



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Preliminary Analysis 2007 IDEA Proposed Rules on Part C

EXECUTIVE SUMMARY

Personnel Qualifications: The proposed rules reflect many of the changes made to the Individuals with Disabilities Education Act (IDEA) statute in 2004, including no longer requiring: (1) state education personnel to meet the highest state requirement for the profession or discipline or (2) the most qualified individuals available who are making satisfactory progress toward completing applicable coursework necessary to meet the state's personnel standards in three years. The proposed regulations do require each statewide system to establish qualification standards to ensure that personnel are appropriately and adequately prepared and trained. ASHA is concerned that the proposed rules do not provide enough guidance to ensure that personnel will be appropriately qualified.

Early Intervention Services: The proposed rules add to the definition of speech-language pathology services sign language and cued language services as well as interpreting and transliteration services for infants or toddlers who are hearing impaired. ASHA is concerned that listing these services – which are often not performed by a speech-language pathologist – under “speech-language pathology” may cause confusion.

Multidisciplinary Teams: The proposed rules provide for “multidisciplinary” teams in the individualized family service plan (IFSP) process. The term “multidisciplinary teams” typically allow a number of professionals to provide assessments, recommendations, and treatment separately from one another and a coordinator integrates everyone’s findings. ASHA is concerned that the use of this term may prohibit the use of other team models, such as interdisciplinary and transdisciplinary teams, that may be better suited to the task. Interdisciplinary teams characteristically work together, communicating on a regular basis with one another, the child, and the family. Transdisciplinary teams, which are based on a primary service provider model, work together on the assessment and recommendations while treatment is often carried out by one team member.

State Option To Make Part C Services Available To Children Over 3 Years Old: The proposed rules implement the change adopted in IDEA 2004 under which states can opt to provide early intervention services to children beginning at three years old until the children enter, or are eligible to enter, kindergarten or elementary school. Under the proposed rules, states may opt to serve a subset of children in this age group, but cannot limit the subset to a certain disability group. A state’s policy for offering Part C services to children over 3 cannot affect the right of any child to receive FAPE under IDEA, Part B instead of early intervention services under Part C. Nevertheless, a state is not required to provide the child FAPE under Part B for the period of time the child is receiving Part C early intervention services. ASHA is concerned that the proposed rules do not do enough to ensure that a parent is fully aware of the consequences – especially the impact on the child’s right to FAPE – when they consent to early intervention services for their child over three years old.

Assistive Technology and Assistive Technology Service: The proposed rules, consistent with IDEA 2004, provide that an “assistive technology device...does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping) or the maintenance or replacement of that device” under Part C. It includes any service that “directly assists with the selection, acquisition or use of an assistive technology device.” ASHA believes that optimization and maintenance of cochlear implants should be included as a covered service under Part C. Procedures for setting and evaluating the effectiveness of a cochlear implant meet the same goal of setting a listening device, a covered service, so that infant or toddler has access to auditory information.

Evaluation and Assessment Timelines: Under both current and proposed rules, a child’s evaluation, assessment, and initial IFSP meeting must occur within 45 days. However, under current rules, the clock starts ticking when the referral is received. Under the proposed rules, the clock doesn’t start ticking until parental consent is received. ASHA is concerned that this change could cause undue delays in providing services that could be harmful to the child.

Preliminary Analysis 2007 IDEA Proposed Rules on Part C

The American Speech-Language-Hearing Association (ASHA) has identified the following issues in the 2007 IDEA Notice of Proposed Rulemaking (NPRM) on Part C, as released by the U.S. Department of Education (ED), as areas of interest or concern for speech-language pathologists and audiologists. Published in the *Federal Register*, on May 9, 2007 and on ED's Web site at <http://www.ed.gov/policy/speced/guid/idea/part-c/nprm/index.html>, these proposed regulations are intended to implement the recently enacted changes made to the Individuals with Disabilities Education Act of 1997 (IDEA) by the Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446, or commonly known as IDEA 2004).

ED also announced a series of regional meetings to be held in June 2007 to solicit comments on the IDEA Part C proposed regulations. All comments on the proposed regulations are due on or before July 23, 2007, reflecting a 75-day comment period, as required by the law.

The issues below have been identified as critically important to the professions of speech-language pathology and audiology. Additional issues are being identified by an IDEA Member Advisory Group (MAG) and a National Office staff team. Please continue to check ASHA's [IDEA Information Center](#) for further updates.

Highlights of Critical Issues

- Personnel standards
- Early intervention services (speech-language pathology services)
- Team models
- State option of Part C services to children ages 3 and older
- Assistive technology
- Evaluation and assessment of the child and family and assessment of service needs-timelines

PERSONNEL STANDARDS (§303.119)

Major Changes:

The proposed rules remove the provision that requires state education personnel standards to meet the highest requirement for a profession or discipline in that state in which a person is providing early intervention services. Such removal was necessary to reflect a change in the law dictated by IDEA 2004. However, the proposed rules Sec. 303.119(a) state that each statewide system must include policies and procedures relating to the establishment and maintenance of qualification standards to ensure that personnel are appropriately and adequately prepared and trained.

Consistent with Sec. 635(a) of the statute and current Sec. 303.361(b)(2), proposed Sec. 303.119(b) would require the establishment and maintenance of qualification standards, to be consistent with any state-approved or state-recognized certification, licensing, registration, or other comparable requirements, and to apply to the profession, discipline, or area in which personnel are providing early intervention services.

Proposed Sec. 303.119(c), allows the use of appropriately trained and supervised paraprofessionals and assistants to assist in the provision of early intervention services and would replace and substantively be the same as current Sec. 303.361(f).

While it retains the provision that allows a state to adopt a policy to hire the most qualified individuals available who are making satisfactory progress toward completing applicable coursework necessary to meet the state's personnel standards in proposed Sec. 303.119(d), the requirement that those persons work to complete the necessary coursework in three years would be removed because of the removal of this three-year requirement from Sec. 635(a)(9) of the Act.

The note following current Sec. 303.361 would be removed because the first paragraph in the note addresses the requirement that personnel standards be based on the state's highest standard, which was removed from the Act.

ASHA's Position:

ASHA continues to be concerned about the potential changes in personnel qualification standards and hiring practices that may result from changes in IDEA 2004 and implementing proposed regulations for Part C as it does for the Part B final regulations. Qualifications that are needed to provide the appropriate quality and quantity of services to students with disabilities have been well established by professional organizations as well as state agencies, such as licensure boards. Such information would be critical to Part C decision makers as they consider appropriate qualifications for related service providers.

In addition, consistency within a state among certifications or licenses for practice in various settings is essential to guard against the creation of a two-tiered system where infants and toddlers with disabilities receive services provided by personnel less qualified compared to the pediatric services provided in other settings, such as hospitals and private clinics.

Availability of qualified personnel is essential to providing services to children with disabilities, especially infants and toddlers with disabilities who benefit immensely from early intervention. ASHA believes that more guidance from ED is needed to ensure that Part C decision makers implement proven strategies of recruitment and retention of qualified personnel to provide services to infants and toddlers with disabilities. The 2006 *Wave 1 Overview Report from the Pre-Elementary Education Longitudinal Study (PEELS)* states that many children with disabilities ages 3–5 did not begin receiving early intervention or special education services until they were nearly 3. The children who began receiving services later were most likely to be those identified as having a speech or language impairment and least likely to be those identified as having an orthopedic impairment, mental retardation, or an other health impairment. Speech or language therapy was by far the most common service, with 93 percent of children with disabilities ages 3–5 receiving such services.

ASHA strongly believes that parameters need to be identified that specify how paraprofessionals and assistants should be trained, used, and supervised. It is critical that ED provide the guidance necessary to ensure that, as federal funds are used to implement the provision for use of paraprofessionals and assistants, there is at least a minimum framework for states to follow in developing policies related to such personnel.

EARLY INTERVENTION SERVICES (§303.13)

Major Changes:

The proposed rules add to the definition of speech-language pathology services sign language and cued language services as well as interpreting and transliteration services for infants or toddlers who are hearing impaired. ED lists the following as one part of speech-language pathology services:

(b)(12)(iv) “Provision of sign language, cued language, and auditory/oral language services, which, as used with respect to infants and toddlers with disabilities who are hearing impaired, includes services to the infant or toddler with a disability and the family to teach sign language, cued language, and auditory/oral language as well as to provide oral transliteration services, sign language, and cued language interpreting services.”

ASHA’s Position:

ASHA commends ED for specifically addressing sign language and cued language services and interpreting/transliteration services. However, ASHA believes that teaching sign language and cued language should not be listed as a speech-language pathology service under Sec. 303.13 (12) (iv). Furthermore, ASHA believes that interpreting/transliteration services should not be listed as a speech-language pathology service under Sec. 303.13 (12) (iv). ASHA recommends that these services be listed under two separate Sec.s: 1) Services for infants and toddlers who are deaf or hard of hearing and 2) Interpreting and transliteration services.

Provision of sign language, cued language, and auditory/oral services is the purview of multiple professionals, including audiologists, speech-language pathologists, and teachers of students who are deaf or hard of hearing. Therefore, it is recommended that these services be listed in a separate section rather than being included as part of speech-language pathology services.

Not all audiologists or speech-language pathologists are trained to provide oral transliteration services, sign language, or cued language interpreting. Therefore, ASHA believes that these services should be removed from the speech-language pathology services section and moved to a separate section.

Provision of sign language, cued language, and auditory/oral services should not be in the same section with interpreting/transliteration services. Services provided to infants and toddlers who are deaf or hard of hearing need to be separated and differentiated from interpreting/transliteration services. These are different types of services and typically are provided by different professionals.

ASHA also suggests that a definition for interpreting and transliteration services be included in the regulations to clarify the differences between the two types of services and demonstrate when each type of service would be needed for infants and toddlers who are deaf or hard of hearing.

MULTIDISCIPLINARY (§303.24)

Major Changes:

The term “multidisciplinary” continues to be used in IDEA 2004 to convey the need for multiple disciplines to be included on a team and to be involved in the individualized family service plan (IFSP) process. However, other team models, that also include multiple disciplines, may be more appropriate than “multidisciplinary teams.” Service providers should be given options and guidance to help them select the most appropriate team model for a particular infant or toddler and the family.

ASHA’s Position:

ASHA believes that guidance is needed on the type of teams that are options in early intervention. The particular type of team model should be selected based on the needs of the infant or toddler and family. Providing a definition of the three major types of team models (i.e., multidisciplinary, interdisciplinary, transdisciplinary) would give service providers the flexibility and responsibility for selecting the most appropriate model for each infant, toddler, and the family. All three models include multiple disciplines. They differ in the nature of the communication, contribution, and collaboration involved in the interaction among team members. A multidisciplinary team implies separateness and a lack of coordination. The use of interdisciplinary and transdisciplinary team models means involvement as well as coordination of two or more disciplines in the provision of integrated early intervention services. ASHA recommends that the terms “multidisciplinary,” “interdisciplinary”, and “transdisciplinary” be defined and incorporated into the regulations. Suggested wording is provided in italics below.

Common team models that are used in early intervention include: multidisciplinary, interdisciplinary, and transdisciplinary.

***Multidisciplinary teams** typically make use of a process whereby infants and toddlers are seen by professionals from different disciplines who each separately complete an evaluation and/or assessment, make recommendations, and deliver their services independently. In these instances, integration of findings and recommendations typically is left to the family or service coordinator. This model may diminish the cohesiveness of services and the number of opportunities for professionals to interact with one another and the family.*

***Interdisciplinary teams** characteristically work together, communicate consistently, coordinate information and resources, and collaborate with the families and each other to achieve priority outcomes. Effective interdisciplinary teams share responsibility for providing services based on identified child and family priorities. Although individual professionals may assess the infant or toddler separately or in small groups, there is some attempt to communicate findings and recommendations to each other.*

In addition, some teams use an arena method whereby all or designated team members are present during the evaluation and/or assessment and professionals interact individually, collaboratively, or through observation of the infant or toddler. Teams may use an integrated tool, discipline-specific tools, or some combination. Further, some teams meet before and after testing to consolidate

their plans, findings, and recommendations. Family participation is also integrated and family members inform the team's ongoing discussion of the child's strengths, preferences, and current skills.

*For **transdisciplinary teams**, based on a primary service provider model, all team members work closely to plan the assessment and the subsequent intervention although typically one team member and the family will be responsible for the day-to-day implementation of intervention. Transdisciplinary teams include some type of role release wherein one or more professionals take on, with the supervision and collaboration of the discipline-trained professional, some aspects of the roles and responsibilities of another professional/s. Ideally, in this model team members provide training to one another about key behaviors to observe/document and then consult with other team members regarding interpretations and recommendations. Arena assessment, in which professionals of different disciplines simultaneously observe a child, may be included in transdisciplinary teams.*

With transdisciplinary teams, infants and toddlers learn new skills across domains simultaneously and synchronously rather than in isolation. Coordination of services is enhanced when the team's message is unified in delivery by a lead member working closely with the family. The team, in concert with the family's preferences, selects the appropriate team member to serve as the primary provider. The team member is selected based on the needs of the child, relationships already developed with the family, and special expertise, but should not be established a priority by program policy or based on logistics such as travel or caseload. For example, if an infant or toddler presents with a communication disability, a speech-language pathologist should be the lead member of the team and the primary service provider.

Early intervention is a field with many disciplines represented as practitioners and in which the roles vary according to the needs of the child. Teams benefit from joint professional development and can enhance each other's knowledge and skills as well as through role extension and role release for specific children and families. It is not appropriate or suitable for professionals to be asked to train others to perform professional level services unique to certain professions, nor should professionals be expected to perform services outside of their scope of practice.

STATE OPTION TO MAKE PART C SERVICES AVAILABLE TO CHILDREN AGES 3 AND OLDER (§303.211)

Major Changes:

Proposed Sec. 303.211 would incorporate the language in Sec. 635(c) of the statute providing states the option to make early intervention services available to children beginning at three years of age until the children enter, or are eligible under state law to enter, kindergarten or elementary school.

Proposed Sec. 303.211(a)(2) would clarify that states may choose to serve a subset of children between age three and the age at which the children enter, or are eligible to enter, kindergarten or elementary school. This provision would take into consideration states that have preschool programs for many or all children starting at age four, and would give those states the flexibility to provide early intervention services until the beginning of the school year following the child's third, fourth, or fifth birthday. Although proposed Sec. 303.211(a)(2) would allow states to serve a subset of children between age three and the age at which children enter, or are eligible to enter, kindergarten or elementary school, the option would not extend to serving only a specific disability group.

Proposed Sec. 303.211(b)(1) would require states that choose to provide early intervention services to children under this proposed section to ensure, consistent with sections 635(c)(2)(A)(i) and (ii) of the statute, that the parents of children with disabilities served under this option would be provided with an annual notice that includes: a description of the rights of the parents to elect to receive early intervention services under Part C of the statute or preschool services under Part B of the statute; an explanation of the differences between early intervention services provided under Part C of the statute and preschool services provided under Part B of the statute, including the types of services and the locations at which the services are provided; the procedural safeguards that apply; and possible costs, if any, to parents of infants or toddlers with disabilities receiving early intervention services. Proposed Sec. 303.211(b)(2) would incorporate the requirement in Sec. 635(c)(2)(B) of the statute that early intervention services provided to children with disabilities under this proposed section include an educational component that promotes school readiness and incorporates preliteracy, language, and numeracy skills.

Proposed Sec. 303.211(b)(3) would incorporate Sec. 635(c)(2)(C) of the statute and would require the statewide system to ensure that the state policy would not affect the right of any child to receive FAPE under Part B of the statute instead of early intervention services under Part C of the statute.

Proposed Sec. 303.211(b)(5) would incorporate the requirement in Sec. 635(c)(2)(E) of the statute that the state obtain informed consent from the parents of any child to receive early intervention services, where practicable, before the child reaches three years of age.

Proposed Sec. 303.211(b)(7) would require a referral for evaluation for early intervention services of a child under the age of three who experiences a substantiated case of trauma due to exposure to family violence, as defined in Sec. 320 of the Family Violence Prevention and Services Statute, consistent with Sec. 635(c)(2)(G) of the statute. Proposed Sec. 303.211(b)(7) would clarify that such referral is dependent upon parental consent. Parental consent would be required to balance the need to protect the safety needs of the parent seeking shelter because of family violence, as defined in Sec. 320 of the Family Violence Prevention and Services Statute, 42 U.S.C. 10401 et seq., with the Child Find mandate under Part C of the statute.

Proposed Sec. 303.211(e)(1) would incorporate the language in Sec. 635(c)(5)(A) of the Statute which states that when a statewide system includes a policy to provide early intervention services to a child with a disability who is eligible for services under Sec. 619 of the Statute, it is not required to provide the child FAPE under Part B of the statute for the period of time during which the child is receiving early intervention services. Proposed Sec. 303.211(e)(2) would incorporate the language in Sec. 635(c)(5)(B) of the Statute which clarifies that a provider of

early intervention services is not required to provide a child receiving early intervention services with FAPE.

ASHA’s Position:

ASHA is concerned that parents will not fully understand the consequences of a decision to opt for the continuation of Part C services for children age 3 and older – that by providing such consent the state and the provider of early intervention services is not required to provide a child receiving early intervention services with FAPE. ASHA recommends that parents be required to sign a specific consent form on this particular issue in addition to the informed consent from parents of any child that the state is required to obtain for the continuation of Part C services to children age 3 and older, before the child reaches 3 years of age.

**ASSISTIVE TECHNOLOGY AND ASSISTIVE TECHNOLOGY SERVICE
(§303.13(b)(1)(i) and (b)(1)(ii))**

Major Changes:

The proposed rules are consistent with Sec. 602(1) and 602(2) definitions in IDEA 2004 that excludes, as a covered service, “a medical device that is surgically implanted, including cochlear implants or the replacement of such device” and includes any service that “directly assists with the selection, acquisition or use of an assistive technology device.” The proposed rules are changed to reflect that optimization (e.g., mapping) and maintenance of surgically implanted devices are not included as a covered service under Part C of the Act.

ASHA’s Position:

ASHA believes that optimization (e.g., mapping) should be included as a covered service. In Sec. 303.13(b)(2)(vi) audiology services the proposed regulations that supports “Determination of the child’s need for individual amplification, including selecting, fitting, dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.” Procedures for setting and evaluating the effectiveness of a cochlear implant meet the same goal of setting a listening device, a covered service, so that infant or toddler has access to auditory information.

Further, ASHA believes that this important service should not be separated from the early intervention services provided to the infant or toddler and their family by other service providers. This service is often a team effort including the early intervention provider, family, and audiologist at the cochlear implant center. Early intervention providers work with the family to help condition the child to auditory tasks often facilitating the audiologist’s ability to obtain an optimal map for the cochlear implant in a shorter amount of time. Also, feedback from the early intervention providers regarding changes in the child’s auditory skills or speech production can be valuable information for the audiologist and other professionals (e.g., speech-language pathologists) at the cochlear implant center.

EVALUATION AND ASSESSMENT OF THE CHILD AND FAMILY AND ASSESSMENT OF SERVICE NEEDS-TIMELINES (§303.320(e))

Major Changes:

Current Sec. 303.321(e)(2), Sec. 303.322(e)(12), and Sec. 303.342(a) require that a child's evaluation, assessment, and initial IFSP meeting occur within 45 days from the date the public agency receives the referral. Proposed Sec. 303.320(e)(1) would retain the 45-day timeline requirement, but the timeline would not begin until the public agency has obtained parental consent for the evaluation. This would increase the amount of time for the agency to complete these actions.

ASHA Position:

Undue delays could be harmful to the child. ASHA is extremely concerned that many children will be lost to follow-up or not be provided services in a timely manner if the lead agencies don't immediately take action for contacting the families and setting up the appointments for the initial interview and/or evaluations following the referral. ASHA proposes that the original language that requires that a child's evaluation, assessment, and initial IFSP meeting occur within 45 days from the date the public agency receives the referral be retained in the regulations.