



ASHA Analysis of the 2011 IDEA Part C Final Regulations

The American Speech-Language-Hearing Association (ASHA) reviewed and analyzed the 2011 Part C final regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities under the Individuals with Disabilities Education Act (IDEA). ASHA identified selected issues critical to the practice of audiology and speech-language pathology to assist members in their practice.

EXECUTIVE SUMMARY

Qualified Personnel/Personnel Standards

The final Part C rules reflect changes in IDEA 2004 and subsequent Part B final regulations that removed the requirement that states must employ only personnel who meet the highest requirement of the profession in the state. Part C rules require that a state establish and maintain qualification standards to ensure that personnel are appropriately and adequately prepared and trained and mirror changes in Part B rules that require that the qualifications for Part C providers must be consistent with any state approved certification, licensing, or regulation for the profession or discipline in the area in which personnel are providing early intervention services. Further, a state must promote the preparation of personnel who are fully and appropriately qualified.

There is no prohibition on the use of paraprofessionals and assistants who are appropriately trained and supervised in accordance with state law, regulation, and written policy to assist in the provision of early intervention services under Part C.

State Option to Extend Part C Services Beyond Age 3

New requirements specify that states can opt to provide early intervention services to children beginning at 3 years of age until the children enter, or are eligible to enter, kindergarten or elementary school. 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 older than 3 years cannot affect the right of any child to receive "free appropriate public education" (FAPE) under IDEA Part B instead of early intervention services under Part C. Nevertheless, a state is not required to provide to the child FAPE under Part B for the period of time the family has opted for the child to receive Part C early intervention services. States are required to obtain written consent from parents of children who will be continuing in Part C services, and parents retain the right to opt-out of Part C services "at any time."

Definitions--Early Intervention Services; Multidisciplinary; Natural Environment; Scientifically Based Research; Native Language

Early Intervention Services

Sign language and cued services

The new regulations establish a separate definition of sign language and cued language services, which includes auditory/oral language and transliteration services. It defines sign language and cued language services to include “teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.”

Speech-language pathology services

Speech-language pathology services continue to be listed as a type of early intervention service and the services included in this definition of speech-language pathology services remain the same.

Audiology services

Audiology services continue to be listed as a type of early intervention service and the services included in this definition of audiology services remain the same.

Multidisciplinary

The definition of multidisciplinary has been revised with respect to the Individualized Family Service Plan (IFSP) team composition to require the parent and two or more individuals from separate disciplines or professions with one of these individuals being the service coordinator.

Natural Environments

Natural environments means settings that are natural or typical for a same-aged infant or toddler without a disability and may include the home, community, or other settings that are typical for an infant or toddler without a disability.

Scientifically Based Research

The final regulations adds a definition of scientifically based research, which cross-references, with appropriate modifications, the definition of the same term contained in section 9101(37) of the Elementary and Secondary Education Act of 1965, as amended (ESEA).

Native Language

The native language of an individual with limited English proficiency is now defined to be the language normally used by that individual, or in the case of a child, the language normally used by the parents of the child, except when conducting evaluations and assessments of the child. When conducting an evaluation and assessment, qualified personnel may determine that it is developmentally appropriate to use the language normally used by the child, depending on the child’s age and communication skills. For children who are deaf, native language is defined as the mode of communication normally used by the individual (including sign language).

Native Language and Related Issues

The regulations ensures that the general notice provided to parents by the lead agency specify the extent to which that notice is provided in the native languages of the various populations groups in the state, in accordance with the definition of native language. Notification to parents

about the extent to which notice is provided in the native languages of the various population groups in the state is included to parallel the requirements in the Part B final regulations.

Child Find and EHDI

State Early Hearing Detection and Intervention (EHDI) systems are now added to the list of programs with which the Part C lead agency must coordinate its Child Find efforts. Also, personnel who conduct screenings must be trained to administer appropriate screening instruments.

Service Coordination Services/Coordinator

In general, service coordination services are those services provided by a primary service provider that enable a child and his family to receive the necessary treatment and supports from qualified providers. Service providers ensure that referrals are made and that assessments and services are delivered in a timely manner. Primary service providers are responsible for ensuring that families have been advised of their rights and procedural safeguards and may be involved in conducting follow-up activities to ensure that services identified in the individualized family service plan are being provided in a timely coordinated manner.

Individualized Family Service Plan (IFSP)

The IFSP must be developed by a multidisciplinary team which includes not only the parent but must also include service coordination services. Provisions delineate the IFSP meeting process and indicate that a service coordinator, designated by the local education agency (LEA) and tasked with implementing the IFSP, must be included. Also, they describe the IFSP content including whether services will be delivered in a natural environment, provisions for children who will continue to receive IFSP services beyond age 3, and finally identification of the service coordinator tasked with implementing the services identified in the child's IFSP.

Traditionally Underserved Groups

All families of an infant or toddler with a disability must be provided with access to culturally competent services when those services are necessary to meet the needs of the child in accordance with implementing all the requirements of this part. States must ensure that traditionally underserved groups must have access to culturally competent services within their local geographical areas and are meaningfully involved in the planning and implementation of Part C services.

Evaluation and Assessment

Requirements specify that unless clearly not feasible to do so, all evaluations and assessments of a child must be conducted in the native language of the child, in accordance with the definition of native language. Also, unless clearly not feasible to do so, family assessments must be conducted in the native language of the family members being assessed in accordance

with the definition of native language. Provisions on procedures for assessment of the family include a listing of the requirements of a family assessment.

The provision on evaluation and assessment timelines requires that a child's evaluation, assessment, and IFSP meeting occur within 45 days from the date the public agency receives the referral unless there are "exceptional family circumstances" or the parent has not provided consent for the evaluation.

ASHA Analysis of the 2011 IDEA Part C Final Regulations

This analysis of the 2011 IDEA Part C final regulations focuses on select critical issues in the final regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities that affect the provision of speech-language pathology and audiology services. Published in the *Federal Register* on September 28, 2011, the Part C final regulations implement changes in the regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities under the Individuals with Disabilities Education Act (IDEA), as amended by the Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446, or commonly known as IDEA 2004). The full text of the 2011 IDEA Part C final regulations can be accessed at www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf.

Additional information of specific aspects of the Part C regulations will follow over the coming months as developed by an IDEA Part C Member Advisory Group (MAG) and an ASHA National Office staff team. Please continue to check ASHA's Advocacy Web site at www.asha.org/advocacy/ for further updates.

HIGHLIGHTS OF SELECT CRITICAL ISSUES

- **Qualified personnel/Personnel standards**
- **State Option to extend Part C services beyond age 3**
- **Definitions--early intervention services; multidisciplinary; natural environment; scientifically based research; native language.**
- **Native language and related issues**
- **Child find and EHDI**
- **Service coordination services//Coordinator**
- **Individualized family service plan (IFSP)**
- **Traditionally underserved groups**
- **Evaluation and assessment**

QUALIFIED PERSONNEL/PERSONNEL STANDARDS

Qualified personnel (§303.31); Personnel standards §303.119 (a), (b)

The final Part C rules reflect changes in IDEA 2004 and subsequent Part B final regulations that removed the requirement that states must employ only personnel who meet the highest requirement of the profession in the state. Part C rules require that a state establish and maintain qualification standards to ensure that personnel are appropriately and adequately prepared and trained (§303.118) and mirror changes in Part B rules that require that the qualifications for Part C providers must be consistent with any state approved certification, licensing, or regulation for the profession or discipline in the area in which personnel are providing early intervention services. Further, a state must promote the preparation of personnel who are fully and appropriately qualified. If a state has a shortage of personnel (e.g., in a specific geographic area), a policy may be adopted by the state to make good faith efforts to hire the most qualified individuals available and who are making satisfactory progress toward completing requirements for the personnel standard (§303.119).

ASHA's Commentary

ASHA continues to be concerned with the definition of personnel qualifications in both Part B and Part C of the Act, which allow states to individually determine requirements for qualified personnel. This process, under Part B of the Act, has resulted in divergent provider qualifications across the country leading to confusion and misunderstanding among consumers, hiring officials, and regulators. ASHA will continue its efforts with states to ensure that children and their families receive early intervention services from the highest qualified providers.

ASHA and other professional standard setting organizations use a rigorous process engaging an independent organization and expert peer reviewers to set and periodically review curricular and clinical practice standards for independent practice as a speech-language pathologist (SLP) or audiologist. These standards not only guarantee that the most competent individuals will be allowed to engage in professional practice, but also ensure that children with communication disorders and their families receive services from those qualified to assess and deliver such services.

Further, public insurers such as Medicaid, private insurers, and state licensure recognize the professional standards set by ASHA for speech-language pathology and audiology practice and require that members and organizations that provide health services for eligible infants and children use only those providers that meet the nationally recognized standards. Allowing a state to identify the competency standards for speech-language pathology professionals may result in a two-tiered system in which children and their families receiving Part C educational services may be served by lesser qualified individuals than those receiving medically-based early intervention services.

Use of paraprofessionals and assistants (§303.119(c))

There is no prohibition on the use of paraprofessionals and assistants who are appropriately trained and supervised in accordance with state law, regulation, and written policy to assist in the provision of early intervention services under Part C.

ASHA's Commentary

Despite ASHA's advocacy for detailed definitions of paraprofessionals and assistants consistent with ASHA guidelines, no changes were made in defining these personnel or specifying the amount of supervision or who provides the supervision. Education Department (ED) stated in its discussion section that it is not necessary to define these terms with greater specificity because defining these terms is best left to individual states based on their laws, regulations, and written policies. ASHA continues to believe that parameters should be identified that specify how paraprofessionals and assistants should be trained, used, and supervised. Leaving such decisions up to each individual state does not assure that such personnel will be used in a manner that is consistent with the requirements of this Act for providing quality services and an appropriate education for infants and toddlers with disabilities. ASHA strongly believes that states need to develop and adopt rigorous standards of training and competency that indicate the highest level of professionalism and proficiency. An example of such rigorous standards is ASHA's Certification of Clinical Competence (CCCs), the nation's most widely recognized symbol of competency for speech-language pathology and audiology professionals. The professionals also must have obtained the knowledge, skills, and abilities necessary to supervise paraprofessionals and assistants and to ensure that the activities and tasks carried out by paraprofessionals or assistants are appropriate for a child with disabilities.

Of particular concern is that some paraprofessionals and assistants may provide services under this part with little or no supervision by qualified personnel. State policies should specify the number of paraprofessionals or assistants to be supervised, limitations on their area of responsibility, and include provisions that make it clear to parents that an individual who has met the highest requirements in the state for the profession or discipline in which services are being provided is responsible for all tasks and activities carried out by the paraprofessional or assistant.

STATE OPTION TO MAKE PART C SERVICES AVAILABLE TO CHILDREN OLDER THAN 3 YEARS (§303.211)

New requirements specify that states can opt to provide early intervention services to children beginning at age 3 until the children enter, or are eligible to enter, kindergarten or elementary school. 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 older than 3 years cannot affect the right of any child to receive "free appropriate public education" (FAPE) under IDEA Part B instead of early intervention services under Part C. Nevertheless, a state is not required to provide to the child FAPE under Part B for the period of time the family has opted for the child to receive Part C early intervention services. In states offering this option, parents have the right to choose between Part C or Part B services.

In §303.211 (b)(5) states are required to obtain written consent from parents of children who will be continuing in Part C services and this written consent must state that the parents fully understand the differences between early intervention services under Part C and preschool services provided under Part B. Additionally, parents retain the right to opt-out of Part C services "at any time."

ASHA's Commentary

ASHA advocated that parents be required to sign a specific consent form on this particular issue, and is pleased with this clarification that would help ensure that parents are made aware of the consequences—especially the effect on the child's right to FAPE – when they consent to early intervention services for their child older than 3 years. Specifically, in §303.209 (f)(2) it was clarified that the first annual notice must be provided at the transition conference when parents are first provided with the option of continuing to receive early intervention services after their child's third birthday. Annual notices must include an explanation of the differences between early intervention services provided under Part C and preschool services provided under Part B. Parents also will be provided with a description of the differences in the procedural safeguards provided under §303.211 compared with those provided under Part B of the Act. Language was clarified in §303.211(b)(5) to ensure that written consent is obtained prior to the child's third birthday.

ASHA recommended that parents retain the right to opt-out at any time after choosing to remain in Part C services past the age of three. This was addressed in the final regulations and §303.211 (b)(3) requires that the Part C statewide system ensures that any child served under §303.211 has the right, at any time to receive FAPE under Part B of the Act instead of early intervention services under Part C of the Act.

DEFINITIONS

Early Intervention Services

Types of early intervention services—

Assistive technology device and Assistive technology service (§303.13(b)(1)(i) and (b)(1)(ii))

The Part C final regulations are consistent with Sec. 602(1) and 602(2) definitions in IDEA 2004 that exclude under the term assistive technology device “a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device.”

“Assistive technology service” is defined as any service that “directly assists with the selection, acquisition or use of an assistive technology device.” Included in these services is a functional evaluation in the child's customary environment; training or technical assistance for the family and professionals or other individuals who are providing services or are otherwise substantially involved in the major life functions of infants and toddlers with disabilities.

ASHA's Commentary

ASHA advocated for a change in the proposed definition of assistive technology device to include optimization (e.g., mapping). It remains ASHA's assertion that procedures for setting and evaluating the effectiveness of cochlear implants is of equal importance to

setting and evaluating the effectiveness of conventional listening devices, a covered service. The goal of both of these procedures is that infants or toddlers with hearing loss have ready access to auditory information. Ongoing mapping and evaluation of the cochlear implant (and hearing aids) is an important aspect of child's service plan allowing for important auditory brain development and leading to improved speech and language outcomes. It is extremely important that providers in the field perform ongoing listening checks and troubleshooting of these devices, as well as supply the audiologist with regular feedback regarding auditory, speech, and language outcomes. Working together, the entire team can help ensure that technology, including cochlear implants, hearing aids, or other recommended hearing assistive technology (e.g., FM listening systems), are providing important access to sound so that auditory learning can continue.

Sign language and cued services (§303.13(b)(12))

The new regulations establish a separate definition of sign language and cued language services, which includes auditory/oral language and transliteration services.

§303.13(b)(12) defines sign language and cued language services to include “teaching sign language, cued language, and auditory/oral language, providing oral transliteration services (such as amplification), and providing sign and cued language interpretation.”

ASHA's Commentary

While ASHA advocated for a new definition of sign language and cued language services to be placed in a separate section from speech-language pathology services, ASHA considers this change to be a substantial improvement that offers more clarity regarding the nature of these early intervention services.

Speech-language pathology services (§303.13(b)(15))

Speech-language pathology services continue to be listed as a type of early intervention service and the services included in this definition of speech-language pathology services remain the same.

ASHA's Commentary

ASHA recommended the addition of dysphagia and aural habilitation or rehabilitation to the list of speech-language pathology services. However, ED in its discussion section indicated that these recommended changes were not added to the definition of speech-language pathology services in §303.13(b)(15) because the services listed are “not intended to be exhaustive.” An infant or toddler with a disability may receive such services if they are determined to be necessary to meet the outcomes identified by the IFSP team. While ASHA's preference would be for dysphagia and aural habilitation or rehabilitation to be specified in the definition of speech-language pathology services, we recognize that these services are not precluded when necessary.

Audiology services (§303.13(b)(2)) – Audiology services continue to be listed as a type of early intervention service and audiology services are defined.

ASHA's Commentary

ASHA is pleased that the definition continues to underscore the importance of appropriate audiologic screening techniques and the responsibility of audiologists to determine the range, nature, and degree of hearing loss.

Multidisciplinary (§303.24)

The definition of multidisciplinary has been revised with respect to IFSP team composition to require the parent and two or more individuals from separate disciplines or professions with one of these individuals being the service coordinator.

ASHA's Commentary

ASHA is satisfied with the change requiring at least two or more individuals from separate professions or discipline. Previously, one professional with expertise in two different disciplines could serve on the IFSP. This means that one professional does not serve as the sole professional member of the team. This provides more checks and balances and may reduce conflicts of interest. Parents now can obtain input from at least two different individuals on the team.

ASHA recommended that the three major types of team models, multidisciplinary, interdisciplinary, and transdisciplinary, be defined in the final regulations. However, in its discussion section ED stated that transdisciplinary and interdisciplinary are specific team models, and that multidisciplinary teams could be based on these models if they meet the state's definition of multidisciplinary which in turn must meet legislative and statutory requirements. Therefore, ED did not feel it was necessary to reference specific team models.

Natural Environments (§303.26)

Natural environments means settings that are natural or typical for a same-aged infant or toddler without a disability and may include the home, community, or other settings that are typical for an infant or toddler without a disability.

ASHA's Commentary

The definition of natural environments now includes a reference to "community settings" and "normal" was changed to "typical." ASHA recommended broadening the definition of natural environments to include the full range of settings that include infants or toddlers with and without disabilities (e.g., home, schools, child care centers, center-based programs) rather than using a vague term such as "natural" or "normal." ASHA supports the changes made to the definition of natural environments and supports the necessity to document the setting in the IFSP. As indicated in the regulations, the IFSP should include a statement of the specific early intervention services necessary to meet the unique needs of the child and the family, including the setting in which services are provided. If the IFSP team decides that the child cannot achieve the identified outcomes in natural environments, then services may be provided in other settings (e.g., clinic, hospital, service provider's office) with the justification specified.

Scientifically Based Research (§303.32)

The final regulations adds a definition of scientifically based research, which cross-references, with appropriate modifications, the definition of the same term contained in section 9101(37) of the Elementary and Secondary Education Act of 1965, as amended (ESEA).

ASHA's Commentary

ASHA agrees that adding a definition of scientifically based research that is consistent with the ESEA definition is a useful addition to the regulations.

Native Language (§303.25(a))

The native language of an individual with limited English proficiency is now defined to be the language normally used by that individual, or in the case of a child, the language normally used by the parents of the child, except when conducting evaluations and assessments of the child. When conducting an evaluation and assessment, qualified personnel may determine that it is developmentally appropriate to use the language normally used by the child, depending on the child's age and communication skills. For children who are deaf, native language is defined as the mode of communication normally used by the individual (including sign language).

ASHA's Commentary

ASHA supports culturally competent service delivery as it provides for customization of the language(s) for assessment and evaluation as appropriate for each child. ASHA is pleased that ED continues to see the importance of evaluating a child's abilities using the language(s) most appropriate for each individual child. Each child's language system may consist of one or multiple languages to which the child has been exposed. Qualified personnel making determinations about the language(s) to use for assessment and evaluation must recognize the range of family situations and values, language exposure, and the myriad of variables that will affect the outcomes of the evaluation, including the languages used by parents and other caregivers routinely interacting with the child, the child's age and developmental progression in other areas, and resources available in all relevant languages (e.g., availability of qualified bilingual professionals, trained professional interpreters or other bilingual staff, resources for low incidence languages (e.g., telephonic interpretation services), the potential for training and using caregivers as interpreters, etc.

NATIVE LANGUAGE AND RELATED ISSUES

Notice to Parents (§303.404(d))

The regulations ensures that the general notice provided to parents by the lead agency specify the extent to which that notice is provided in the native languages of the various populations groups in the state, in accordance with the definition of native language in §303.25. Informing parents about the extent to which the notice is provided in the native languages of the various populations groups in the state is included to parallel the requirements in the Part B final regulations.

ASHA's Commentary

ASHA concurs that providing information to parents in their native languages is critical to ensure understanding and active participation by those who speak languages other than English. This is critical when there are large numbers of different language communities in a state. Parents and advocacy personnel also may be better positioned to advocate for children when they are aware of the information that will or will not be available for parents in their native languages.

CHILD FIND AND EHDI

Comprehensive Child Find System §303.302(c)(1)(ii)

State Early Hearing Detection and Intervention (EHDI) systems are now added to the list of programs with which the Part C lead agency must coordinate its Child Find efforts.

ASHA's Commentary

ASHA advocated for the addition of EHDI systems to the list of programs with which the lead agency must coordinate. This will help insure that children identified with hearing loss through newborn hearing screening are transitioned into early intervention services in a timely fashion.

Screening Procedures (§303.320(b)(2))

This provision indicates that personnel who conduct screenings must be trained to administer appropriate screening instruments.

ASHA's Commentary

ASHA advocated for specific regulatory language identifying the need to provide services by qualified bilingual personnel or with the assistance of professional interpreters, when appropriate, to ensure that evaluations and assessments would be conducted to yield the most accurate information about a child's abilities. ASHA members are urged to ensure that individuals responsible for screening infants and toddlers have the requisite training in nondiscriminatory assessment including an awareness that testing materials designed to assess speech and language that have not been developed to assess children in languages other than English carry inherent bias. It is critical that when using interpreters and translators or paraprofessionals to conduct screenings, that appropriate training be provided to eliminate bias in screening protocols and instruments.

SERVICE COORDINATION SERVICES/COORDINATOR

Service Coordination Services and the IFSP (§§303.34, 303.343, 303.344(g)(2))

§303.34 defines service coordination services, including the role of the primary service provider. In general, service coordination services are those services provided by a primary service provider that enable a child and his family to receive the necessary treatment and supports from qualified providers. Service providers ensure that referrals are made and that assessments and services are delivered in a timely manner. Primary service providers are

responsible for ensuring that families have been advised of their rights and procedural safeguards and may be involved in conducting follow-up activities to ensure that services identified in the IFSP are being provided in a timely coordinated manner. §303.24 and 303.343 state that the IFSP team must include among others the service coordinator. §303.321(4) requires that all assessments must be conducted by qualified personnel in order to determine the child's strengths and weaknesses and early intervention services necessary to meet those unique needs.

ASHA's Commentary

While ED did not accept ASHA's recommendation to define other kinds of teaming models (i.e., interdisciplinary and transdisciplinary) that may also be appropriate for specific children and their families, it appears that the description of the primary service provider and service coordination services (§303.34) best aligns with the transdisciplinary team model. The transdisciplinary team model involves close collaboration of team members to plan the assessment and subsequent treatment for the child and family. Intervention using this model typically involves one team member (professional whose services are primary) who serves as the primary contact and service provider for the family.

ASHA supports the definition and identification of service coordination activities as part of the multidisciplinary team in §303.34. Service coordination activities do not constitute service delivery, however, and it is important that the Department monitor the development of IFSP team, specifically the use of the primary service provider. Just as a physical therapist would not be expected to provide feeding and swallowing services for a child whose primary disability is dysphagia (i.e., swallowing disorder), a primary service provider whose responsibility includes, service coordination, referral, and conducting follow-up activities would not be expected to provide professional services to families outside of his or her realm of expertise.

INDIVIDUALIZED FAMILY SERVICE PLAN

Individualized Family Service Plan (IFSP) – §§303.114, 303.340, 303.343, 303.344, 303.346)

Defined in §§303.114 and 30.340, the IFSP must be developed by a multidisciplinary team which includes not only the parent but must also include service coordination services. §303.343 delineates the IFSP meeting process and indicates that a service coordinator, designated by the LEA and tasked with implementing the IFSP, must be included. §303.344 describes the IFSP content including whether services will be delivered in a natural environment, provisions for children who will continue to receive IFSP services beyond age 3, and finally identification of the service coordinator tasked with implementing the services identified in the child's IFSP.

ASHA's Commentary

Although the specific definition of service coordination services include assisting, coordinating, facilitating access to, and monitoring services as the key components to facilitating and participating in the development and review of the IFSP (§303.34), ASHA remains concerned that the service coordinator as defined in §303.343(g) may be expected to implement the IFSP even if those activities include delivering discipline-specific services for which the service provider is not trained. Service coordination activities do not constitute service delivery and it is important that ED and state Departments of Education monitor the development of the IFSP team, specifically the use of the primary service provider.

TRADITIONALLY UNDERSERVED GROUPS

Traditionally Underserved Groups (§303.227(a) and (b))

All families of an infant or toddler with a disability must be provided with access to culturally competent services when those services are necessary to meet the needs of the child in accordance with implementing all the requirements of this part. States must ensure that traditionally underserved groups must have access to culturally competent services within their local geographical areas and are meaningfully involved in planning and implementation of Part C services.

ASHA's Commentary

ASHA advocated for traditionally underserved groups to be meaningfully involved in the planning and implementation of Part C services as well as the right to have access to culturally competent services. We commend ED for the clarification in its discussion section that this provision does not limit the requirement to provide culturally competent services, but focuses on the access of traditionally underserved groups to culturally competent services, which is consistent with other provisions requiring that states provide meaningful involvement of underserved groups in the planning and implementation of all the requirements. ASHA members are reminded that every individual has a culture and thus, cultural competence is required for clinical competence in serving every client, patient, or student.

EVALUATION AND ASSESSMENT

Evaluation and Assessment of the Child and Family (§303.321 (a)(5) and (6))

Requirements specify that unless clearly not feasible to do so, all evaluations and assessments of a child must be conducted in the native language of the child, in accordance with the definition of native language in §303.25. Also, unless clearly not feasible to do so, family assessments must be conducted in the native language of the family members being assessed in accordance with the definition of native language.

ASHA's Commentary

The further explanation provided by ED on the “unless clearly not feasible to do so” standard is helpful in understanding that the assumption for best effort exists in providing services in the native language of the child or other family members. This additional information makes it clear

that there is an expectation that every effort will be made to exhaust options for providing services in the native language. This intent is consistent with ASHA policy that requires an exploration of alternatives beginning first with the use of a bilingual professional and moving through less desirable options toward the alternative of last resort, using a parent or other family member as an interpreter. ASHA member professionals should not assume that because they are not bilingual that there are no options for providing services in the child or family's native language.

Procedures for Assessment of the Family (§303.321(c))

The provision includes a listing of the requirements of a family assessment; it must: 1-be voluntary on the part of each family member participating in the assessment; 2-be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and 3-include the family's description of its resources, priorities, and concerns related to enhancing the child's development. The rationale provided indicates that these new requirements will ensure that each family is involved and has the opportunity to meet with a lead agency or early intervention service (EIS) provider to identify their priorities and concerns regarding the development of the child. Family involvement is believed to help ensure that services identified in the IFSP will be relevant and culturally competent.

ASHA's Commentary

ASHA advocated for the assessment of the family to include a voluntary personal interview with the family and with an awareness and respect of cultural differences in family values and child rearing practices as a means to relaying the importance of providing culturally competent services not only to the child but to the family as well. The revised requirement will increase the likelihood that parents will have a direct opportunity to provide information on family values and child rearing practices that may affect assessment outcomes. ASHA members are encouraged to ensure that interviews and assessment tools include probes in these areas.

Procedures for IFSP Development, Review and Evaluation (§303.342)

§303.342(d)(1)(ii) requires that IFSP meetings be conducted in the native language of the family or other mode of communication used by the family unless it is clearly not feasible to do so.

ASHA's Commentary

ASHA recommended that the standard of *clearly not feasible to do so* be applied in this instance to relate to having exhausted all other possible options. Concern was expressed that the current regulatory language allows too much room for a lead agency to claim that it is "not feasible" to conduct the IFSP meeting in a family's native language. Given the availability of resources such as bilingual staff, interpreters, and telephonic interpreter services, it should be feasible to ensure that IFSP meetings are conducted in the family's native language in many instances. ED, in its discussion section, indicated that lead agencies should consider the availability of native language resources such as those suggested by ASHA, when determining whether it is feasible to conduct the IFSP meeting in the native language of the family. ASHA members are

encouraged to exhaust all possible options before determining that it is not feasible to conduct an IFSP meeting in the native language of the family.

Post-Referral Timeline (§303.310 (a))

This provision requires that a child’s evaluation, assessment, and initial IFSP meeting occur within 45 days from the date the public agency receives the referral unless there are “exceptional family circumstances” or the parent has not provided consent for the evaluation.

ASHA’s Commentary

ASHA advocated that a child’s evaluation, assessment, and initial IFSP meeting occur within 45 days from the date the public agency receives the referral, and is pleased that the final regulations contains this provision. ASHA had originally expressed concern that many children would be lost to follow-up or not be provided services in a timely manner if the lead agencies didn’t immediately take action for contacting the families and setting up the appointments for the initial interview and/or evaluations following the referral.