



Comparing Early Childhood Systems: IDEA Early Intervention Systems in the Birth Mandate States



A project of the Michigan Association of Administrators of Special Education

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Executive Summary

The Michigan Association of Administrators of Special Education established the Comparing Early Childhood Systems (CECS) project in response to concerns about the type and intensity of services available in Michigan for infants and toddlers with developmental delays and disabilities and their families. These services are required under Part C of the Individuals with Disabilities Education Act (IDEA).

Michigan, where Part C is known as *Early On*[®], has been a birth mandate state since 1971; infants and toddlers with delays and disabilities were being provided with services from birth to age 3 prior to the federal requirement to do so. There are four other birth mandate states: Iowa, Maryland, Minnesota and Nebraska. These states have a similar history of providing special education for infants and toddlers from birth to age 3 prior to the federal mandate. This project investigates the systems of the other four states and compares them to Michigan's system of services with the goal of learning ways in which Michigan might improve *Early On*[®] services in the state.

The four comparison states were found to have a single system of eligibility with one cohort of eligible children, while Michigan has a two-tiered system of eligibility which results in differential access to services. In the four comparison states, families and children have equal access to all of the types of Part C services provided by qualified personnel. In Michigan, the type, amount and frequency of service, as well as the qualifications of service providers, vary based on geographic location, meaning that families and children in many parts of the state may not have equal access to all types of Part C services. Finally, the four comparison states provide significant state funding to support the entire system of Part C services, while Michigan provides state funding for only about one third of all the children eligible under Part C: those who are also eligible for early intervention through Michigan Mandatory Special Education.

Based on the current state of the system in Michigan and what has been learned from the exploration of the other four birth mandate states' systems, the following topics emerged as potential areas in which the Michigan Association of Administrators of Special Education may wish to consider advocating for change:

- 1) Develop a Single Cohort System
- 2) Revise Eligibility Criteria
- 3) Expand State Funding for Part C
- 4) Unified Administration of the Early Intervention System
- 5) Include Early Intervention in a Multi-Tiered Statewide Early Childhood System

Frequently Used Abbreviations and Terms

DD—Developmental Delay; one of the two eligibility categories under Part C of IDEA; not to be confused with Early Childhood Developmental Delay (ECDD) which is one of the 13 eligibility categories under MARSE or Part B in Michigan

Early On[®] -Michigan’s early intervention system for meeting the requirements of Part C of IDEA; children are eligible for services under one or both of two categories: developmental delay and established conditions. Children may be additionally eligible for Michigan Mandatory Special Education (MMSE) as part of the *Early On*[®] system.

EI-Early Intervention, as it is used in the Individuals with Disabilities Education Act (IDEA). The term “early intervention” is sometimes used to describe a broader age range as well as non-IDEA initiatives; however, the term as used in this report refers specifically to IDEA and statewide systems of Part C services for children aged birth to three who have disabilities and/or developmental delays and their families.

ECDD-Early Childhood Developmental Delay; one of the 13 eligibility categories under MARSE or Part B in Michigan

ECSE teacher-Early Childhood Special Education teacher; in birth mandate states, at a minimum, a teacher qualified to teach children aged birth through five who have disabilities and developmental delays. Although another early childhood credential is available in Michigan, the term ECSE teacher will be used in this report as the majority of Michigan teachers providing early childhood special education, as well as teachers in the four comparison states, currently have the ECSE credential.

FAPE-Free Appropriate Public Education; one of the requirements in Part B of IDEA

FTE-Full Time Equivalency refers to the amount of time in educational programs which generates per pupil state funding

HHS-Department of Health and Human Services

IDEA-the Individuals with Disabilities Education Act; federal special education law

IFSP-Individual Family Service Plan; a plan developed for each child and family eligible for Part C services

IEP-Individual Education Program; a plan developed for each individual receiving programs and services under Part B of IDEA

ISDs-Intermediate School Districts in the state of Michigan, which include Education Service Areas (ESAs), Regional Education Service Areas, (RESAs) and Regional Education Service Districts (RESDs). Under Part C in Michigan, the term “service area” is used to identify the geographic area served. The service areas follow ISD boundaries and the ISDs are the local Part C lead agencies.

LEAs-Local Education Agencies, including traditional public school districts

MAASE-Michigan Association of Administrators of Special Education; a professional membership organization

MARSE-Michigan Administrative Rules for Special Education; students may be found eligible under any of 13 eligibility categories; the rules address program, personnel and other requirements

MMSE-Michigan Mandatory Special Education; Public Act 198 of 1971 (later incorporated into the School Code under Public Act 451 of 1976) is the basis for Michigan’s requirement to provide special education programs and services to eligible students aged birth to 26

OGS-Office of Great Start; the administrative unit for early childhood programs within the Michigan Department of Education

OSE-Office of Special Education; the administrative unit for special education within the Michigan Department of Education

OSEP-Office of Special Education Programs; the administrative unit for special education within the U.S. Department of Education

OT-Occupational Therapist

Part B-the specific part of IDEA which addresses programs and services for individuals ages 3 through 21

Part C-the specific part of IDEA which addresses programs and services for infants and toddlers (ages birth to 3) with disabilities and developmental delays and their families

“Part C only” or “*Early On*® only”-these terms are used in quotes as their use is unique to Michigan and also to clearly indicate which group of children is being referenced in this report. The term “*Early On*® only” is used when referring to the pool of children eligible only under Part C in Michigan’s two-tiered system of eligibility. In contrast, the term *Early On*® is inclusive of children who are also eligible for MMSE.

PSP-Primary Service Provider; a model in which one discipline is designated, based on need, as the primary provider of early intervention services to a child and family. The PSP is a member of a professional team of providers which supports the child and family in early intervention.

PT-Physical Therapist

Service Areas-refers to ISD geographic boundaries; in this report the term “service area” and “ISD” may be used interchangeably

SLP-Speech and Language Pathologist

SDBM-Standard Deviation Below the Mean; a term used in relation to normative evaluation instruments, indicating a delay or deficit of one unit below the mean or norm

Introduction

The purpose of the “Comparing Early Childhood Systems” project is to examine current practice relative to the implementation of Part C of IDEA in the five birth mandate states: Iowa, Maryland, Michigan, Minnesota and Nebraska. The project also examines current challenges to implementing Part C in Michigan and, based on what has been learned about practices in the other birth mandate states, suggests areas that might be considered for modification. This project was initiated because Michigan’s Part C program, known as *Early On*[®], is currently facing significant challenges in its efforts to meet the needs of the infants and toddlers who qualify for services and their families.

All five birth mandate states have provided special education services to infants and toddlers and their families since before the passage of Part C of IDEA, which took effect in 1986. Whereas most states in the country begin the provision of special education services at age 3, these states recognized the importance of providing services beginning at birth long before research identified the first three years of life as the most critical period of brain development and such rationale was included in IDEA. It makes sense to compare the birth mandate states because of this common history and evolution of the structures and system elements related to Part C. It is useful to see how each state’s system operates in 2013, twenty-seven years after the initiation of the part of IDEA that was created to meet the needs of infants and toddlers with disabilities and/or developmental delays and their families.

The activities related to this project were conducted over the course of fourteen months from October of 2012 through December of 2013. A MAASE study group was created to determine what information was needed from the four comparison states, analyze the information learned about the other states, compare the other states’ practices to Michigan, and provide input to the report. The study group developed a survey format to be used in interviewing the leaders of the Part C systems of the other states. Interviews with comparison states were conducted by the Project Chair. Once the interviews were completed, a summary of information was developed for each state. The summaries were then sent to those who had been interviewed to provide an opportunity for corrections, additions and verification. The complete summaries of the survey results for each state may be found in Appendix A.

The Project Chair compiled the answers to the Michigan survey questions with feedback provided by study group members. It should be noted that some of the information for Michigan was not available as pure data because such data is not collected by the Michigan Department of Education; this data was gathered instead through surveying *Early On*[®] coordinators and administrators across the state. The study group contributed corrections, additions and verification for the Michigan survey.

The study group reviewed the four comparison states’ survey information, compared Michigan’s system to the other states’ systems, and discussed challenges and possible modifications to Michigan’s system based on what was learned.

Comparing the Birth Mandate States

The five birth mandate states were compared based on four major system components. These components include:

1. Lead Agency
2. Eligibility Criteria
3. Services
4. Funding

Lead Agency

In all of the birth mandate states, Education is the lead agency, with Nebraska having a co-lead with Health and Human Services. In Michigan, administration of the system is assigned to two different offices within the Michigan Department of Education. IDEA Part C is administered through the Office of Great Start while Michigan Mandatory Special Education (MMSE) is administered through the Office of Special Education. Every birth mandate state, except Minnesota, has agency partners involved in providing services.

Eligibility

Eligibility refers to the criteria by which infants and toddlers are determined to be eligible to receive services under IDEA. The two eligibility categories identified in IDEA under Part C are developmental delay (DD) and established conditions. In contrast, IDEA Part B identifies thirteen different eligibility categories, each with its own set of descriptors. Under both Part C and Part B, states may set their own definitions of categories as well as eligibility thresholds.

In the four comparison birth mandate states, there is one set of eligibility criteria for all children aged 0-3, resulting in one pool of children eligible for Part C services. In the four comparison states all children in the Part C pool are also eligible for special education, because the Part C system in each of the four states is part of the state's special education continuum.

In Michigan, there are two sets of eligibility criteria, one for Part C and one for Part B (Michigan Mandatory Special Education, or MMSE), which creates a two-tiered system of eligibility and thus two pools of children eligible for services. Approximately two-thirds of the children in Michigan are eligible under "Part C only" and one-third of the children are eligible under both Part C and MMSE. This two-tiered eligibility system in Michigan leads to differences in the types and levels of service available for these two pools of children. The impact of this two-tiered eligibility system will be discussed further in the following section regarding services.

Iowa uses the eligibility categories identified in Part C for birth to three, i.e., DD and established conditions. The DD eligibility threshold is a 25% delay in one or more developmental domains. Iowa uses no eligibility categories for ages 3 to 21 and instead has a global set of eligibility criteria for Part B. Children transitioning at age 3 into Part B programs and services must meet Iowa's Part B criteria.

Like Iowa, Maryland also uses the eligibility categories identified in Part C for birth to three. The DD eligibility category in Maryland requires a 25% delay, regardless of age. Evidence of educational need is required beginning at age 3 but not before.

Minnesota uses the categories of DD and established conditions with the option of using its Part B special education categories as well. The categories of DD and established conditions are most commonly used for birth to 3, with the Part B categories being used primarily when the child clearly meets the criteria. The DD category is used under both Part C and B, but is more restrictive at age 3 when Part B begins. The eligibility threshold for DD for birth to 3 is 1.5 standard deviations below the mean (SDBM) in one or more developmental domains. The DD threshold at age 3 is 1.5 SDBM in more than one developmental domain, plus evidence of educational need.

Nebraska uses only its Part B eligibility categories for birth to 3. The DD category is one of the Part B categories, and the Part C established conditions category is subsumed under other Part B categories such as Other Health Impairment and Visual Impairment. The DD eligibility threshold is 2.0 SDBM in one developmental domain, or 1.3 SDBM if there is a delay in more than one developmental domain.

In Michigan, the two-tiered system applies different eligibility categories for Part C and MMSE. Children can be found eligible under “Part C only” or both Part C and MMSE. For Part C, Michigan uses the eligibility categories of DD and established conditions. The Part C DD eligibility threshold is set at either 20% delay or 1.0 SDBM for children ages 2 months to 3 years, and any degree of delay under 2 months of age. The MMSE categories are Michigan’s Part B categories, and eligibility under MMSE automatically makes a child under the age of 3 eligible under Part C/*Early On*[®] as well. Part C and Part B eligibility determinations can be made simultaneously or at separate times, using the appropriate evaluation and eligibility determination procedures for each.

In summary, the four comparison states have one set of eligibility criteria for Part C resulting in one pool of children who are all eligible for service. Additionally, these states do not require evidence of educational need for eligibility below age 3. Michigan Mandatory Special Education does require evidence of educational need, even for infants and toddlers under the age of 3. Michigan’s two-tiered eligibility system, driven by the requirement to apply two different sets of eligibility criteria, has created two pools of children who are differentially eligible for services.

Services: Type, Amount Frequency and Qualifications of Providers

In the four comparison states, all children eligible under Part C have equal access to services based on need, similar to the way services are available under MMSE. However, for children eligible under “Part C only” in Michigan (i.e., who do not meet both Part C and MMSE eligibility criteria) service varies across the state in terms of amount, frequency, and type.

Early intervention services are defined in the Part C regulations as being “designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant’s or toddler’s development, as identified by the IFSP Team, in any one or more of the following areas, including physical development; cognitive development;

communication development; social or emotional development; or adaptive development.” A weekly home visit is referenced frequently in the early intervention literature as the norm (2013 ITCA Tipping Points Survey and other sources). The amount and frequency of service are to be determined individually, based on the needs of the child and family.

The amounts and frequencies of service appear to be relatively consistent within each of the four comparison states and are determined based on need. In Minnesota, one hour per week is reported to be the most common amount of service. Maryland provides an average of 1 to 2 hours of service per week. Nebraska reports bi-weekly visits to be the current norm with a goal to provide weekly visits. Iowa has reduced typical levels of service to bi-weekly or monthly for many children, and concern has been expressed that this level of service is inadequate. Iowa and Nebraska indicate that, due to funding concerns, some services to children and families have decreased; however, average levels of service are still higher than those for Michigan’s “Part C only” population. Both Iowa and Nebraska are exploring a Primary Service Provider (PSP) model of service delivery as a means to maintain and improve levels of service.

In Michigan, the minimum service requirement for children eligible under MMSE is 72 clock hours over one year. Service levels are generally based on need, but in order to be eligible for state school aid act funding, districts must meet the minimum service requirements. For children who are eligible under “Part C only” there is no mandated amount of service, and the amount of service varies widely across the state, reportedly ranging from approximately one hour per month to twice per year, depending on the service area. Instead of child-centered determination of service needs, some service areas provide only one of the following: service coordination, playgroups, visits that focus on general parenting topics, periodic phone calls, or provision of handouts on general parenting topics.

The MDE does not collect data on the levels of service; coordinators and administrators from all of the state’s service areas provided the information reported here. It is likely that the variation in levels of service across Michigan for children who are eligible under “Part C only” is related to the level of local funding, as there is no state funding for “Part C only”. Funding will be discussed further in the subsequent section.

Part C services are to be “provided by qualified personnel (as that term is defined in 303.31).” The term “qualified personnel” includes, but is not limited to, audiologists, family therapists, nurses, occupational therapists, orientation and mobility specialists, pediatricians and other physicians (for diagnostic and evaluation purposes), physical therapists, psychologists, registered dietitians, social workers, special educators (including teachers of children with hearing impairments/deafness and teachers of children with visual impairments/blindness), speech and language pathologists, and vision specialists (including ophthalmologists and optometrists.)

All the birth mandate states, including Michigan, have established qualifications for providers of early intervention services. The four comparison states report that the most common providers of service are ECSE teachers, OTs, PTs and SLPs, regardless of whether a state has agency partners providing services. Iowa also utilizes social workers. In Michigan, ECSE teachers, OTs, PTs and SLPs are also the most common providers of service for children who are eligible under MMSE, but this is not true for children who are eligible under “Part C only.”

In Michigan, the “Part C only” service providers come from many backgrounds. Some meet the stringent requirements for special education service providers while others may have degrees in related fields. Some “Part C only” service providers have only high school diplomas or GEDs. Qualifications of service providers also may vary significantly across service areas and agencies.

In many Michigan service areas, school districts are the only providers of early intervention services as there are no agency partners. When agency partners are involved, they may provide the type of service the agency typically provides or more general parenting education services. Some service areas exclusively use other agencies to provide service for “Part C only” children, with local school districts providing only special education. In other service areas, local districts provide special education and the ISD provides “Part C only” services. Some service areas have separate staff providing the “Part C only” and the MMSE services within an ISD, while in others special education staff provide services to children eligible under “Part C only” and also to those eligible under MMSE.

In Michigan, access to different types of services may vary in any given service area depending on the types of providers available for children eligible under “Part C only” and their families. Some therapies, along with ECSE teacher services, are available only to children who meet the eligibility criteria for both Part C and MMSE. Even in those parts of the state that provide the same types of services to all children eligible under Part C, the frequency and amount is usually much less than the 1 or 2 hours per week that is typical under MMSE.

There are two main types of services provided under Part C: **Special Instruction** and **Family Training/Counseling/Home Visits**. The qualifications for the various types of service providers are generally similar among the five birth mandate states for therapies and health, social work and psychological services. The qualifications required for similar types of services under MMSE closely match the Part C requirements in the comparison states; however, Part C in Michigan does not match the qualifications because all of the same types of services are not available to children eligible under “Part C only” in all service areas in Michigan.

The service category known as **Special Instruction** is defined in the Part C Regulations as including “(i) The design of learning environments and activities that promote the infant’s or toddler’s acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; (ii) Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the IFSP for the infant or toddler with a disability; (iii) Providing families with information, skills, and support related to enhancing the skill development of the child; and (iv) Working with the infant or toddler with a disability to enhance the child’s development.”

The four comparison states indicate that providers of Special Instruction are ECSE teachers. One state also lists Teacher Consultants for students with Visual Impairments, Hearing Impairments and Autism Spectrum Disorders. The four comparison states all have established state standards for qualifications of special education personnel.

In the past, Michigan's Part C system used various types of personnel to provide Special Instruction, including those with non-related degrees and/or high school diplomas. Recently, the state has redefined qualified providers of Special Instruction as those with Michigan teacher certification; however, the teacher certification requirement in Michigan for Part C is less specialized than in the four comparison states. In Michigan an elementary teaching certificate is sufficient to provide Special Instruction under Part C. A more specific credential is required to deliver educational/instructional services for students who are eligible under both Part C and MMSE. The MMSE requirements are very similar to the qualifications required by the comparison states. The requirements under Michigan's "Part C only" system do not match those of the comparison states.

Another category of service under Part C is **Family Training/Counseling/Home Visits**. As defined in the Part C regulations this means "services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an infant or toddler with a disability in understanding the special needs of the child and enhancing the child's development."

The qualifications of individuals providing Family Training/Counseling/Home Visits varies across all of the birth mandate states. Iowa indicates that social workers or ECSE teachers provide Family Training/Counseling/Home Visits. Maryland indicates that all Service Coordinators generally may provide this service, but only psychologists or social workers may provide mental health counseling. Further, when paraprofessionals are used to provide this service in Maryland, they must meet rigorous state education requirements (2 years of study/48 semester hours), must be supervised by the professional for whom they are providing assistance, and must work on practicing of skills rather than new skill development. Minnesota indicates that Family Training/Counseling/Home Visits are provided by social workers and psychologists. Nebraska indicates that any qualified service provider can provide this service.

In Michigan, Family Training/Counseling/Home Visits may be provided by any Part C service provider, from those with advanced degrees in social work or psychology to those with GEDs. Michigan has changed its interpretation of who is qualified to provide this type of service at least twice. The initial interpretation was that any provider of *Early On*® services could provide Family Training/Counseling/Home Visits. A reinterpretation determined that only social workers and psychologists could provide counseling. Currently Michigan allows any service provider to provide Family Training/Counseling/Home Visits, regardless of qualifications and including those with high school diplomas or GEDs.

Funding

There is a significant difference between Michigan and the other birth mandate states in the area of funding. All of the birth mandate states receive federal Part C grant funding to support their systems. All five states bill Medicaid for reimbursable services. The four comparison states provide funding through the State Education Agency to support the early intervention system, while in Michigan state funding is only provided for children who are eligible under MMSE (approximately one-third of all the children eligible for early intervention.)

Neither school districts nor state agencies in the birth mandate states bill insurance for direct services. When agencies outside of education participate in the delivery of Part C services, revenue may be accessed through the means typically used by that agency. In some states, such as Maryland, funding is allocated to a service area or jurisdiction, and education and other agencies partner in providing services for the area. In Michigan, Part C funds may be used to purchase services from other agencies.

Iowa provides direct services at no cost to children eligible under Part C and their families based on the principle that a free, appropriate, public education must be provided at no cost to families. Service coordination is also provided at no cost to families. State funding flows to nine service areas, known as Area Education Agencies (AEAs) based on an annual child count using both Part C and Part B funds. At one time some limited local funds were also used to support Part C but this is no longer the case.

Maryland's Part C funding comes from state general education funds designated for birth to 3, IDEA Part B funds, and the IDEA Part C grant. Funding is based on the number of children served the previous year and is distributed to 29 jurisdictions. A Consolidated Local Implementation Grant application is developed by each jurisdiction and submitted annually.

Minnesota uses general education funding to support Part C services. Each child eligible for Part C generates revenue equal to a minimum of about \$2000 per child enrolled for any level of service up to 231 hours per fiscal year. Additional hours of service generate an additional prorated amount of general education revenue. The state also reimburses the serving district for a proportion of certain costs related to providing early intervention services. The state reimburses 68% of salaries for essential personnel, a percentage of some supplies, home visitor travel costs, and a portion of contracted placements. This reimbursement is capped annually at a prorated amount equal to about 90 cents on the dollar.

Nebraska funds services at the rate of 90-100% reimbursement of costs to local school districts, which provide all direct services to children and families under Part C. Direct services are provided at no cost, consistent with the free, appropriate, public education mandate in IDEA. State funds and IDEA Part B funds are used for all services under Part C except Service Coordination. Service Coordination is provided by Health and Human Services, which bills Medicaid or parents' insurance for Service Coordination. The State Education Agency bills Medicaid for eligible services, but not parents' insurance. Part C grant funds are used only to support the state Part C infrastructure and for professional development activities.

Michigan provides a per pupil foundation allowance only for students who are eligible under MMSE based on the FTE generated by two annual pupil counts. Funding is generated through programs that provides a minimum of 72 clock hours of service within one year, typically about 0.2 to 0.4 FTE per child. The state also reimburses allowable costs at a rate of 28%; however, districts receive either the foundation allowance or the allowable costs, whichever is the greater amount.

In Michigan there is no state funding to support "Part C only". Districts receive a portion of the federal Part C grant based on a formula and many districts use these funds for direct services to

children eligible under “Part C only”. Some service areas also allocate local funds to support direct services. The amount of local funding varies significantly across the state and is dependent on local resources and dispositions, as well as funding structures of the service area.

The following chart summarizes the four major components of the Part C system in Michigan and the four comparison birth mandate states.

	Lead Agency	Eligibility	Services	Funding
Iowa	Education One pool of children	25 % delay in one or more domains Established Conditions	All children have access to all services based on need. Most common providers: ECSE teachers, OTs, PTs, SLPs, SWs.	State funds Part C grant Part B funds No local funds
Maryland	Education One pool of children	25% delay in one or more domains Established Conditions	All children have access to all services based on need. Most common providers: ECSE teachers, OTs, PTs, SLPs.	State funds Part C grant Part B funds Some local funds
Minnesota	Education One pool of children	1.5 SDBM in one or more domains Established Conditions Part B categories may be used	All children have access to all services based on need. Most common providers: ECSE teachers, OTs, PTs, SLPs.	State funds Part C grant Some local funds
Nebraska	Education/Health and Human Services co-lead One pool of children	2.0 SDBM in one domain, or 1.3 SDBM in two or more domains Part B categories Established Conditions covered by the Part B categories	All children have access to all services based on need. Most common providers: ECSE teachers, OTs, PTs, SLPs.	State funds Part C grant Part B funds Some local funds No Part C grant funds are used for services or service coordination.
Michigan	Education Two pools of children: Approximately 2/3 eligible under “Part C only” Approximately 1/3 eligible under both Part C and MMSE	For “Part C only”: -20% delay in one or more domains, 2 months to 3 years -any degree of delay birth to 2 months -or an Established Condition For MMSE: -13 categories with specific characteristics Children eligible for MMSE are automatically eligible for <i>Early On</i> ® but not vice versa.	For children eligible under “Part C only” access to services varies statewide. Some areas provide services based on need, others provide only specific types of services. For children eligible under MMSE all services available based on need. Most common providers: ECSE teachers, OTs, PTs, SLPs.	“Part C only” : Part C grant Local funds in some service areas MMSE: State funds Local funds Part C grant for some service areas

Current Challenges in Michigan

A number of challenges stem from the two-tiered system that has been developed in Michigan. These fall into the categories of:

- Structural Issues
- Eligibility Issues
- Issues with Referrals, Evaluations and Access to Services
- Funding Issues

Each of these challenges is discussed in more detail below.

Structural Issues

When Part C, originally known as Part H, came into being, states were allowed to determine many of the structural elements of the new system such as selection of the lead agency, eligibility criteria, and procedures for interagency collaboration to meet the new requirements. In the birth mandate states, Education was the logical choice for lead agency as the majority of early intervention services were already being provided through existing special education delivery models.

Michigan, as a birth mandate state, was already providing special education services for infants and toddlers under Michigan Mandatory Special Education, and the types of services provided through MMSE included many of the services described under Part C. Therefore, the Office of Special Education and Early Intervention Services became the primary provider of early intervention services in Michigan and other agencies that also served infants, toddlers and their families, including the Department of Human Services and the Department of Community Health, became partners in early intervention through collaborative agreements at state and local levels. Subsequently, the Offices of Special Education and Early Intervention were decoupled, and administration of Part C became split across two offices. IDEA Part C is administered through the Office of Great Start while Michigan Mandatory Special Education (MMSE) is administered through the Office of Special Education. These two offices have different administrators and different policies, practices and procedures relative to Part C, which are not always coordinated. This can create confusion for the field.

Over time, the level of participation of other agencies in the provision of direct services has varied significantly across the state, and this continues to be an issue. Funding has declined for the partner agencies over the years, and at the same time there has been a decrease in the federal Part C grant. As a result, other (than Education) agency participation in the provision of early intervention services has declined or become nonexistent in many parts of the state.

There are some large service areas that still maintain substantive partnerships with other agencies. Two of the largest, for example, contract with agencies outside of Education for all of the “Part C only” services; however the types of services offered by other agencies are limited. Some ISD’s provide “Part C only” services while their local districts provide MMSE. Other ISDs have a distinct and separate staff designated for “Part C only” and MMSE. Some ISDs provide all of the educational services under “Part C only” and MMSE, and may or may not have

agency partners involved. When responsibilities for service delivery are divided, the types of services available to children eligible under “Part C only” versus those eligible under both Part C and MMSE may or may not be equivalent.

The differentiation in services described above likely came into being because of the very generous initial definition of eligibility for Part C in Michigan. Michigan originally established the threshold for Part C eligibility as “any degree of delay”. Additionally, Part C included an Established Conditions category, which includes conditions likely to lead to a delay if intervention is not provided. The intent was to serve as many infants and toddlers as possible for whom any concern had been identified. However, there was also a sense that children with only a slight delay, or the potential for delay, would not require highly specialized services; thus providers from more general backgrounds were often hired to provide services to the less delayed segment of the “Part C only” population. These providers from more general backgrounds tended to focus on developmental monitoring and general parenting training versus targeted early intervention services designed to address a specific delay or disability. Over time this has evolved into highly disparate service models for children eligible under “Part C only” versus those eligible under both Part C and MMSE.

While many children were found eligible under the initial definition of developmental delay in Michigan who may have needed developmental monitoring rather than highly specialized services, the population has changed as Michigan changed its developmental delay criteria. Several years ago Michigan raised its eligibility threshold to require a 20% delay for children aged 2 months to 3 years and retained the “any degree of delay” only for those 2 months and younger. This was largely in response to the fact that the field did not have the capacity to serve all who were eligible under the more generous “any degree of delay” threshold. Even with this change in eligibility, Michigan is still struggling with capacity to serve.

It should be noted that there is a mandate to find and serve all who are eligible, given parental consent. IDEA and MMSE services cannot have waiting lists nor can they claim to be full as other programs serving infants and toddlers are able to do. The early intervention system must stretch to accommodate all who are eligible and whose parents desire the services to which they and their children are entitled by law.

Eligibility Issues

Challenges in the identification of children eligible under Part C also relate to the nature of the different eligibility categories under MMSE, the process/timelines for evaluations under Part C, and the training/expertise of the evaluators. These challenges have contributed to the overuse of the Early Childhood Developmental Delay (ECDD) category which can result in differences in early intervention services to eligible children.

First, a phenomenon that has developed in Michigan appears to be a widespread misunderstanding that a 50% delay is required for a child to be eligible under MMSE. ECDD is one of the 13 MMSE eligibility categories, and it does, indeed, require that a child demonstrate a delay equal to or greater than one-half of expected development. However, this category is meant to be used only when the “primary delay cannot be differentiated through existing criteria in” the

other eligibility categories. The definition of ECDD “does not preclude identification of a child through existing criteria in” the other eligibility category rules.

The overuse of the ECDD eligibility category for children eligible under both Part C and MMSE may stem from a variety of sources. Because of its very name, the category of ECDD may be misunderstood as the only category applicable to early childhood. There may also be a sense that the name of this category is easier for parents of young children to accept than other eligibility categories that include the word “impairment”. The category of ECDD also may be used frequently because it can, in fact, be challenging to determine eligibility for very young children in the other eligibility categories. However, the degree of delay required under the ECDD category is significantly greater than what is required for other eligibility categories. Most of the other eligibility categories do not have a specific threshold for eligibility, such as a percent delay or required standard deviation below the mean (SDBM). This means that it may be more difficult for a child to meet the eligibility criteria for ECDD, which is one of the most commonly used eligibility categories for young children under Part C.

For example, one eligibility category that does specify a threshold for eligibility is Cognitive Impairment (CI). The threshold for CI eligibility is set at 2.0 standard deviations below the mean which roughly equates to a 30% delay. This is far less significant than the 50% delay required for ECDD eligibility, and application of the CI eligibility category might capture more children as eligible. However, for a variety of reasons the category of Cognitive Impairment is not often used with infants and toddlers until they are ready to transition out of early intervention, thus the more restrictive ECDD category is commonly used for children exhibiting a cognitive delay. Early identification of a cognitive delay is critical. Children exhibiting a cognitive delay at such a young age, if not provided with appropriate early intervention, may later struggle with academic skills because they may not have developed the foundation or prerequisite skills during the prime brain development period.

Other eligibility categories available under MMSE do not include specific thresholds for eligibility, but still may not be used with very young children. In some cases, the description of the eligibility category may suggest that it applies to older individuals, such as the definition of a learning disability which references specific academic skills typically associated with students in grades K-12. Certain other categories are traditionally less preferred for use with infants and toddlers except, perhaps, when nearing transition out of Part C into Part B programs. For example, while very young children may exhibit cognitive and emotional delays or disorders, the field tends to be reluctant to use these categories with infants and toddlers because children can change so dramatically, especially in the first three years of life. A child who may appear to have a cognitive or emotional impairment may not continue to do so if early intervention is appropriate and of adequate intensity. The problem with avoiding the use of certain eligibility categories is that it holds children to a more significant standard of delay under the ECDD rule, making it less likely that they will qualify for targeted early intervention services under Part C and MMSE.

An additional issue with eligibility under MMSE occurs when individual districts set local eligibility thresholds for categories that do not have thresholds established in state rule, such as Speech and Language Impairment (SLI). The most common threshold used for SLI eligibility is

1.5 SDBM (approximately a 22.5% delay.) If a child has a speech and language impairment, the child will qualify for MMSE in most districts with a delay of 1.5 SDBM, but if the child has a cognitive impairment, according to state rule he/she must demonstrate a delay of 2.0 SDBM (approximately 30% delay) in order to receive MMSE services under the category of CI. If the district is utilizing mainly the ECDD category (with the very significant eligibility threshold of 50% delay) the child must demonstrate a much greater cognitive delay in order to qualify for services. This is but one example of how variations in the application of eligibility criteria and categories can create inequities in eligibility and resulting access to services.

The evaluation process and timelines under Part C also present challenges relative to eligibility determination for infants and toddlers. First, evaluators typically are unfamiliar with the child upon initial referral; the child is likely not part of a classroom program at this age and Part C is often the family's first contact with the educational system. Access to the child may be limited because the child is in the home rather than in a more readily accessible school-based, classroom situation. The time allowed for the Part C evaluation and IFSP process is relatively short compared to the Part B timeline and may not allow for lengthy/multiple observations of the child or use of a Response-to-Intervention type of model as may occur with a child attending a classroom program. Despite these challenges, decisions around eligibility must be made relatively quickly.

The available evaluation tools and processes may also pose challenges to eligibility determinations for infants and toddlers. Evaluation instruments may not be sensitive enough or contain sufficient increments in order to be able to ascertain accurate skill levels. Some evaluation instruments may have only a few items appropriate to the developmental level of young children, particularly infants. The child may be too young to respond to verbal commands or directions, thus requiring elicitation of responses in other ways. Observation and parent interview are necessary to obtain information about the child's functioning and abilities. Characteristics of a delay or disability may not yet be easily observed or are as yet very subtle. Medical diagnoses, such as cerebral palsy or vision impairment, may not yet have been made. Children with Down syndrome or other genetic conditions may not yet exhibit a delay or demonstrate "educational need", which is a requirement for eligibility for MMSE. Despite less-than-ideal tools and scant information, decisions around eligibility must be made in a timely manner.

The training/expertise of the evaluators may also pose challenges to eligibility determination for infants and toddlers. University training programs typically prepare evaluators to work with the entire spectrum of ages, of which infants and toddlers are only a small percentage. Evaluators may not be sufficiently trained in the appropriate observation and interpretation of infant and toddler behavior to make the most informed recommendations regarding eligibility.

In fact, determining a specific level of skill delay is very difficult to do with infants, especially for those born prematurely. For example, a premature infant may not reach the 50% level of delay when evaluated, and this may exclude extremely premature infants from receiving necessary feeding services because the providers of these services only serve children eligible under MMSE (those with the supposedly required 50% delay) and their families. In areas in which the types of available services are the same for MMSE and "Part C only", the frequency of

services likely will be significantly less if a child is eligible under “Part C only”, even when more intensity is needed.

All of the factors described above contribute to challenges with identification of children eligible under Part C and overuse of the ECDD eligibility category for those eligible under both Part C and MMSE. This is problematic as it may be resulting in significant under-identification of infants and toddlers who are eligible or likely to be eligible for MMSE. In areas where providers or referral sources believe the criteria for access to MMSE is a 50 % delay, children may be found ineligible when the delay approaches, but does not reach, the 50% threshold. Other eligibility categories may not be considered, or children who are likely eligible may not be referred, because the exhibited delay is lower than what the threshold is incorrectly understood to be. In service areas where the types of available services are different for “Part C only” versus MMSE, and where the 50% delay threshold is being implemented, a child and family will not receive needed services.

Issues Regarding Referrals, Evaluations and Access to Services

In Michigan, there are two sets of evaluation procedures and requirements to qualify infants and toddlers for services due to the two-tiered system of eligibility. All referrals are initially considered Part C referrals. A referral to MMSE may be made simultaneously with a Part C referral if it is recognized at onset that a child might be eligible for MMSE. In this case, a combined evaluation can be conducted. Conducting a combined evaluation may be more convenient and less stressful for the family, as well as ensuring that child find obligations are met in a timely way. However, the potential eligibility for MMSE may not be immediately recognized, thus postponing the MMSE referral and evaluation until the potential disability is more clearly evident. This requires that the child and family to go through the process of a second evaluation, sometimes within a relatively short period of time after the initial Part C evaluation was completed. This can be confusing and frustrating for families, and may delay needed services.

Some service areas/districts have implemented a practice of waiting to make the MMSE referral; the child and family first receive services through “Part C only” for a period of time. This may be considered a form of tiered instruction or support while the child and family are “covered” by the “Part C only” services. However, while this practice may allow providers more opportunity to observe the child before referring to MMSE, children are rarely “covered” under “Part C only” at the same level of intensity or with the same types of service as those eligible for MMSE. The practice of holding off on a referral to MMSE may delay access to services of the needed type and intensity if equivalent services are not available in that service area for children and families eligible under “Part C only.” Additionally, this practice, if done while already recognizing the need for a referral to MMSE, is contrary to child find obligations under IDEA.

The years from birth to age three are a critical period of development, and access to early intervention services is of paramount importance. Practices that delay referrals to such early intervention services through MMSE may come from good intentions. Providers may be reluctant to indicate to the parent that a child may be eligible for MMSE if the parent has not already entertained this possibility. Parents of infants and toddlers may still be coming to terms with the fact that their child has a disability or a delay and may struggle with the idea of

“labeling” their young child, increasing the reluctance on the part of providers to broach the subject.

Early intervention is a critical service provided over a very short period of time in a child’s life, and timely access is crucial. At most, the window for provision of services is three years, but for the majority it is less than three years because children are referred at all ages within the three year span. For example, it is typical for a child to be initially referred to Part C at about age two when the child is exhibiting more easily observable characteristics leading to a concern being identified. Policies and practices that delay referral to MMSE may delay or deny access to needed services that are available only within a limited age window.

The charge of early intervention is to identify and appropriately and adequately serve eligible children as soon as possible, in order to prevent delays and/or decrease the potentially negative impact of a disability on the child’s learning and development. A sense of urgency surrounds early intervention due to the fact that birth to three is the most critical period of brain development. Early intervention is meant to be preventative in nature.

Access to needed services also may be limited by the structures in place within a service area. In IDEA the list of services under Part C and Part B (MMSE) are very similar, with most of the same services being included in both. However, in Michigan the services provided through MMSE, such as therapies and special education teachers, may only be available to children eligible under both Part C and MMSE. In some service areas, there may be only one or two types of service, such as social work or general parent education, available for children eligible for “Part C only”, rather than the full array of early intervention services that may be needed. Other service areas report that the full array of services is available, but many (usually the types of services provided through MMSE) are only available on a consultative basis. Consultation may be sufficient for some children, but when direct service is needed access may be restricted by the structure in place in the service area or ISD.

The following scenario is an example of one that can and does result from the two-tiered system in Michigan: A child is found eligible for Part C with a 40% delay in the communication domain, and needs the services of a Speech and Language Pathologist (SLP). The district provides SLP services only through MMSE. The district is implementing the presumed threshold of 50% delay for MMSE eligibility. The only services available for “Part C only”, and thus the only services available to this child and family, are general parenting services provided by a person with a high school diploma. This common scenario is clearly not the intent of IDEA Part C and can be attributed in large part to the two-tiered eligibility system as well as lack of funding (which will be discussed in the subsequent section.)

Funding Issues

IDEA Part C includes a list of services which are to be available to those infants and toddlers who are eligible for early intervention and who are determined to need such services. Districts are attempting to meet the requirements of Part C, as Michigan has chosen to implement it, with very limited resources available for early intervention. Specifically, the Auditor General’s report indicated that “MDE did not ensure that ISDs complied with federal regulations by providing *Early On*[®] only children access to a comprehensive selection of early intervention services

delivered by qualified personnel. As a result, ISD's were not in compliance with federal regulations and some children eligible for *Early On*[®] and their families may not have received the most appropriate type and quantity of EI services for their conditions." (See the "Audit Report - Performance Audit of *Early On*[®]" from the Michigan Office of the Auditor General, November 2013, for more information about Michigan's provision of the required array of early intervention services and qualifications of providers under Part C.)

Michigan's current threshold of a 20% delay for Part C eligibility continues to be one of the most generous in the nation, but current funding is insufficient to support the system. While some children currently receiving services in *Early On*[®] under "Part C only" may not require intensive or specialized services, the vast majority do. Children who exhibit a delay just above the 20% threshold, or those with milder medical conditions who qualify under Established Conditions, may only require an hour per month for developmental monitoring, or the family may only need help in monitoring the effect of the medical condition on the child's development. However, many of the children eligible under "Part C only" may have greater needs than this and therefore require more intensive and specialized services.

Under IDEA Part C, states are charged with developing a "system of payments" to support the services provided as early intervention. The federal Part C grant is intended to support the overall collaborative (participating agencies) system and provide some additional funding to support the costs of the Part C requirement of service coordination for each family involved in early intervention. Part C allows the use of the federal grant funds to be used for direct services only as a payer of last resort, demonstrating that federal grant funding was not intended to be the sole source or even the main source of funding to support direct services. States are required to develop the funding structure to support the system of direct services.

In Michigan, MMSE was in place, providing services to infants, toddlers and their families before the federal mandate through Part C (originally known as Part H.) When Michigan developed its two-tiered system, the children eligible for MMSE continued to receive those services. The Part C requirements were layered over the existing MMSE system, and families also began to receive services such as service coordination. The children currently eligible for *Early On*[®] under both Part C and MMSE are about one third of the total number eligible for early intervention. It is only for these children that MMSE provides state funding through the per pupil foundation allowance or reimbursement of allowable costs (approximately 28%), whichever is greater.

The amount generated from the foundation allowance is based on full time equivalency, and is typically a much smaller amount per child at ages birth to three because the amount of time staff spends directly with the child is much less than with a child in a K-12 classroom. A basic tenet of early intervention is that the family is an active participant in the intervention and the primary provider of interventions during the course of the family's daily routines within the natural environment. The role of the early interventionist is to support the family by sharing information and teaching/coaching the family in intervention strategies and methodologies. A child and family receiving early intervention services typically will not receive direct service provided in a classroom program because service is predominantly provided individually through the family in the natural environment with ongoing support available between intervention visits or sessions.

Because the foundation allowance generated by full time equivalency is very low, state funding in Michigan for birth to three is more often based on the 28% reimbursement of allowable costs. Local service areas provide the remaining funds for services (roughly 72%.) The Part C grants to ISDs help to support the system, but are quite small and may not be used for direct services except as a payer of last resort.

A new cohort of children became eligible for early intervention services when Part C (then H) began to be implemented in Michigan in the early 1990s. Currently, this cohort of children, eligible only under Part C, is about two thirds of the total number eligible for *Early On*[®]. Services for this group of children are typically funded through the Part C grant and in some service areas, ISD or local funds. Medicaid is billed for eligible services, but cannot be billed if the provider of the services is paid through federal funds (Part C grant). As the federal Part C grant is often the only source of funding for services, many service areas are unable to bill Medicaid for “Part C only”. On a limited basis in some parts of the state, some funding may be provided through some of the other agency partners’ funding structures. There is no state-level funding to support “Part C only” services in Michigan as there is in the other four birth mandate states.

Conclusions and Considerations for the Future

Conclusions

Michigan is struggling in its efforts to provide services to infants and toddlers with disabilities and developmental delays. A two-tiered structure in Michigan's Part C early intervention system, *Early On*[®], has created two sets of eligibility criteria and limited access to appropriate types and/or intensity of services for approximately two thirds of the children eligible. The lead agency for implementation of the system is the Michigan Department of Education, but the two tiers are administered through two different offices. IDEA Part C is administered through the Office of Great Start while Michigan Mandatory Special Education (MMSE) is administered through the Office of Special Education. The challenges arising from this bifurcated model have been discussed in this report.

The lack of state funding is also a major factor in the struggle to provide adequate services under Part C. Districts or service areas use federal Part C grant funds, which are quite small and have continued to decrease over recent years, to support services for children who are eligible under "Part C only." Some service areas also use local funding sources to meet the Part C obligation. The state funding structure that is in place for children eligible under both Part C and MMSE covers only about 28% of costs, requiring school districts to fund the remaining 72% of costs with local dollars. Partnerships with other agencies have been supported primarily through federal Part C grant funds via contracts with intermediate school districts. The participation of agency partners has diminished significantly or is non-existent in large portions of the state.

Michigan has demonstrated a commitment to early childhood in recent years which has resulted in increased funding for some preschool programs and some types of home visiting programs for infants and toddlers unrelated to Part C. This is a positive trend, as research has demonstrated that the primary period of brain development is from birth to three and long term studies of programs for young children have demonstrated a significant savings-to-investment ratio. The foundations for later academic learning and adult work skills are established at a very young age, and children who fall behind in the early years often continue on a downward developmental trajectory if intervention is not provided. This will inevitably result in increased costs for education and to society in a variety of ways. Evidence and information about the research is readily available in the literature. Specifically, the MDE Office of Great Start report entitled "Great Start, Great Investment, Great Future - The Plan for Early Learning and Development in Michigan" provides a significant amount of information about the importance of early childhood and about the current state of the broader early childhood system in Michigan.

The above referenced report includes a list of six high-leverage areas to improve opportunities and outcomes for young children. Included in the list of high-leverage areas are: 1) Focus first on children with highest needs; 2) Fund quality; 3) Ensure early childhood service provider quality; and 4) Increase access to and capacity of *Early On*[®]. These high-leverage areas directly correlate with the topics of discussion in this report. *Early On*[®] certainly serves children with the highest needs: those who have a disability and/or those who, already in their young lives, exhibit a significant delay in their development. The survey of stakeholders referenced in the report frequently mentioned *Early On*[®] as being significantly underfunded and as a program that should

be considered a priority for consideration of increased funding. Although eligibility for *Early On*[®] is not based on income, included in the population are many children who are experiencing all of the risk factors identified for other groups, on top of a disability or developmental delay. However, the current funding being provided for the expansion of home visiting programs specifically *excludes* use for Part C early intervention.

Infants and toddlers who qualify for Part C early intervention, and their families, need and deserve highly qualified service providers and the funding required to provide services of the appropriate type and intensity. IDEA Part C was created with the intent of fulfilling this need. The state was wise at the inception of Michigan Mandatory Special Education in including infants and toddlers. It is time to recognize the importance and uniqueness of early intervention for infants and toddlers and that the early intervention program in Michigan known as *Early On*[®], which includes children eligible for “Part C only” as well as those additionally eligible for MMSE, needs to be restructured with increased financial support from the state.

Considerations for the Future

The struggles facing Michigan in its attempt to meet the needs of its youngest, most vulnerable population point to the need for major changes to the system. This is very timely as IDEA Part C has added a new indicator requiring states to identify problems or issues with state’s Part C delivery system and develop a plan to improve.

Based on the current state of the system in Michigan and what has been learned from the exploration of the other four birth mandate states’ systems, the following topics emerged as potential areas in which the Michigan Association of Administrators of Special Education may wish to consider advocating for change:

1. **Develop a Single Cohort System**

Create a single system with one set of eligibility criteria and one cohort of children, with all children eligible for Michigan Mandatory Special Education, utilizing the MMSE existing standards for qualified personnel for education staff.

Rationale:

This mirrors a recommendation contained in the audit report “Performance Audit of *Early On*[®]” from the Michigan Office of the Auditor General (November 2013, page 16.) Implementing a single cohort model would ensure equal access to services, based on need, for all eligible children and families. It would also provide a funding structure. This would not negate the participation of other agency partners in direct service, but would ensure that all eligible children and their families have access to all types of service, regardless of where they live in the state.

2. **Revise Eligibility Criteria**

Utilize the categories of Developmental Delay (DD) and Established Conditions for determining special education eligibility for birth to three. Discontinue use of the current MMSE categories with the exception of children who enter a Part B program at age 2.5. Consider establishing the threshold for DD eligibility at 1.5

standard deviations below the mean or a 25% delay. Review the list of established conditions to ensure that it includes all conditions potentially warranting early intervention. Discontinue the requirement for “evidence of educational need” relative to children from birth to age three.

Rationale:

Challenges with the application of the 13 MMSE categories have been discussed in this report, both in terms of overuse of the ECDD category and in terms of equity of access through eligibility. A clearer definition of Part C eligibility is important both for the field and for the many referral sources, including parents. Parents may struggle to accept a typical special education “label” for a child at such a young age. The categories of developmental delay and established conditions are more easily used at birth to three and more acceptable to many families as well as providers. It can be argued that identifying young children with a special education eligibility label may limit expectations for growth and development. Many children involved in appropriate and adequate early intervention services make significant progress and change, often not needing special education services or needing less intensive services as they age out of early intervention.

Due to age, infants and toddlers may not exhibit “educational need” per se and evaluators may not be able to detect it. For example, there are children in Michigan with established conditions who are not eligible under MMSE because they do not yet demonstrate a sufficient developmental delay or an “educational need.” Waiting for evidence of educational need is contrary to the intent of Part C. Other birth mandate states do not require evidence of educational need to qualify infants and toddlers for services.

3. **Expand State Education Funding for Part C**

Develop a funding structure that provides sufficient and sustainable funding in order to provide services of the appropriate types and intensity. Such a structure would not be reliant solely on a per pupil foundation allowance based on full time equivalency, but would also include supplemental funding of allowable costs to bring the total funding up to a level that is adequate to support mandated services.

Rationale:

In Michigan, the FTEs generated in early intervention are not sufficient to adequately fund the program, necessitating significant contributions from local districts. The limited amount of funding generated by FTEs puts early intervention at a significant disadvantage compared to programs for older children and students in grades K-12.

Additionally, there should be supplemental funding, greater than the current reimbursement of allowable costs for K-12 programs, to bring the total funding for Part C services up to an adequate amount. Minnesota serves as an example of how this can be done. Minnesota’s education system provides a minimum amount

per child through its child count system and reimburses districts for certain costs. (See the survey summary for Minnesota in Appendix A for more detail.) The other birth mandate states have also developed a system of funding support at the state level through education specific to early intervention. It should not be impossible to provide eligible children and families with adequate types and intensity of service. The norm referenced throughout the literature is one hour of service per week. Other home visiting programs in Michigan for infants and toddlers who are at-risk provide weekly home visits. Certainly the most vulnerable children and families who are receiving early intervention services deserve appropriate types and levels of support as well.

Once a sufficient funding structure is in place for services, the state could utilize some of the Part C federal grant to develop a structure of ongoing professional development to support the implementation of quality service models and ongoing learning.

4. **Unify the Administration of the Early Intervention System**

MDE should administer the unified Part C program through one office if at all feasible.

Rationale: It is often difficult for the field to efficiently and effectively implement a program that is administered by two separate offices within the Department of Education, due to conflicting requirements and differing communication systems. If it is not feasible for one office to administer the early intervention program then the two offices must collaborate and meet on a regular basis to establish consistent policies/procedures, share information, and resolve issues.

5. **Include Early Intervention in a Multi-Tiered Statewide Early Childhood System**

As the state expands its broader early childhood system, a multi-tiered system of programs and services should be developed with fluid systems of referral from tier to tier. For birth to three, general parent education programs would comprise the first or bottom tier, which would be the broadest base, targeted toward the needs of children who are developing typically and their families, offering services to families who wish to receive general parent education and support. A second tier would include statewide prevention programs, such as the evidence-based, at-risk home visiting programs currently being provided through Early Head Start. Tier II would serve a targeted population in need of more focused services than what is provided in the broader base at Tier I. *Early On*[®], which is Michigan's early intervention program, would be the third tier, providing the most specialized and intensive services for a more specific and targeted eligible group. Tier III would logically serve the smallest population which demonstrates the most significant need, commensurate with the prevalence within the population.

Rationale:

Tiered models of systematic support are strongly supported in the literature. School districts across Michigan are using models such as MiBLSI in a Response-to-Intervention/Multi-Tiered System of Support (RtI/MTSS) framework to support all learners, improve outcomes for those at-risk for school failure, prevent the need for costly special education programming, and preserve intensive instruction for those who truly require it. A similar approach within early childhood would support the goal of having all children well-prepared to be successful in kindergarten.

Any system-level change requires a transition period if/when changes are implemented. There must be a transparent, well-reasoned move from the old model to the new, with clearly articulated strategies, timelines, and responsibilities. If some/all of the suggestions above are selected by the state for implementation, Appendix B includes a description of preliminary ideas for how such a transition might be accomplished for *Early On*[®] Michigan.

Resources

- 1) Great Start, Great Investment, Great Future – The Plan for Early Learning and Development in Michigan, Michigan Department of Education, Office of Great Start, May 2013.
- 2) Audit Report – Performance Audit of *Early On*[®], Michigan Department of Education, November 2013.
- 3) 2013 ITCA Tipping Points Survey – Part C Implementation: State Challenges and Responses.
- 4) The Role of Special Instruction in Early Intervention, Council for Exceptional Children, Division for Early Childhood webinar, July 2011.
- 5) Early Intervention For Infants And Toddlers With Disabilities And Their Families: Participants, Services, And Outcomes, Final Report of the National Early Intervention Longitudinal Study (NEILS), January 2007.

Appendix A:
Summaries of Survey Responses by State

I. Iowa

The responses to the Iowa survey questions were provided by Cindy Weigel, Iowa IDEA Part C Coordinator, during a phone conversation in 2013 with the Project Chair. Responses were summarized in a rough draft form and provided to the Iowa Department of Education to allow the opportunity for correction, verification and addition of information prior to inclusion in this report.

1. What is the lead agency?

Department of Education, Bureau of Learner Strategies and Supports (through special education). There is a Memorandum of Understanding with other state agencies to support the IDEA Part C system: Iowa Department of Public Health; Iowa Department of Human Services; and, Child Health Specialty Clinics of the University of Iowa. Iowa State University provides professional development to the field. The name of the early intervention program is: “Early ACCESS”.

2. Are there partners agencies involved in providing services? To what extent? In service coordination?

Yes. The University of Iowa provides Child Health Specialty Clinics (CHSC). Parents access nutrition and nursing services by going to the clinics. CHSC does provide some service coordination. The Iowa Department of Public Health (IDPH) was doing some service coordination but this ended July, 2013. IDPH does Child Find activities and will continue screening children found ineligible for Early ACCESS, referring them back six months later or sooner if needed (providing a safety net). Service coordination is done by direct service providers and some specially trained service coordinators who are not direct service providers of other early intervention services (dedicated service coordinators) through Iowa’s Area Education Agencies and CHSC. The state is divided into 9 geographical regions called Area Education Agencies (AEAs). Some AEA direct service providers also provide service coordination. CHSC contracts with parents who have experienced IDEA Part C services to provide the service coordination. The AEAs provide Early Childhood Special Education (ECSE) teachers and related service providers such as Occupational Therapists (OTs), Physical Therapists (PTs), Speech and Language Pathologists (SLPs), and Social Workers (SWs) who provide direct services to children and families in the natural environment. Other related services are also available through the AEAs and CHSC as needed. The Department of Human Services (DHS) sends Child Abuse Prevention and Treatment Act (CAPTA) referrals to Iowa’s single point of contact for potential referrals and provides relevant training to AEA staff. The Family Survey and the State Interagency Coordinating Council provide parents with opportunities for input into the promotion of family centered practices.

3. What is the percent delay (or standard deviation) under the eligibility category of developmental delay?

25% in one or more areas of development. Iowa is non-categorical for all of special education. Birth to 3 utilizes the categories of developmental delay and established conditions for participation in IDEA Part C. Special education is provided from birth to 21.

4. *How are services funded? Is funding attached to amount of service or a formula?*

Funding for early intervention services comes from both federal and state sources. Federal and state funding flows through to the AEAs based on number of children served. There is an annual application process which requires explanation and budget for how the funding will be used.

Some federal funds stay with the Department of Education (DE), IDPH, DHS and CHSC and are tied to the Memorandum of Agreement for supporting the statewide early intervention system. In addition, CHSC receives a state allocation to provide nutrition services statewide.

The child count is completed on the last Friday in October of each year and is used in funding calculations for the 9 AEAs.

Part C federal and state funds do not completely cover the cost of early intervention. The AEAs employ OTs, PTs, SLPs, etc. for Part B who also serve infants and toddlers who qualify for Part C, “there’s not enough in Part C”. Thus, Part B funding is used to support Part C. Some local Early Childhood Iowa funding used to be used but it was very little and is no longer being used.

Funding is accessed for services eligible for Medicaid billing. Each AEA negotiates Medicaid reimbursement rates based on the cost of the service in their area. In Iowa, Medicaid pays for the services then recoups the funds from private insurance. The Early ACCESS system does not participate in billing insurance or collecting fees from families because of the birth mandate that a Free Appropriate Public Education (FAPE) is provided at no cost to families. This includes service coordination.

5. *Is there fee for service for any group? Is Medicaid billed?*

No fee for service. No insurance billing. Yes, Medicaid is billed and Medicaid bills private insurance to recoup any covered services. Services are at no cost to families and their eligible children.

6. *When Part H (C) came into being, was the (at that time) current cohort of children placed under Part C or did the state expand the eligibility to include a broader population?*

As a birth mandate state, Iowa already served infants and toddlers with disabilities or developmental delays. In the early 2000s, the state expanded the category of established conditions to include all who are born prematurely, all in out-of-home placement through foster care, and all exposed to drugs prenatally. (NOTE: States may choose whether or not they will provide services to children who may be considered “at risk” due to environmental or familial factors. Iowa has chosen not to do so, but has a generous eligibility cut-off.)

- 7. Do the services vary for any group under Part C, such as the children who are eligible for Michigan's special education typically receiving more, and more specialized, service than those identified as "Part C only"?**

No. All eligible children have access to all services based on need and services are individually determined by IFSP.

- 8. Is there any variation in service or funding for particular groups, such as Michigan's differentiation between "Part C only" and Part C/SE eligible?**

There is no differentiation.

- 9. When Part H(C) came into being were any of the legal rights of children and families changed?**

Special education rights were already there. The Part C legal rights were added. Early intervention is part of the special education system. Iowa implements both Part B and Part C for birth to 3.

- 10. Are procedural safeguards the same for all eligible children and families, or are there two sets, such as has been traditional in Michigan's system?**

Part C and Part B have their own procedural safeguards based on the federal regulations for each and are applicable to birth to 3.

- 11. Is an IFSP only, used for birth to 3? Which elements of special education are included in the IFSP?**

Yes. The IFSP only is used for birth to 3. At third birthday, children transition to an IEP if eligible under Part B of IDEA and services are provided based on special education rules and regulations. IDEA Part C has its own Iowa Administrative Rules, policies and procedures separate from Part B.

- 12. At what age can just an IEP be used? If a child is going on in special education at age three, is an evaluation for eligibility done? Can a child go to pre-K Part B programs before age three? (How is this documented?)**

An IEP only, is used at age 3. An IEP is rarely used before age 3 (twice in 5 years) and only with pre-approval from the AEA Special Education Director and the DE. As there are no special education categories in the 3 to 21 system, there is a review process at transition to determine if the child meets the eligibility requirements for the "Part B only" programs and services. The state is trying to have no overlap but child find can be moved to Part B at referral of a child at age 2 years 9 months. Criteria are different for "Part B only" (3 to 21) and birth to 3. Requirements are more restrictive for 3 to 21. Early intervention is more inclusive as it is meant to be preventative. Part B programs and services are accessed at age 3. Part C and Part B are all part of the same web-based data system. The state is tracking children who are re-referred if first found ineligible.

- 13. Are any of the state's special education (SE) rules and regulations used or are Part C rules used exclusively? If any SE rules are used, what are they – eligibility categories, program rules, etc.? If SE eligibility categories are used, what is the percent delay of**

the equivalent to Michigan's ECDD category? Is there separate eligibility for special education, without Part C?

Part B and Part C have separate rules and regulations. There are no SE eligibility categories in this state (other than the two used at birth to 3). Children eligible for Part C are not automatically eligible for Part B. There is separate eligibility for early intervention (Part C) and special education (Part B).

14. Does the state still have birth mandate status? Is there FAPE language for birth to 3 or the underpinnings of FAPE?

Yes, the state has FAPE language applicable to birth to 3.

15. What are the most common types of services or providers of service?

Early Childhood Special Education (ECSE) teachers, Occupational Therapists (OTs), Physical Therapists (PTs) and Speech and Language Pathologists (SLPs), Social Workers (SWs). Most have a Master's degree. Other related services are also provided as needed.

16. What are the qualifications /who provides the following services?

a. Special instruction?

ECSE teachers, Teacher Consultants for Visually Impaired, Teacher Consultants for Hearing Impaired, Teacher Consultants for Autism Spectrum Disorder.

b. Family training, counseling, and home visits?

Social workers or ECSE teachers.

17. Is there a specific early intervention credential?

No, but the state is working on developing one at a Master's degree level, through Iowa State University.

18. Are paraprofessionals used?

Yes but not often. Paraprofessionals may serve as a Service Coordinator with training. Some paraprofessionals may provide service through the Child Health Specialty Clinics, specifically, nursing types of services. Paraprofessionals must be supervised by a professional.

19. What is the most common service delivery system? Is it statewide or a local choice? Does the state follow the Division for Early Childhood's Recommended Practices? Does the state base its service on functional outcomes?

The service delivery system varies by service area and is decided locally. There is an ongoing training initiative on the Primary Service Provider (PSP) model in some parts of the state, which includes improving in writing and working on functional outcomes. A statewide initiative, the Distance Mentoring Model (DMM) of Professional Development is in the first of five years of implementation. Iowa DMM promotes caregiver coaching rather than direct teaching to the child and focuses on using family-guided routines-based intervention. Florida State University (Juliann Woods & Emily Lakey) has been contracted to lead the initiative. DEC recommended practices are incorporated into this work. Working on functional outcomes for families and children is an ongoing process.

20. What is the typical or average amount of service per child/family? (Individual needs assumed) Are there state requirements for a minimum amount of service?

1 hour per week is rare, with some receiving 1 hour every other week due to caseloads growing. Many receive only 1 hour per month. This may be because the state has chosen to serve a broad at-risk population and Iowa cannot have a waiting list due to birth mandate to serve all eligible children under FAPE. The state is engaged in a Distance Mentoring Model with Juliann Wood through Florida State University to develop a caregiver coaching service delivery model due to their concerns with their inability to provide an adequate amount of service (deemed to be 1 hour per week for most). “You can’t make a difference with only 1 or 2 hours per month.” There is a fulltime state level person responsible for overseeing the professional development system.

21. What are the state’s service coordination and evaluation practices? How is service coordination provided - externally or integrated? How does the state meet multi-disciplinary requirements? Who does the evaluations - providers, designated teams, etc.? What instruments are used?

Most of the service coordination is done by AEA service providers, most often the early childhood special education teachers. The direct service providers do the evaluations. Eligibility is determined quickly to ensure that services begin as soon as possible. The evaluation process is not perfect and varies from area to area. The state is working at more consistency across the service areas. Some areas have designated Service Coordinators (SC’s) who only provide SC services. Service Coordination is considered a profession, but educational requirements are less for those providing service coordination only. They may have only a high school diploma, but there are specific training requirements for SC (training module). Providers of service typically have Masters Degrees. Some ECSE teachers provide the service coordination as well as special instruction. The Child Health Specialty Clinics (CHSC) through U of I do some service coordination. Public Health did SC but this will end as of July 1, 2013. Parents have been trained to provide SC through CHSC (clinics provide nursing and nutrition services). Multi-disciplinary requirements are met through teams of the direct service providers listed above. Various instruments are used across the state, especially the Developmental Assessment of Young Children (DAYC). Professional development is provided through online modules posted at Iowa State University Extension website.

II. Maryland

The original responses to the Maryland survey questions were provided by Donna Riley, the previous Maryland IDEA Part C Coordinator, during a phone conversation in 2013 with the Project Chair. Follow up information was provided by Brian Morrison, the current Part C Coordinator for Maryland. Responses were summarized in a rough draft form and provided to the Maryland Department of Education to allow the opportunity for correction, verification and addition of information prior to inclusion in this report.

1. *What is the lead agency?*

Education, through the Division of Special Education/Early Intervention Services. The program was in another department - the Governor's Office for Children, Youth, and Families, but was moved to the Maryland State Department of Education, Division of Special Education, due to the need for monitoring. The program's name is: Maryland Infants and Toddlers Program (MITP). With the MITP moving to the Department, the Division name was changed to the Division of Special Education/Early Intervention Services.

2. *Are there partner agencies involved in providing services? To what extent? In service coordination?*

Yes. Maryland has 24 jurisdictions, which are county level service areas, including Baltimore City, as a jurisdiction in and of itself. Each jurisdiction provides services through collaboration among agencies (Education and Health and Human Services). In Maryland, the local lead agency (LLA) is determined at the local level. Nineteen of 24 jurisdictions have education as the LLA, whereas the other 5 are run through the local Health Department. The hiring of providers is also completed at the local level. In all jurisdictions special instruction is provided by the school system, but health related services and service coordination may be provided by the school system, health department, or other private or contracting agency. In most jurisdictions, service coordinators are also service providers, but some jurisdictions have dedicated service coordinators.

3. *What is the percent delay (or standard deviation) under the eligibility category of developmental delay?*

25% in one or more areas of development and/or atypical development. Maryland uses the categories of developmental delay and established conditions. The 13 Part B categories are used from age 3 to 21. The Part B DD category is also set at 25% but at age three there must be evidence of educational need. This evidence is not required for birth to three.

4. *How are services funded? Is funding attached to amount of service or a formula?*

Funding is based on the number of children served in the previous year and distributed to the jurisdictions. There is a Consolidated Local Implementation Grant (CLIG) application developed by each jurisdiction. They submit the plan, as an annual application, to the State Department of Education, to demonstrate how they will use the funding. Funds are derived from state general education funds designated for birth to 3, the IDEA Part B funds, and the IDEA Part C grant. Funding also supports Family

Support Network Centers. These centers provide information to parents and the public about the early intervention system, how to find services, the process, etc. The centers are staffed by parents. The parents are paid for their services and have received training.

5. *Is there fee for service for any group? Is Medicaid billed?*

Education - No fee for service. No insurance billing. Education services are free to eligible children and their families.

Health Related Services - Medicaid may be billed given parent consent, consistent with the IDEA.

No private insurance or parent fees are charged for any service provided by the Maryland Infants and Toddlers Program.

6. *When Part H (C) came into being, was the (at that time) current cohort of children placed under Part C or did the state expand the eligibility to include a broader population?*

25% delay, atypical, and high probability condition have been the 3 eligibility criteria in Maryland for a very long time. There have been some changes over the years to the category of high probability conditions. (Note: “high probability conditions” would be medical or mental, physical or sensory conditions that are likely to lead to a developmental delay if intervention is not provided.)

7. *Do the services vary for any group under Part C, such as the children who are eligible for Michigan’s special education typically receiving more, and more specialized, service than those identified as “Part C only”?*

No. All eligible children have access to all services based on need and services are individually determined by IFSP.

8. *Is there any variation in service or funding for particular groups, such as Michigan’s differentiation between “Part C only” and Part C/SE eligible?*

There is no differentiation.

9. *When Part H(C) came into being were any of the legal rights of children and families changed?*

Yes, the Part C rights were added. There is one procedural safeguards manual, which includes and differentiates IDEA Part C and Part B.

10. *Are procedural safeguards the same for all eligible children and families, or are there two sets, such as has been traditional in Michigan’s system?*

Part C procedural safeguards are used, and any differences between Part B and Part C are identified in the procedural safeguards manual.

11. *Is an IFSP only used for birth to 3? Which elements of special education are included in the IFSP?*

Yes. All children birth to 3 are served on an IFSP but the IFSP may include components of the Part B system (e.g., educational component or setting)

12. *At what age can just an IEP be used? If a child is going on in special education at age three, is an evaluation for eligibility done? Can a child go to pre-K Part B programs before age three? (How is this documented?)*

An IEP or an Extended IFSP is used at age 3. At transition, an evaluation is done to determine under which Part B category the child is eligible. Part B programs and services are accessed at age 3. Parents of children who are eligible for Part B and receiving services on an IFSP at age 3 may elect to continue to receive services on an Extended IFSP until the beginning of the school year following the child's 4th birthday.

13. *Are any of the state's special education (SE) rules and regulations used or are Part C rules used exclusively? If any SE rules are used, what are they – eligibility categories, program rules, etc.? If SE eligibility categories are used, what is the percent delay of the equivalent to Michigan's ECDD category? Is there separate eligibility for special education, without Part C?*

Part B and Part C are used for birth to 3. There are no program rules. The Part B eligibility categories are not used until age 3. There is no separate eligibility for Part C and special education, "they're all part of the same system, the same law".

14. *Does the state still have birth mandate status? Is there FAPE language for birth to 3 or the underpinnings of FAPE?*

Yes, the state has FAPE language applicable to birth to 3. Services are free, appropriate, educational, and at public expense, based on the IFSP.

15. *What are the most common types of services or providers of service?*

Early Childhood Special Education (ECSE) - Specialized instruction (Special Instruction); Occupational Therapy (OT); Physical Therapy (PT); and Speech and Language Pathology (SLP). Other related services (e.g., Vision, Audiology, Mental Health) are also provided as needed.

16. *What are the qualifications /who provides the following services?*

a. *Special instruction?*

ECSE teachers with a minimum of a Bachelor's degree.

b. *Family training, counseling, and home visits?*

Family training and home visits can be completed by a service coordinator. The minimum requirement for a dedicated service coordinator in Maryland is a high school diploma; however the vast majority of service coordinators have college and post graduate degrees. The family counseling and training often includes developmental monitoring, resource provision, and anticipatory guidance. All service coordinators are supervised. Supervision varies by jurisdiction. Mental health counseling must be completed by psychologists or social workers

17. *Is there a specific early intervention credential?*

Yes. The State requires that any provider that provides EI services greater than 10% of their time must be suitably qualified (which is an additional 120 competency hours distributed through 7 areas).

18. *Are paraprofessionals used?*

Yes. Some programs use assistants (not known by the term paraprofessionals) under the supervision of a credentialed therapist. They must be suitably qualified, i.e. have met the minimum degree requirements for their respective disciplines (Bachelor's). Instructional assistants must meet Maryland's "NCLB Highly Qualified Paraprofessionals" standards, which includes 2 years of study (48 semester hours) at an institution of higher education. (See Maryland's educational requirements for more information.) They must provide support under the direction/supervision of a certified educator. They do not introduce new skills, but provide reinforcement and practice.

19. *What is the most common service delivery system? Is it statewide or a local choice? Does the state follow the Division for Early Childhood's Recommended Practices? Does the state base its service on functional outcomes?*

The service delivery system varies by individual child needs and is decided locally. The state provides technical assistance and training on providing functional outcomes.

20. *What is the typical or average amount of service per child/family? (Individual needs assumed) Are there state requirements for a minimum amount of service?*

There is no "typical amount" as services vary based on need. There is no minimum. The average amount of service children receive statewide is somewhere between 1-2 hours per week.

21. *What are the state's service coordination and evaluation practices? How is service coordination provided - externally or integrated? How does the state meet multi-disciplinary requirements? Who does the evaluations - providers, designated teams, etc.? What instruments are used?*

The direct service providers are often service coordinators and evaluators. They team for the multi-disciplinary requirement. Various evaluation instruments are used. The State has a recommended toolbox of assessment instruments.

III. Minnesota

The answers to the Minnesota survey questions were provided by Kara Hall Tempel, Minnesota IDEA Part C Coordinator and Lisa Backer, Early Learning Supervisor, during a phone conversation in 2013 with the Project Chair. Answers were summarized in a rough draft form and provided to the Minnesota Department of Education to allow the opportunity for correction, verification and addition of information prior to inclusion in this report.

1. *What is the lead agency?*

Education, through the Minnesota Department of Education, Office of Early Learning and Early Childhood Special Education. The program is called Infant Toddler Intervention. The child find and public awareness initiative is called "Help Me Grow."

2. *Are there partners agencies involved in providing services? To what extent? In service coordination?*

No. All services and service coordination are provided through the local school district, or cooperatives (districts combined to provide services) - Early Childhood Special Education (ECSE) Teachers, Occupational Therapists (OTs), Physical Therapists (PTs), Speech and Language Pathologists (SLPs) and other related services as needed. The Department of Health and Human Services does not provide services or service coordination.

3. *What is the percent delay (or standard deviation) under the eligibility category of developmental delay?*

1.5 standard deviations below the mean (SDBM) in one or more areas of development. Minnesota uses the Part C categories of developmental delay and/or established conditions as well as its Part B categories. Deciding which to use depends on how sure the multi-disciplinary team is that a Part B category's criterion can be met. When they're not as certain, or it's more appropriate, the Part C categories are used, thus, developmental delay at 1.5 SDBM and/or established conditions are most often used. If the Part C categories are used, an evaluation will be done at transition to determine which, if any, of the Part B categories a child may be eligible under. If a Part B category is used, and is still appropriate at transition, the category will "carry" the child into Part B programs and services. This determines which Prior Written notice (PWN) requirements need to be met. A difficulty the state is currently working to resolve is that Part C does not require "educational need" in order for a child to be eligible for special education, but Part B does, which poses a problem with concurrent evaluations.

4. *How are services funded? Is funding attached to amount of service or a formula?*

Each eligible child generates state general education revenue equal to a minimum of about \$2000.00 per child enrolled for any level of service up to 231 hours per fiscal year. A prorated amount of additional general education revenue is provided for each additional hour of service. The state also reimburses the serving district for a proportion of certain costs of providing early intervention services. The state reimburses 68% of salaries of essential personnel, a percent of some supplies, home visitor travel costs, and a portion of contracted placements. This reimbursement is capped each year so there is a

statewide proration that amounts to about 90 cents on the dollar of allowable expenditures. The state retains 20% of the Part C grant, another 10% is used for professional development initiatives and another 10% is used for child find activities at the regional level. 60% of the Part C grant goes to the local school districts. Medicaid funds are accessed by the districts as reimbursement for health related services that are provided to Medicaid eligible children. The state is divided into 12 regions, which include all school districts or special education cooperatives. The state funding formula is the same as for general education except that the funding is based on a child count for early intervention.

5. Is there fee for service for any group? Is Medicaid billed?

No fee for service. No insurance billing. Yes, Medicaid is billed (as reimbursement to districts). Services are free to families and their eligible children, due to FAPE.

6. When Part H (C) came into being, was the (at that time) current cohort of children placed under Part C or did the state expand the eligibility to include a broader population?

OSEP indicated that Minnesota needed to expand their developmental delay category to include more children. Thus, they have used the 1.5 SDBM cut-off point, applicable to any developmental domain, since 2006-2007.

7. *Do the services vary for any group under Part C, such as the children who are eligible for Michigan's special education typically receiving more, and more specialized, service than those identified as "Part C only"?*

No. All eligible children have access to all services based on need and services are individually determined by IFSP.

8. *Is there any variation in service or funding for particular groups, such as Michigan's differentiation between "Part C only" and Part C/SE eligible?*

There is no differentiation. State funding is provided through the general education system, with the funding based on head count for the birth to 3 early intervention system.

9. *When Part H(C) came into being were any of the legal rights of children and families changed?*

Yes, Part C rights were added. Minnesota has separate booklets for Part C and Part B procedural safeguards. They are working on combining these into one booklet as OSEP told them this is allowed. The state also added year round services when Part H (C) came into being. Previously the program had run on a school year calendar.

10. Are procedural safeguards the same for all eligible children and families, or are there two sets, such as has been traditional in Michigan's system?

As above, there are currently 2 sets of procedural safeguard manuals that are given to all families. The state is working to combine them.

11. Is an IFSP only, used for birth to 3? Which elements of special education are included in the IFSP?

Yes, but can also use an IEP with the IFSP, but not an IEP without the IFSP. The IEP is optional but most don't use it as everything that is needed is in the IFSP. OSEP had worked with the state to add the necessary Part B elements to the IFSP. All Part C and Part B elements are included. "If a child is Part C eligible he/she is already Part B eligible."

12. At what age can just an IEP be used? If a child is going on in special education at age three, is an evaluation for eligibility done? Can a child go to pre-K Part B programs before age three? (How is this documented?)

An IEP only, can be used at age 2 years, 9 months, if appropriate. If accessing Part B programs and services at age 2 years, 9 months to 3 years, justification must be provided. As mentioned above, an IEP can be used with an IFSP for birth to 3. If not already eligible under one or more of the Part B categories, an evaluation will need to be done at transition. This also applies to a need for change of category of eligibility. The category of developmental delay (which would be the equivalent category to Michigan's category of "Early Childhood Developmental Delay, ECDD) is set at a cut off of 1.5 Standard Deviations Below the Mean (SDBM) in 1 or more areas of development for birth to 3. At age 3, for Part B programs and services, the child must exhibit a delay of 1.5 SDBM in 2 or more areas of development and demonstrate "educational need".

A child can access Part B programs and services at age 2 years, 9 months, but justification must be provided which is documented on the IFSP. For the purposes of transition, then, Part B eligibility determination can begin at age two.

13. Are any of the state's special education (SE) rules and regulations used or are Part C rules used exclusively? If any SE rules are used, what are they – eligibility categories, program rules, etc.? If SE eligibility categories are used, what is the percent delay of the equivalent to Michigan's ECDD category? Is there separate eligibility for special education, without Part C?

The state's special education rules and regulations include Part C and Part B for birth to 3, "it's all part of the special education system". Part C or Part B eligibility rules may be used. There is no separate eligibility for Part C and special education; both are part of the birth to 3 system, with equity. There are no program rules. The developmental delay category applies to both Part C and Part B, but is more restrictive at age three as previously described.

14. Does the state still have birth mandate status? Is there FAPE language for birth to 3 or the underpinnings of FAPE?

Yes, the state has FAPE language applicable to birth to 3. They follow statute and rule for Part C for infants and toddlers. They are working on development of a policy due to the aforementioned issue of concurrent evaluations, when they are using the Part B categories, and the discrepancy of the requirement of demonstration of "need". Part B requires that a child demonstrate an educational need for special education in order to be eligible. Part C does not. (AUTHOR'S NOTE: The charge of Part C is different than

the charge for Part B. Part C recognizes that a child with a disability may not demonstrate the “need” at such a young age. Part C is meant to be preventative and intervention includes the family as an equal participant on the team of interventionists. Thus, the main focus of early intervention is to help the family in learning Intervention methods and strategies that will help their child’s development and learning, to provide necessary information to the family, and to help build the family’s capacity to advocate for and address their child’s needs. This family support may result in children no longer being eligible for Part C or Part B (at age 3), or it may reduce the impact of an innate or organic disability, such as genetic conditions that typically lead to developmental delay.)

15. What are the most common types of services or providers of service?

Minnesota provides the Part C list of services. The most common service providers are ECSE teachers, OTs, PTs and SLPs. Other related services are also provided as needed.

16. What are the qualifications /who provides the following services?

a. Special instruction?

ECSE teachers – required to have credential in a category as well as early childhood.

b. Family training, counseling, and home visits?

Social workers and psychologists.

17. Is there a specific early intervention credential?

No.

18. Are paraprofessionals used?

No. They do not feel this would be appropriate in home visiting. They would be used in Part B classrooms if accessed before age 3.

19. What is the most common service delivery system? Is it statewide or a local choice? Does the state follow the Division for Early Childhood’s Recommended Practices? Does the state base its service on functional outcomes?

The service delivery system varies by service area and is decided locally. There is an ongoing statewide training initiative on the Primary Service Provider (PSP) model, with Julianne Wood through Face to Face meetings, and some districts have begun to implement. The model is not yet formalized and is currently voluntary. The state is working on implementation of DEC’s recommended practices for the Primary Service Provider model through a higher education consortium which includes universities and the Minnesota Department of Education. This process would include work on improvement of the development of functional outcomes.

20. What is the typical or average amount of service per child/family? (Individual needs assumed) Are there state requirements for a minimum amount of service?

Best practice is used with monitoring to ensure that service levels are adequate. The state is working on development of a Primary Service Provider model that should better ensure adequate levels of service. Services are typically provided 1 hour per week, sometimes more, sometimes less if only developmental monitoring is needed for a child who is typically developing (with an Established Condition).

21. What are the state's service coordination and evaluation practices? How is service coordination provided – externally or integrated? How does the state meet multi-disciplinary requirements? Who does the evaluations – providers, designated teams, etc.? What instruments are used?

Minnesota has had external and integrated service coordination practices. Most service areas now use service providers for multi-disciplinary evaluations and as service coordinators. The ECSE teachers and therapists do the evaluations. If using the PSP model, the PSP will be the service coordinator. Multi-disciplinary teams consist of ECSE teachers and a therapist or 2 teachers with different certifications. The doctor's report will be added if needed for evidence of an established condition. The instruments used vary across the state. The Bayley is often used, as well as others. An instrument that can provide a standard score is required due to the developmental delay category being demonstrated through standard deviations below the mean (1.5).

IV. Nebraska

The answers to the Nebraska survey questions were provided by Joan Luebbers and Amy Bunnell, Nebraska's IDEA Part C Coordinators, during a phone conversation in 2013 with the Project Chair. Answers were summarized in a rough draft form and provided to the Nebraska Department of Education and the Nebraska Department of Health and Human Services to allow the opportunity for correction, verification and addition of information prior to inclusion in this report.

1. *What is the lead agency?*

Education (special education) and Health and Human Services (co-lead). The name of the program is: Early Development Network (Babies Can't Wait)

2. *Are there partner agencies involved in providing services? To what extent? In service coordination?*

Yes. Service coordination is provided free through Health and Human Services (HHS). All direct intervention services are provided free through special education - Early Childhood Special Education (ECSE) teachers and related services such as Occupational Therapy (OT), Physical Therapy (PT), Speech and Language Pathology (SLP) and others. Service providers work at the district level and teams often provide services for the full early childhood age range - birth to 8. Services are provided year round. There are 29 Planning Region Teams. These teams act as Local Interagency Coordinating Councils for their area. There is a state statute regarding collaboration between the agencies rather than a Memorandum of Understanding. The statute is stronger. When the statute was originally written there were more agencies involved. Since then, Health and Human Services merged. There are certain divisions within HHS that must collaborate – the Developmental Disabilities division, Public Health, and insurance. Some entities are at the table with regard to the state plan but do not fund the system. Education funds all services except service coordination. Service coordination is funded as targeted case management under HHS, funded through Medicaid and parents' insurances.

3. *What is the percent delay (or standard deviation) under the eligibility category of developmental delay (DD)?*

2.0 standard deviations below the mean (SDBM) in one developmental area or 1.3 SDBM in more than one area are the recommended cut off points. Informed Clinical Opinion (ICO) is also used. Nebraska uses only its 13 Part B categories, having added Developmental Delay in 2000 upon Office of Special Education Programs (OSEP) requirement. All "established conditions" are eligible under Otherwise Health Impaired or other category (these categories include a "high probability of delay" factor). The Developmental Delay category is the most commonly used, next is Otherwise Health Impaired (OHI), then Speech and Language Impaired (SLI). All districts must consider eligibility under Developmental Delay (DD).

4. *How are services funded? Is funding attached to amount of service or a formula?*

Part C funds are not used for services! The state funds services @ 90 – 100% reimbursement (FAPE funds) to local school districts. IDEA Part B funds are used for all services except service coordination. HHS uses Medicaid or parents' insurance for

service coordination. Education bills Medicaid for services but not insurances. The state legislature allocates funds which flow through based on 2002 child counts for service areas. Some service areas have received more, some less, depending on how their current population compares to 2002. Funding is based on a combination of federal, state, local, and some private agency funding. It is not attached to amount of service.

5. *Is there fee for service (such as insurances) for any group? Is Medicaid billed?*

No fee for service. No insurance billing through education, but yes, through HHS for service coordination. Yes, Medicaid is billed. Services are free to families and their eligible children due to FAPE.

6. *When Part H (C) came into being, was the (at that time) current cohort of children placed under Part C or did the state expand the eligibility to include a broader population?*

Nebraska continued to use its 12 special education eligibility categories. Nebraska provides special education from birth to 21. OSEP indicated they needed to add a developmental delay (DD) category (so there are now 13 categories). It was added in 2000 and is now the most utilized category (2.0 SDBM in one developmental domain or 1.3 SDBM in more than one developmental domain).

7. *Do the services vary for any group under Part C, such as the children who are eligible for Michigan's special education typically receiving more, and more specialized, service than those identified as "Part C only"?*

No. All eligible children have access to all services based on need and services are individually determined by IFSP.

8. *Is there any variation in service or funding for particular groups, such as Michigan's differentiation between "Part C only" and Part C/SE eligible?*

There is no differentiation. Medically fragile children get nursing care through Medicaid. Feeding issues are addressed through early intervention services including OT and Nutrition services. Medicaid will pay for these services. If a swallow study is needed for a child with cleft palate and the child is not Medicaid eligible, the schools will pay for the evaluation for diagnostic purposes.

9. *When Part H(C) came into being were any of the legal rights of children and families changed?*

Yes, the state added the rights under Part C. Nebraska implements both Part B and Part C for birth to 3.

10. *Are procedural safeguards the same for all eligible children and families, or are there two sets, such as has been traditional in Michigan's system?*

Procedural safeguards are unified, including elements of Part C and Part B.

11. *Is an IFSP only used for birth to 3? Which elements of special education are included in the IFSP?*

Yes. All Part C and necessary Part B elements.

- 12. At what age can just an IEP be used? If a child is going on in special education at age three, is an evaluation for eligibility done? Can a child go to pre-K Part B programs before age three? (How is this documented?)**

An IEP is used at age 3. The eligibility category is already established as the categories are what is used for eligibility at birth to 3. They will re-evaluate if needed to change category or determine continuing eligibility for SE. Access to Part B programs and services is at age 3.

- 13. Are any of the state's special education (SE) rules and regulations used or are Part C rules used exclusively? If any SE rules are used, what are they - eligibility categories, program rules, etc.? If SE eligibility categories are used, what is the percent delay of the equivalent to Michigan's ECDD category? Is there separate eligibility for special education, without Part C?**

The state's special education rules incorporate both Part C and Part B for birth to 3. Special education eligibility rules are used for birth to 3. There are no program rules.

- 14. Does the state still have birth mandate status? Is there FAPE language for birth to 3 or the underpinnings of FAPE?**

Yes, the state has FAPE language applicable to birth to 3.

- 15. What are the most common types of services or providers of service?**

Early Childhood Special Education (ECSE) teachers, Occupational Therapists (OTs), Physical Therapists (PTs) and Speech and Language Pathologists (SLPs). Other related services are also provided as needed.

- 16. What are the qualifications of/who provides the following services?**

- a. Special instruction?**

ECSE teachers

- b. Family training, counseling, and home visits?**

Any qualified service provider.

- 17. Is there a specific early intervention credential?**

No.

- 18. Are paraprofessionals used?**

No.

- 19. What is the most common service delivery system? Is it statewide or a local choice? Does the state follow the Division for Early Childhood's Recommended Practices? Does the state base its service on functional outcomes?**

The service delivery system varies by service area and is decided locally. There is an ongoing statewide training initiative with Robin McWilliam to improve in writing and implementation of functional outcomes, use of a Primary Service Provider (PSP) and routines based intervention.

20. *What is the typical or average amount of service per child/family? (Individual needs assumed) Are there state requirements for a minimum amount of service?*

1 hour every other week is typical due to funding having been frozen at 2002 levels. The state is working with Robin McWilliam to develop a Primary Service Provider model to help address the overall reduction in service, using a more efficient delivery system.

21. *What are the state's service coordination and evaluation practices? How is service coordination provided – externally or integrated? How does the state meet multi-disciplinary requirements? Who does the evaluations – providers, designated teams, etc.? What instruments are used?*

Service Coordination is provided by Health and Human Services. Multi-disciplinary evaluations and services are provided by special education staff. The evaluation instruments used vary across the state. The Bayley and others are used. The Ages and Stages Questionnaire is used for screening.

V. Michigan

The answers to the Michigan survey questions were provided by the Project Chair, based on information shared by providers, stakeholders and administrators at the local, state and federal level, and the author's experience and information gleaned from more than twenty years of experience with the Michigan early intervention system. Feedback was provided by the CECS project study group. Information regarding levels and types of service is based on a survey of *Early On*[®] Coordinators and administrators from all of the service areas in the state. Pure data is not available because it is not collected by the state. The questions used are the same as the questions asked of the other states, even when asked for comparisons to Michigan, for ease in comparing answers to specific questions.

1. *What is the lead agency?*

Education, Office of Great Start. The program was moved a few years ago from the Office of Special Education and Early Intervention Services to the Office of Great Start, after being housed in the Office of Early Childhood in previous years. The name of the program is *Early On*[®].

2. *Are there partner agencies involved in providing services? To what extent? In service coordination?*

Partner agencies include the Department of Community Health and the Department of Human Services. Agency partnerships for provision of service vary widely across the state and include agencies other than those mentioned above. The practice of services being provided by agencies other than education partners has decreased as a whole. Some service areas have agencies other than education engaged in provision of services as a parallel, partner system, but they may serve "Part C only". This model does not appear to be common across the state and the number of districts with this model has decreased due to partner agencies no longer being able to participate due to funding cuts. Some large service areas have agencies providing all of the "Part C only" services, while Michigan Mandatory Special Education (MMSE) is provided by local school districts. Funding of the agency relationships also varies across the state, but is often paid for primarily through the *Early On*[®] (Part C) federal grant allocation provided to that service area. Recently, there has been insurance coverage for Community Mental Health (CMH) services for children with autism. See also, question 7.

3. *What is the percent delay (or standard deviation) under the eligibility category of developmental delay?*

Michigan has two sets of eligibility due to its two-tiered system. Part C eligibility is set at a 20% delay in one or more areas for children older than 2 months, and any degree of delay for 2 months or less. MMSE eligibility is based on 13 categories defined in the Michigan Administrative Rules for Special Education (MARSE). The developmental delay category (ECDD) is set at half the child's expected development for chronological age, commonly referred to as a 50% delay. Children eligible for MMSE are automatically eligible for Part C.

4. *How are services funded? Is funding attached to amount of service or a formula?*

State and local funds are used for MMSE services. State funds are based on 28% reimbursement of excess costs for SE and foundation funding based on 2 pupil count dates. Foundation and reimbursement are not added together, however, but rather whichever amount is greater will be received. Thus, most funding for MMSE birth to 3 is local. Part C services funding varies widely across the state. Some service areas use federal Part C grant funds and local funds for services. Other service areas use only Part C grant funds. Some use a variety of sources knitted together to fund services but this appears to be rare. There is no state funding for “Part C only”, which includes about two thirds of the infants and toddlers who are eligible for early intervention services. Thus the level of service varies widely across the state. The range appears to be about 1 hour per month to 2 contacts per year. A few service areas report that they are able to provide weekly or bi-weekly home visits for some families, but this also appears to be rare. The early intervention literature typically refers to a weekly home visit (as a norm) for infants and toddlers with delays and disabilities and their families. The 2013 Infants and Toddlers Coordinators Association (ITCA) Tipping Points Survey report indicates that the median amount of delivered direct service (excluding service coordination, evaluation and assessment activities) across the nation is four hours per month with a median of five hours planned. (2013 ITCA Tipping Points Survey - Part C Implementation: State Challenges and Responses).

5. *Is there fee for service for any group? Is Medicaid billed?*

No fee for service. No insurance billing through education. Agencies can bill insurances as per their fiscal model, such as CMH for services for children with autism. Medicaid is billed for eligible services providing the service provider is not paid through federal funds.

6. *When Part H (C) came into being, was the (at that time) current cohort of children placed under Part C or did the state expand the eligibility to include a broader population?*

The state established a separate tier of eligibility under Part C. The MMSE eligibility and services were already there. The children who were eligible under Part C but not found eligible or not referred to MMSE are the children referred to as “Part C only” in this report. Approximately two thirds of the children eligible for early intervention are eligible for “Part C only”. Children eligible under the MMSE categories are automatically eligible for *Early On*[®].

7. *Do the services vary for any group under Part C, such as the children who are eligible for Michigan’s special education typically receiving more, and often more specialized, services than those identified as “Part C only”?*

Yes. Services vary significantly for “Part C only” across the state. Some areas offer all listed Part C services to “Part C only” and MMSE eligible, but access is not usually equitable in terms of the available frequency of service, regardless of need, with children eligible for MMSE receiving significantly more service than those eligible for “Part C only”. Some service areas provide only (other than education) agency based services to “Part C only” eligible children. ECSE teachers, therapies and other related services are

only accessed through MMSE. In some service areas, ISDs provide the “Part C only” services, while local districts provide the MMSE services. The types of services available may or may not be the same and all services may not be available for the “Part C only” children and families. Some service areas provide only service coordination to “Part C only” eligible children and families. Some service areas provide, to “Part C only” eligible, only “parent education” or topic based information, such as is found in program models/curricula which are designed for use with families whose children are typically developing and not designed to meet the specific individual needs of children with disabilities and their families. Many areas have no agency (other than education) involvement in provision of services.

8. *Is there any variation in service or funding for particular groups, such as Michigan’s differentiation between “Part C only” and Part C/MMSE eligible?*

Yes. There is state funding for MMSE eligible children. ISDs and local districts provide funding as well. There is no state funding for any service area for “Part C only”, and some service areas provide no local funding for “Part C only”, relying exclusively on the federal grant to fund services. (The federal grant is intended to support the Part C system, and help with the extra cost of the required service coordination. It is allowable for services as a payer of last resort, but it was not intended to be the funding source for services. States are to set up systems for funding the services including use of funding sources already in place.)

9. *When Part H(C) came into being were any of the legal rights of children and families changed?*

Yes, the state added the Part C components. There were separate booklets and procedures. Subsequent to the introduction of MARSE Part 10 (a section in the MARSE developed specifically for infants and toddlers), work is being done to combine and to streamline the system of dual requirements. The state established, at the beginning, a separate tier of eligibility for Part C in MI. Approximately two thirds of the children eligible for early intervention are eligible under “Part C only”. Children eligible under the MMSE categories are automatically eligible for *Early On*[®].

10. *Are procedural safeguards the same for all eligible children and families, or are there two sets, such as has been traditional in Michigan’s system?*

The Office of Special Education guidance now is that Part C Procedural Safeguards only are used for all birth to 3, including MMSE. Previously, two sets of procedural safeguards were used.

11. *Is an IFSP only used for birth to 3? Which elements of special education are included in the IFSP?*

Yes. The state recently moved to use of an IFSP only. All Part C and required MARSE elements should be included in the IFSP. A state approved document has been newly developed to include all elements of Part C and MARSE. Previously both an IFSP and an IEP or a combined IFSP/IEP were used.

12. *At what age can just an IEP be used? If a child is going on in special education at age three, is an evaluation for eligibility done? Can a child go to pre-K Part B programs before age three? (How is this documented?)*

An IEP only can be used at age 2yrs. 6 mos. if accessing a Part B program. An IEP only can be used for children who are referred to Part C too late to complete the Part C evaluation and IFSP (45 days before the third birthday). The referral would be considered a referral to MMSE with a subsequent evaluation and IEP.

13. *Are any of the state's special education (SE) rules and regulations used or are Part C rules used exclusively? If any SE rules are used, what are they – eligibility categories, program rules, etc.? If SE eligibility categories are used, what is the percent delay of the equivalent to Michigan's ECDD category? Is there separate eligibility for special education, without Part C?*

The state's special education rules are used for MMSE eligible children. Part C rules are used for all. Eligibility categories, program and services rules, etc. apply for MMSE. Part C and SE function as separate systems at the state level and are administered through two separate offices. Some service areas integrate these to some extent as in the same staff providing both Part C and MMSE services while other service areas have very distinct and separate systems within the educational entity or even as separated as education providing MMSE while other agencies provide "Part C only".

14. *Does the state still have birth mandate status? Is there Free Appropriate Public Education (FAPE) language for birth to 3 or the underpinnings of FAPE?*

Yes, has birth mandate status. There is disagreement between OSE and MAASE and others as the applicability of FAPE to birth to three. Michigan law predates federal law which uses the term FAPE. MMSE includes free public education for infants and toddlers which, hopefully, is appropriate! The MARSE have moved closer to alignment with Part B language over the years. Note: The other four states do apply FAPE to birth to three as it is integral to their special education systems of which birth to three is a part.

15. *What are the most common types of services/providers?*

For MMSE eligible children, the most common service providers are: Early Childhood Special Education (ECSE) teachers, Occupational Therapists (OTs), Physical Therapists (PTs) and Speech and Language Pathologists (SLPs). Other related services are provided as needed. "Part C only" services/providers vary across the state. Some areas include the same providers as for MMSE and possibly services from other agencies; however, the amount of service is typically less than that for children eligible for MMSE. Other service areas provide services only through agencies other than education and access to the types of services provided through MMSE such as therapists and ECSE teachers are not available to children eligible under "Part C only". Still other areas provide services to "Part C only" through non-certified and non-licensed staff. These services are often limited to general parent education rather than individualized early intervention services. (See also "Audit Report - Performance Audit of *Early On*[®]", November 2013, from the Michigan Office of the Auditor General for more information on types of Part C services and service providers in Michigan.)

16. What are the qualifications /who provides the following services?

a. *Special instruction?*

The state has historically used this category of service generically, including teachers, nurses, those without degrees, etc. The state has moved toward recognition of special instruction as falling within the domain of educators. It is currently being viewed broadly within the arena of certified teachers, including those with only elementary certification, etc. ECSE teachers are included, but the special education certifications and/or approvals are not being required for “Part C only”. (NOTE: special instruction is a type of Part C service. MMSE requires teachers to have the ECSE or ZS credential.)

b. *Family training, counseling, and home visits?*

This category of Part C service has gone through a few iterations. It was once used generically - anyone providing home visits in *Early On*[®]. Then, it changed to a service provided by social workers, psychologists or counselors. It has now moved back to being generic and may be provided by individuals with a GED or degrees in non-related fields and include the use of only a general parent education curricula such as Parents as Teachers.

17. Is there a specific early intervention credential?

No. There is a sub-group of the *Early On*[®] Center for Higher Education that is working on one. This would be a credential that an individual could receive above and beyond their discipline specific credentials.

18. Are paraprofessionals used?

Paraprofessionals are used in Part B classroom programs if accessed before age 3. MI uses, in many areas of the state, individuals who could be categorized as paraprofessionals for “Part C only”. Training of these individuals is often in service coordination.

19. What is the most common service delivery system? Is it statewide or a local choice? Does the state follow the Division for Early Childhood’s Recommended Practices? Does the state base its service on functional outcomes?

The service delivery system varies by service area and is decided locally. There have been training sessions on various models. Some areas have begun to use the Primary Service Provider model, which is a current trend across the nation, and others are working toward implementation of the model. Additionally, there are ongoing professional development opportunities on the development and use of functional outcomes as a basis for service delivery, which is also a national trend and integral to the effective provision of early intervention.

20. What is the typical or average amount of service per child/family? (Individual needs assumed) Are there state requirements for a minimum amount of service?

For MMSE eligible children the bona fide program under rule 340.1862 (previously 340.1755) is set at a minimum of 72 clock hours over one year. Thus, in the bona fide program, services are delivered 1 to 2 hours per week. Some children receive more than

the minimum required or the bona fide program, thus generating a greater amount of FTEs. Some children do not receive the level of service determined as a bona fide program, thus the district would not be eligible to receive foundation funding for that child (student). “Part C only” levels of service vary widely across the state. Some service areas typically provide 1 hour per month. Many service areas are able to provide much less service. Services may be one hour every 3 months, 3 hours per year, service coordination only, playgroups only, having families attend Great Parents Great Start playgroups (general parenting education), a phone call now and then, and anything in between. Some service areas may be able to provide weekly or bi-weekly services for some families but this does not appear to be widespread nor is it the norm. As mentioned previously, the norm in the early intervention literature is typically one hour per week with variations based on need. Several service areas are attempting to implement a Primary Service Provider model to help with their inability to provide an adequate amount of service, but this is being done primarily within MMSE programming thus far. It should be noted that there is no state funding for services for the approximately two thirds of children eligible “only” under Part C. Thus, levels and types of service are dependent on the amount of funding provided by school districts, and on the amount of the federal Part C grant. The grant is meant as a supplement only, and primarily to offset the extra cost of providing service coordination. The intent of the federal grant, which is quite small, is not to be the primary funding source for services. States are responsible for developing systems of funding for services.

21. *What are the state’s service coordination and evaluation practices? How is service coordination provided – externally or integrated? How does the state meet multi-disciplinary requirements? Who does the evaluations – providers, designated teams, etc.? What instruments are used?*

Service coordination (SC) and evaluation practices vary across the state. Some service areas have designated SCs; others use service providers as SCs. Multi-disciplinary practices for Part C may include more than one provider discipline (plus medical if needed, as for diagnosis of an established condition) in some service areas, while in others one evaluator plus a physician statement is used. It is allowed under Part C to use one individual for evaluation if that individual has qualifications in more than one discipline. MMSE eligibility is determined based on the MARSE. Various instruments are used for determining eligibility for Part C and for MMSE. The Infant Toddler Developmental Assessment is common for Part C. The Battelle Developmental Inventory, Preschool Language Scale, Rossetti, Peabody Motor Scale, and Bayley, are some of the instruments commonly used in MMSE.

Appendix B:
**Preliminary Considerations for Transitioning to a
New Model for Part C in Michigan**

The following concepts are presented as preliminary considerations for transitioning to a new model for Part C service delivery in Michigan. If some/all of the suggestions contained in the body of the CECS report are adopted by the state, these concepts might be considered as part of the transition plan from the old Part C model to a new model.

1. Part C referrals come in on an ongoing basis, and children and families must continue to receive uninterrupted services as changes are being implemented. Many of the current service providers meet state requirements for special education personnel. These individuals, such as ECSE (or ZS) teachers, OTs, PTs and SLPs, could continue to provide educational services and could be available to all eligible children and families. Other qualified special education personnel could also continue to provide services.
2. Other agencies, if providing services as defined in Part C, could continue to provide services and would be able to team with providers from multiple agencies if they are not already doing so. They would be able to bring their specific areas of expertise, such as nursing, nutrition or social work, to a team of providers. This could be a more efficient and appropriate use of their expertise than is currently in place in some areas. A social worker or nurse, for example, might not be expected to be the sole type of provider available to children and families, attempting to meet all needs. Professionals across agencies could benefit from working in teams with other early intervention providers, and those teams could be strengthened by the shared expertise.
3. Individuals with general early childhood degrees or general early childhood teaching certificates could continue to provide service with the proviso that they would attain the ZS credential within a specified period of time. It would be essential that all early intervention educators have knowledge of disabilities and intervention methodologies if they are to help families and children, because the ECSE or ZS teacher, while having knowledge and skill in all developmental domains, is often the team member called upon to address cognitive and social-emotional delays as well as global developmental delays. The ZS credential should contain sufficient coursework in typical and atypical infant/toddler development, types and impact of disabilities and delays, individualization of instruction, and the methodologies of intervention. Additionally the credential should include coursework in appropriate evaluation methods and interpretations, family centered practice, teaming, coaching, adult learning, etc. An upcoming position paper from the Council for Exceptional Children's Division of Early Childhood is anticipated to provide more details regarding the appropriate delivery of Special Instruction under Part C.
4. Individuals currently providing Part C service who do not meet requirements under more stringent standards for direct service providers, such as those with high school diplomas or degrees that do not qualify them as providers of early intervention services, might meet standards as designated service coordinators if districts choose to use them in this way, assuming they have had or receive training in service coordination. They could be retained as service providers while districts hire more qualified personnel within a specified transitional period. These individuals could

choose to pursue upgraded credentials. MDE currently includes paraprofessionals as allowable service providers. A rigorous credentialing system, such as Maryland's could be pursued to ensure adequate training of such personnel. Additionally, the role of the paraprofessional might be specifically defined as assisting a supervising professional and working on practicing of skills versus introduction of new skills, as Maryland has done. This may be useful in parent-child playgroups as opposed to home visits in which new skills are often emerging. Individuals who choose not to pursue upgraded credentials might be shifted to other home visiting programs. This could help those programs to serve children and families needing some types of services who might not meet revised eligibility criteria for early intervention (assuming criteria are made consistent for all children under Part C.) Grandfathering for children and families already receiving early intervention services, but who do not meet the new eligibility standard, could be considered until the child ages out if the family so desires.

5. Service areas will need sufficient time to change their structure, particularly those in which different groups of providers or different agencies provide services under "Part C only" and MMSE. A transitional period, such as three years, might be established during which districts could gear up to full implementation of a new model.