteria, and so on.
- These are good recommendations, topics worth considering. The second bullet point about "who should be served by Early On and who should be served by the

rest of the early childhood system” is fundamental, and should ideally be determined before finalizing any changes to Early On eligibility

- Thanks for all your hard work. I am hoping that this process will bring consistency to the children in this state who are in need of early intervention. I have been following many children 0-3 with special healthcare needs and there are many children not getting the services that they should be.
- Link the results of the Eligible Population Task Force with the larger early childhood system efforts. Define who should be served by Early On and who should be served by the rest of the early childhood system. **I applaud the goal of connecting Early On with other early childhood efforts. I also agree with defining the roles and responsibilities of each of the members of the early childhood system. This would help create a system that encompasses a continuum of services in which all families with young children belong. Sharing resources and responsibilities could make this become a reality. One example of shared responsibility is to do universal developmental screenings on all children. This could drastically increase the appropriateness of referrals made to Early On. Currently, agencies are referring to Early On because it is mandated (CAPTA) or they don't know what else to do. This has resulted in Early On evaluating many children who are subsequently deemed ineligible for Early On. With the proposed change of eligibility criteria to a 25% delay, I foresee even more referrals resulting in an ineligible determination. To fully understand the impact of inappropriate referrals to the Early On system, one need only review the Eligibility Determination Process Chart. Each referral sets into motion a process that is complex, time-consuming and increasingly burdensome to parents and staff. The disheartening part is going through the entire process only to find out that the child isn't eligible for Early On and having nothing else to offer the family. By joint collaboration with other agencies and initiatives to provide such things as developmental screenings and para-pro home visiting, early childhood services could be geared to families at the level that works best for them.** The results of the Eligible Population Task Force should be reported to the Children's Cabinet and the ECIC. It would help show that the state needs to make a case for this population. **The state not only needs to make a case for this population, but needs to fund early childhood programs. Please review the Zero to Three State Policy Updates to see how other State governments are supporting and funding early childhood at [www.zerotothree.org/policy/stateupdates.html](http://www.zerotothree.org/policy/stateupdates.html)**

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