



STATEWIDE SPECIAL EDUCATION TASK FORCE

Conceptual Framework for Special Education Task Force Early Childhood Special Education Subcommittee

2014-2015

Sam Neustadt, Committee Chair

Committee Members

Lucia Arias, Cindy Chandler, Nancy Hurlbut, Linda James Perry, Patty Schetter

Introduction:

Research has clearly demonstrated the importance of early intervention and quality early childhood education. Studies have shown that early intervention contributes to cognitive, language, social-emotional development, general well-being, and life long success. High-quality early childhood services not only benefit children and families, but also have far-reaching economic benefits for society as a whole. James Heckman, a Nobel Memorial Prize winning economist, is well known for his economic models that prove that investing in quality early childhood experiences makes substantial economic sense. Temple & Reynolds (2007) evaluated the results from three diverse but high quality preschool programs from various regions of the U.S. to look at the effectiveness and cost-benefit analysis of providing quality preschool programs. The major long-term effects of the three programs show that preschool participants have rates of special education 40-60% lower than those who do not receive preschool, have significantly higher rates of high school completion and college attendance, and have a 40% decrease in arrests. The present value of net benefits for the preschool programs ranges between \$67,595 and \$122,642 per participant, and the benefit-cost ratio ranges between \$4 and \$10.15 per dollar invested.

Equally compelling is brain-development research that tells us that between birth and the age of four, 92 percent of the brain's networking is formed. Neuroscience can now tell us that the experiences and environment in the first years of life affect the way the brain develops. Research on early intervention for children with certain disabilities, such as Autism Spectrum Disability (ASD) has demonstrated how critical the implementation of early intervention is. In a recent study of the Early Start Denver Model (ESDM) for autism treatment, those who received ESDM exhibited significant improvements in symptoms of autism, IQ, language, and adaptive and social behaviors. Changes were also noted using brain imaging. This was one of the first studies to demonstrate that early intervention is associated with normalized patterns of brain activity using functional MRI. Studies like this are suggestive that well timed, and high quality early intervention

programs can, in fact, correct neurologically based issues by taking advantage of the neuro-plasticity that is characteristic in early development.

Providing young children with high quality early learning experiences is critical to long term success and achievement. By contrast, children who experience prolonged exposure to unhealthy and deprived environments and circumstances are at risk for lifelong learning, behavioral and mental health related issues. Thus, early interventions should be viewed as a “prevention” service for any young child who may be at risk, either biologically or due to socio-economic and/or environmental factors that have the potential to impact their development.

This workgroup was charged with identifying the current challenges and possible solutions to insuring all young children with disabilities (or with the potential for developing disabilities due to risk) receive the highest quality early childhood educational experiences. A critical factor in evaluating this issue is the premise that through high quality early childhood education, many potential disabilities, previously unidentified disabilities and mental health issues can be prevented, corrected or resolved before more intensive services or lifelong interventions and supports are required. For this reason, we chose to view ALL early childhood education as a component of “preventative for IDEA eligible special education.”

Many questions related to early childhood special education were generated in our process including questions related to: professional training and competencies, use of evidence based practices, developmental and progress monitoring, context of interventions, and access to the least restrictive environment as well as the need for better coordination of services and parent training/participation. We will address each of these issues in this report, describing the current issues as well as potential solutions that will improve services and outcomes for children.

Issue 1: Building Quality Inclusive Early Childhood Education Opportunities/Least Restrictive Environment (LRE)

Background and Rationale:

Indicator 6 of the Individuals with Disabilities Education Act (IDEA) Part B Annual Performance Plan (sometimes referred to as Preschool LRE) concerns itself with the number of children with disabilities in preschools who received their special education services in general education settings, alongside their peers without disabilities. This is in keeping with the principles and requirements of IDEA with respect to children’s placement in the least restrictive environment (LRE).

The indicator reads as follows:

Percent of children aged 3 through 5 with IEPs attending a:
Regular early childhood program and receiving the majority of special education and related services in the regular early childhood program; and
Separate special education class, separate school or residential facility. [20 U.S.C. 1416(a) (3) (A)]

Current data on LRE (Indicator 6 from the Annual Performance Report) indicate the overall percentage of children in California ages 3 through 5 years with Individualized Education Programs (IEPs) attending a regular early childhood program with typically developing peers and receiving the majority of special education and related services in the regular early childhood program is only 20.2 percent.

One major contributing reason why LRE numbers are so low is the limited availability and capacity of existing preschool programs to provide spaces for individuals with special needs. Only about 40% of public school districts in the United States even offer preschool, and where it is available, it is mostly part-day with specific criterion for acceptance that limits access to many children and families. In addition to access issues, there are significant racial disparities that plague our current system, as well as alarming rates of suspension and expulsion of High Risk students. According to a recent Yale study, which is the first nationwide study of expulsion rates in state-supported preschools, findings indicate that preschools are expelling students at three times the rate of K-12 schools. Boys are being expelled from preschool 4 1/2 times as frequently as girls. African American preschoolers are twice as likely to be expelled as white or Latino children, and five times as likely as Asian Americans. Twice as many 5-year-olds face the threat of expulsions as 4-year-olds. This data indicates that although children are being identified with risk factors and behaviors, the current system and model resorts to expulsion rather than interventions as the means of addressing high risk students.

The federally funded preschool program, Head Start, is required to reserve 10% of spots per individual grantee to children with special needs. However, that does not come close to the actual numbers of Head Start eligible preschool students with special needs who require a program. To its credit, Head Start is the only preschool program in California that does have a policy of reserving spaces for students with disabilities. Many of the students with disabilities enrolled in Head Start are those with less severe disabilities, including speech and language delays. Because Head Start is not an option for most children with more significant disabilities, there are even fewer options for a preschool program with typically developing peers for these children. Presently, The California State Preschool program does not carry the same requirement to reserve spaces for children with special needs. According to the California Resource and Referral Network and California Childcare Portfolio, Children Now Data book, only 8-10% of 3-4 year olds receive Head Start or State preschool services. Three out of every four children who are eligible for State Preschool or Head Start are not able to access these programs due to limited capacity issues.

In efforts to meet the IDEA Part B obligation to provide a Free and Appropriate Public Education to eligible students between the ages of 3-5 years, many Local Education Agencies (LEAs) have established non-categorical special day classrooms taught by credentialed special educators. While these preschools are often not able to provide opportunities for interaction with non-disabled peers, they do provide opportunities for intensive instruction to take place and a classroom context to begin work on school readiness. The issues and challenges related to this type of a service delivery system, aside from the obvious lack of LRE related to outcomes, also include challenges of managing costs of transportation and access to facilities, resources to support the current entry and transition process and the lack of a universally adopted set of standards inclusive of assessments that monitor student progress in those standards.

Conceptual Recommendations: Least Restrictive Environment (LRE)

1. The Early Childhood Special Education Workgroup supports access to the LRE for preschoolers with special needs and those who are at risk of disabilities. We support a requirement that state preschools must serve a percentage of students with special needs. We support policy and fiscal incentives for local education agencies to provide affordable preschool programs that promote inclusive practices and options. Examples to promote inclusive preschools include: Rural collaboratives or consultative supports for childcare/community preschool centers (e.g., using telemedicine/technology), blended programs by adding a permit teacher to the non-categorical special education classes currently offered by LEAs, and public school employee preschools that are blended (refer to Texas Education Agency and Education Service Center, Region 20, 2014).
2. We support having a method of preschool entry that promotes a more seamless transition from IDEA Part C (birth to three) to Part B (three to 22). Examples include having 2-3 different “entry” points across the year (e.g., August, January, June). These set but staggered start times would allow teachers to bring new students into the school routine at predetermined times of the school year, rather than bringing new students into the school year on their third birthday. Personnel and resources could be allocated based on actual numbers and students could be taught critical school routines as a unit, as opposed to trying to integrate a new student into existing routines. This will require better coordination between Part C and Part B services and possibly exercising the states right to extend Part C services. [635(c) (1)].

Issue #2: Provider Competencies and Workforce/Teacher Preparation

The first task in identifying provider competencies was for our workgroup to define who is a “provider” of early childhood special education. To this end, we identify a distinction between “schooling”, “childcare” and “early intervention services.” Schooling, consistent with the demarcation between Parts C and B in the IDEA, occurs at age 3, at which point

in time a child who qualifies for Part B services would receive special education and related services through the IEP. Providers of specialized academic/pre-academic instruction and designated instructional services are providers. Before that age, children with disabilities may receive Part C services, referred to as early intervention programs/services and infant development programs, which may include special instruction and/or other supports. For our purposes, early intervention/infant development providers do fall under the umbrella of special education as providers. Childcare may take place at anytime from birth on. Although childcare providers (licensed through community care licensing) certainly do serve in a role that can influence development, their services are intended to provide for the health and comfort of the young child, as well as to address economic development issues by allowing employment of parents. This role and expectation does not fall under the umbrella of special education and therefore, childcare workers are not considered providers.

Depending on the context in which the child is being served and under which umbrella the service falls (e.g. Part C, community care licensing, Part B), there exists substantial variation in the current personnel requirements and standards for training. For example, in a community care licensing circumstance, a childcare provider is only required to attend an orientation and pass a home inspection and the required background checks to assume responsibility for caring for young children. There are not currently any academic classes required or competencies that must be demonstrated to become a childcare provider. Under Part C, for vendored (or contracted) early intervention and infant development service providers of the Regional Center, who provide more than 90% of the Part C services in our state, section 56724 of the Title 17 regulations indicates that direct care staff of infant development programs must possess the following minimum qualifications:

- (A) Education and experience required in the job description; and
- (B) The ability to perform the functions required in the program design. In addition,
- (C) The vendor shall assign staff to carry out administrative support functions.

To work as a child development/preschool teacher or associate teacher in any state funded child development center, the requirements include the completion of early childhood education units as well as completion of a required number of hours of experience, which vary based on the level of teaching (e.g. lead teacher versus teaching assistant) (Title 5). It should be noted that the hours of experience do not have any supervision or competency measures required.

Under Part B as well as Part C, where service for Low Incidence Disabilities is provided through local education agencies, personnel are required to possess appropriate California teaching credentials, which require the completion of a degree program, a teacher credentialing program that meets the California Commission on Teacher Credentialing (CCTC) requirements, passage of subject matter exam(s), completion of student teaching/supervision and a teacher induction program operated by the employer during the first two years of holding a teaching position.

There needs to exist a range of viable contexts for early intervention services and supports to take place, which requires a more robust training for ALL providers of early childhood programs and a standardization of qualifications. The nature of training should go beyond simply identifying the number of classes that a provider is required to take to be “qualified” and should instead embody the development of both knowledge and demonstrable competencies. The content of training and competencies should be differentiated based on the nature and context of the providers work, and should promote flexible assignments with the ability for practitioners to progress upward in an Early Childhood Education career.

The California Department of Education (CDE) in collaboration with First 5 established the California Early Childhood Educator (ECE) Competencies (2011). The ECE competencies were designed to align with significant initiatives and resources in the early childcare and education field. For example, the competencies reflect an effort to maintain consistency with the California Community Colleges’ Early Childhood Curriculum Alignment Project (CAP) and the California State University Baccalaureate Pathways in Early Care and Education (BPECE). This type of alignment is important to promote the scaffolding of skills and competencies that would allow upward mobility of Early Childhood Education (ECE) professionals. The Interagency Coordinating Council (a required advisory group pursuant to Part C) approved these standards and is in support of these standards being applied across provider systems (e.g. standards that all regional center vendored providers and LEA providers must possess). Currently, however, the Department of Developmental Services (DDS), which is the lead agency for Part C indicates that these personnel standards are “available as a resource, but not required.”

While the California ECE Competencies provide a platform for standardization, they do not, however, include a focus on a Multi-Tiered System of Supports (MTSS), Universal Design for Learning (UDL), nor content on Positive Behavior Interventions and Supports (PBIS), leaving out some critical evidence-based practices and frameworks that are highly relevant to serving students with special needs and those who are at risk (including male children of color as indicated previously). Furthermore, they do not provide a suggested method for assessing or supporting provider implementation outside of classroom didactic instruction/coursework.

Research on effective professional development has clearly indicated that didactic, theory-based professional development or training does not result in changes to implementation. In order for staff development to actually impact practices, there must be the added cycle of demonstration, practice, coaching, reflection and feedback. As indicated in the table below, research on professional development outcomes strongly supports the added aspects of practice with coaching support and feedback to promote the actual transfer and use of skills into the classroom (Joyce and Showers, 2002).

	Knowledge	Skill	Transfer to Use
Study of Theory	10%	5%	0%
Demonstration	30%	20%	0%
Practice	60%	60%	5%
Coaching and Feedback	95%	95%	95%

Competency-based teacher preparation /credentialing should promote:

- Flexibility in staff assignment
- Developmentally appropriate, evidenced-based, high quality first teaching, including Universal Design for Learning
- Data informed intervention, including universal screening and progress monitoring
- Improved access to the Least Restrictive Environment
- Consultative teams that employ a multidisciplinary problem-solving approach to intervention
- Differentiated Instruction
- Tiered access to more intensive interventions when necessary and indicated

Key Documents/Resources:

- California Early Childhood Educator Competencies:
www.cde.ca.gov/sp/cd/re/documents/ececompetencies2011.pdf
- Early Start Personnel Manual:
www.dds.ca.gov/earlystart/docs/ICC_PersonnelManual.pdf
- California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health: cacenter-ecmh.org/wp/wp-content/uploads/2012/03/Training-Guidelines-031212.pdf
- Curriculum Alignment Project for the Community Colleges:
www.childdevelopment.org/cs/cd/cd/print/htdocs/services_cap.htm
- Special Education Credentials (all ages – DEC/CEC personnel standards
http://www.dec-sped.org/About_DEC/Personnel_Standards_for_Early_Intervention_and_Early_Childhood_Special_Education
- CONNECT Modules: community.fpg.unc.edu

Conceptual Recommendations: Teacher Qualifications/Personnel Preparation and Training

Overall, the intent of these recommendations is to create a system that, by design, promotes a high level of fidelity in the implementation of evidenced- based practices, statewide. This workgroup is keenly aware that simply increasing requirements will only result in a statewide shortage of “qualified teachers”. For this reason, we believe that new levels of competency will need to be acquired by current practitioners over time, based on individualized professional development plans and the targeted use of

professional development funds to enable teachers to “true up” to the new proposed competencies”, being given full credit for competencies already demonstrated to date (similar in concept to the Elementary and Secondary Education Act’s High Objective Uniform State Standard of Evaluation “HOUSSE” provision).

1. We support the full adoption of the CDE Early Childhood Educator Competencies and believe that these should be the minimum standards that are required by all providers of Part C services both through the Department of Developmental Services/Regional Centers and through CDE.
2. We support a more robust pre-service training program for credentialed teachers, for Preschool Teachers and Early Childhood Providers that includes more content and competencies in Child Development and in Atypical Development, Cultural Competency, English Language Learner/Dual Language considerations, Universal Design for Learning (UDL), Multi-tiered System of Supports (MTSS) and use of Evidence Based Practices, Positive Behavior Intervention and Supports (PBIS) and Special Education Laws/regulations. In addition, we support a competency-based model for professional development rather than the current model based primarily on the completion of coursework, pencil and paper testing, and limited field-based observations and experiences.
3. We support a more robust training for Special Education teachers, built on the foundation of the general education credential as characterized above that emphasizes competencies aligned with the CDE Early Childhood Educator Competencies and that supports the development of consultation and collaboration skills to better support an MTSS model. The intent of this approach is to replace the current mild-moderate and moderate-severe credentials that limit flexibility in assignment, with a single, broad special education credential that covers a wider range of service, based on a much more comprehensive approach to competency-based teacher preparation. Supplemental authorizations should be kept to a minimum, as restrictions limit flexibility in staff utilization (low incidence disabilities such as for students who are Deaf or Hard of Hearing or Blind, for example will still be warranted).
4. We support a more robust model of coaching/and ongoing competency-based monitoring to support fidelity of implementation by teachers and implementers in the classroom. We support a more robust training program, also based on the identified competencies for Administrators, to enable them to support and evaluate ALL teachers in their work with all students.

Issue #3: Preschool Standards and Progress Monitoring

In addition to the lack of standardization and consistency of personnel standards, Student Learning Standards vary across organizations and providers in our State. Private

community care licensed preschools are not required to implement any learning standards, and instead have a provision of the child's rights which outline the child's rights for safety, dignity, health and comfort.

A set of standards developed by CDE in 2008, called the California Preschool Learning Foundations followed in 2009 with the Infant and Toddler Learning and Development Foundations, outlines key developmental skills that most children can achieve when provided with the kinds of interactions, instruction, and environments that research has shown to promote early learning and development. The foundations provide early childhood educators, parents and the public with a clear understanding of the wide range of knowledge and skills that preschool children typically attain when given the benefits of a high-quality preschool program. See the link for the Preschool Learning Foundations: <http://www.cde.ca.gov/sp/cd/re/psfoundations.asp>.

While these standards are supposed to be used within all publicly-operated programs, most special education preschool programs are not aware of or actively using these standards. There has been limited attention to the implementation of a set of core standards in preschool and early childhood programs, in spite of the significant attention that has been paid to State Standards and now, Common Core State Standards for school-aged children.

In contrast to state-funded centers, federally-funded Head Start uses the Head Start Child Development and Early Learning Framework. It aligns with and builds from the five essential, or core, domains for children from birth through age five school readiness, focusing on critical areas of learning and development for 3 to 5 year old children, including dual language learners and children with disabilities. The Framework guides curriculum selection, implementation, and assessment and can be used when planning and assessing teaching and learning experiences and children's progress toward school readiness goals. See the link to the Head Start frameworks: <http://eclkc.ohs.acf.hhs.gov/hslc/sr/approach/cdelf>

With the absence of a common set of standards, there can exist limited accountability for reporting accurately student growth and outcomes. This challenge of being able to report growth and outcomes is an issue that is currently plaguing our Part C services and aspects of our annual performance measures for Part B. As we move into the new federal Results Driven Accountability framework, the lack of standards and measures designed to both inform instruction, real time, and accurately monitor student/child growth will become a more pronounced issue that must be addressed.

Currently mandated assessments required by the state (the Desired Results Developmental Profile (DRDP) – Access) are not universally being perceived by providers as informing instruction on a real time basis, either because they were not introduced to the field in that manner, are cumbersome in their ability for teachers to access the essential information they need on a daily basis, or both. In its current form, presently teachers are not consistently using the DRDP Access assessment to inform families of present levels or to inform instruction in order to result in better student

outcomes. The current use of the DRDP Access is functioning in too many cases as a compliance-only system. The primary purpose of assessment should be to continuously improve learning by informing standards-based instruction, also accounting for children's individual growth and development (which is quite variable in the early years as noted previously), with compliance and summative accountability functions emanating out of that assessment as secondary priorities.

Until recently, MTSS has been viewed as a K-12 initiative, but many programs and states are applying core principles of Response to Intervention (RTI) (here forward to be referenced as the broader systemic MTSS) in Early Childhood (EC) programs because these core principles align with EC-recommended practices (Greenwood et al. 2011).

Among the core principles of various MTSS approaches that align with recommended practice in EC are the following:

- Specification of a multi-tiered system of supports;
- Early provision of support and intentional teaching /Intervention with sufficient intensity to promote positive outcomes and prevent later problems;
- Use of child data to inform teaching and responsive intervention practices; and
- Use of research-based, scientifically-validated practices to the maximum extent possible (Batsche et al. 2005).

Such principles are at the core of EC-recommended practices related to assessment, intentional teaching, differentiated instruction/Universal Design for Learning, and ongoing progress monitoring (Coppie & Bredekamp 2009; Division for Early Childhood, 2007; NAEYC & NAECS/SDE, 2003; Sandall et al. 2005).

Response to Intervention in EC may be seen as a means of providing high-quality teaching and responsive caregiving through the delivery of differentiated support for all young children. In other words, in EC, MTSS frameworks are a means for implementing a hierarchy of support that is differentiated through a data-based decision-making process (Greenwood et al. 2011; National Professional Development Center on Inclusion 2012). As MTSS frameworks have evolved in EC, four common features have emerged: a multi-tiered system of teaching and caregiving practices; a high-quality curriculum; ongoing assessment and continuous progress monitoring; and collaborative problem-solving among team members.

Conceptual Recommendations: Student Outcomes and Evidence-Based Practices

1. We support the use of one set of standards/foundations to be used across the state and across all early childhood and preschool programs irrespective of lead agency – specifically, all providers of public-funded and publicly-operated preschool and/or infant development programs should be required to use California's INFANT/TODDLER and PRESCHOOL LEARNING FOUNDATIONS, already developed and presently required in State Preschools. We are also aware of California's Quality Rating Improvement System (QRIS), which could also be

referenced. Therefore it is recommended that the legislature enact law to this effect.

2. We support the use of a tiered system of interventions at the preschool level, recognizing that due to the individualized nature and variations of early child development that Universal Screening and some other components of the model will need to vary from a traditional K-12 MTSS model. Many of these variations have been addressed in the Office of Special Education Programs (OSEP)-funded project called CONNECT: the Center to Mobilize Early Childhood Knowledge (University of North Carolina's, Frank Porter Graham Center). See <http://connect.fpg.unc.edu/sites/connect.fpg.unc.edu/files/resources/CONNECT-FactSheet.pdf> . This project provides training modules and Technical Assistance resources to implement this model of tiered supports. In addition, the CSEFEL/TACSEI (Center for the Social and Emotional Foundations for Early Learning/ Technical Assistance Center on Social Emotional Intervention) project has outlined core components for social emotional development that also fit into the tiered system of support.
3. We support a single valid measure for preschool-aged students that monitors individual student progress/growth in the adopted curriculum/standards (Preschool Learning Foundations), whose primary function is to continuously improve learning by informing instruction and from which data can be extracted for compliance indicators that are organic to instruction and meaningful with respect to student progress. We recommend one measure that is used for ALL children, not just children with disabilities that can be implemented with fidelity across ALL preschool teachers (properly authorized teachers including those with special education credentials and degrees - competencies). NOTE: it is the opinion of this Subcommittee membership in a review of the current required assessment (DRDP – Access in its current form), that it does not appear to meet these criteria.

Issue #4: IDEA Part C; and Part C to Part B Transition

The Subcommittee has reviewed several documents and data sets in the presentation of the recommendations for improving services for children, infants and toddlers, under the Part C Early Start Program (including the annual performance reports, State Systemic Improvement Plan). We have also interviewed representatives from the CDE, the Department of Developmental Services and the Infant Development Association to better understand opportunities for improvements to eligible individuals and their families. Information from other states was also considered including a report prepared by the National Early Childhood Technical Assistance Center (NECTAC) regarding Part C lead Agencies (See NECTAC Notes No 26, www.nectac.org).

At present, the Department of Developmental Services (DDS) serves as the lead agency in California for Part C Early Start, the program for infants, birth to age 3. Early Intervention Services and Infant Development Programs are provided through a Purchase of Service (POS)/vendor system that is managed by the twenty-one independently-operated 403B Regional Centers statewide. CDE, through some of the SELPAs, provides infant development services for children ages birth to three.

Additionally, the Department of Healthcare Services (DHS) is also involved, to the extent that Medi-Cal is an offset to some services provided through the Regional Centers and is the lead agency providing the Healthy Families Program. Infants, young children and families may also come into contact with providers through the Department of Public Health Services, who oversee the Center for Family Health programs (Maternal Childhood and Adolescent Health {MCAH}, Women Infant and Children {WIC} and the Genetic Disease Screening Program). The system for serving infants, young children and their families in California is fragmented and inefficient. Parent stakeholder input and State Performance Plan reports indicate that the current distribution of services and funding responsibilities results in a system with widely varying experiences for families and outcomes for children. The competing budgetary interests across state agencies, as reflected in state budget decisions in recent years has not helped. Due to the diffuse construction of our current system, it is possible that significant federal Medicaid dollars are left without being accessed that might otherwise benefit Part C eligible children and their families. Further, there have been challenges in coordinating the efforts of the CDE and DDS in compliance with the federal government's data reporting requirements, resulting in disruptions in the flow of funds to LEAs who provide services under Part C.

In reviewing the Annual Performance Report for Part C (2012), Table 4, on page 21 (<http://www.dds.ca.gov/EarlyStart/docs/PartCAnnualPerformanceReportFY2012.pdf>) illustrates the wide variability across the Regional Centers (RCs) related to Indicator 3 (Percent of Infants and Toddlers with Individual Family Service Plans who demonstrate improvement in Social Emotional Skills, acquisition of knowledge and skills, and use of appropriate behaviors). This wide range of child improvement in these domain areas could be the result of variable service quality and access between centers or a result of the lack of a consistent metric for measuring progress across centers, or both.

Data from the same report looking at Indicator 4: percentage of families who report that Early Intervention services have helped the family to know their rights, communicate their child's needs and help their child develop and learn indicates a significant discrepancy between families receiving services through the regional centers as compared to those receiving services through the LEAs. The parent survey scores reveal that on average, parents rate the helpfulness of services received through LEAs 12% higher than those received through regional centers. For full descriptions of the parent survey questions and a direct comparison of scores refer to Table 1, indicator 4, on page 28 of the Annual Performance Report.

Several of the Indicators in the 2012 APR for Part C showed slippage from previous years. These include indicator 1 (number who received timely services), indicator 2

(number served in natural environment), indicator 5 (number of infants served compared to National Average), and indicators 8a and b (timely transition planning from Part C to Part B). There are two theories offered as to why there was slippage from previous years. First, DDS/RCs were denied authority (that they previously had) to serve “at risk” children who, presumably, have less severe impairments, excluding outcome data for “at risk” children, which therefore, may have “skewed” the sampled children downward (by eliminating the higher performers). Alternately, and supported by DDS provided data, many of these children may have been served anyway, but under a different Part C eligibility. If true, this may also be attributed to varying policy interpretation regarding eligibility across Regional Centers.

Based on all data that is available, it is clear that our current system is not working and needs to be reevaluated. National research regarding other states’ approaches to funding, delivery of services, and improved outcomes for children under Part C may offer an alternative. The American Academy of Pediatricians (AAP) have described for years, a model that integrates medical service delivery and case management for children and families known as “Medical Home Model.” In its initial version, the AAP defined the medical home as the center of a child's medical records. At the time, the care of children with special health care needs was the primary focus of the medical home concept. Over time, however, the definition of the medical home has evolved to reflect changing needs and perspectives in health care. The modern medical home expands upon its original foundation, becoming a home base for any child's medical and non-medical care.

Today's medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. In this model, the physician delivers direct medical services, and also provides parent education and case management support (connecting families to related agencies and other service providers). In fact, this is a primary function of Early Start services, and as a result, the most popular lead agency nationwide for Part C/Early Start is neither Education nor Developmental Services, but rather, the Department of Health Services. In fact, 24 states including Massachusetts, New York, New Jersey, Wisconsin and Florida all employ this model.

In our view, Massachusetts is the exemplar for a few reasons. First, they take the long view regarding the provision of health services to citizens, who may likely require support from the State for a significant period of their lives, if not for lifelong support. Under their model, early intervention is key to enhanced outcomes, long term cost containment, and maximizing federal contributions to the total costs of providing medically necessary services for these individuals. In that state, by virtue of an IDEA-related diagnosis, the child is rendered Medicaid-eligible (Early and Periodic Screening, Diagnosis and Treatment -EPSTD), and all public schools are deemed Medicaid clinics for the purposes of service provision and billing for EPSDT Medicaid funding. To the extent that California schools continue to provide any services under Part C (or Part B for that matter), the Massachusetts model provides an innovative way to offset total costs.

Traditionally, special education embodies a story that relies on the distinction between educational need and medical necessity. We question whether this story continues to serve the children in optimal fashion. There may be an alternative story that leads to better services and outcomes for our youngest (aged birth-5) and most vulnerable to school failure, including trauma-exposed, chemically-exposed, autistic, and children stressed daily by impoverishment - many of the very children targeted by the local control funding formula.

Consider the Desert Mountain SELPA Care Clinic, which is a trans-disciplinary model. By referral through a trans-disciplinary screening team, children are referred to the Care Clinic for 60 days of diagnostic intervention. Children and their parents receive intensive "front loading" of evidenced-based practices to assess the medical and overlapping educational implications of those medically-diagnosed needs (mental health, language development, behavioral, and sensory-motor) through this clinical trial (aka RTI) assessment model. The assessment process informs eligibility and further service under the IDEA, and the clinic provides the assessment to the IEP team and assists in transitioning to the child's next learning environment. In fact, the 60 days of intensive services received leads to some children not needing any further intervention at all. Those that do, and their parents, come to the learning in far better shape, and are able to be served in less restrictive educational settings. A very different "story", indeed.

This service is made possible due to the Desert Mountain Children's Center's ability to access Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding for medical evaluations. This access is not available to all SELPAs or LEAs statewide, but only under contract to, and at the discretion of County government. The authority for County government to have sole proprietary access to EPSDT for specialized mental and healthcare services, including assessments, comes from a waiver to the state's managed care plan, under the direction of the State Department of Health Care Services. This waiver is known as a "freedom of choice" waiver, which creates a monopoly for county government to be the sole provider of specialized mental health care for MediCal beneficiaries, statewide.

Conceptual Recommendations:

1. Based on the continual underfunding of Part C, the challenges with diffused responsibilities for the funding, provision of services, and unacceptable performance outcomes of early intervention services across multiple state agencies, it is recommended that the responsibility for the Part C Early Start program be centralized under one state agency.
2. Given the limited role that the education community currently plays, serving less than 6000 children eligible for Early Start presently, the Subcommittee does not believe that CDE is the appropriate agency to operate Early Start moving forward. Further, given the diffuse governance structure and concomitant inconsistency of delivery and resultant outcomes in Regional Centers across the state, DDS is also not recommended to manage the Early Start program moving forward either.

Instead, we suggest a review of options through the Department of Health Care Services to possibly lead Early Start in California moving forward in concert with their sister agency Department of Managed Care (lead agency for MediCal), the opportunity to apply medical constructs and the incentive for the state to maximize the federal contribution for the provision of these services, as has recently been the case with respect to MediCal's coverage of behavioral healthcare services (Applied Behavioral Analysis, ABA) for children with autism.

Senate Bill 946 declared these services as "medical" for coverage under private health insurance in California as well. Recent policy has also indicated that "Behavioral Health Treatment for ASD" will be covered by MediCal. This is a major population eligible under Early Start presently, and it only makes sense to align the program fully to this new fiscally and clinically prudent approach. This new alignment may result in a better funded program, with clearer outcomes, that are consistent with the American Academy of Pediatricians' initiative regarding "medical family homes". CDE would continue responsibility as lead agency consistent with Part B eligibility at age 3.

3. The Subcommittee further recommends that LEAs be provided direct access to EPSDT funding for healthcare services, including for mental health services and trans-disciplinary assessments. This would act both as an equitable funding mechanism and as an incentive for schools to intervene early, by providing targeted services BEFORE those children most vulnerable to school failure - those who are trauma exposed, chemically exposed, with autism, developmentally challenged, and children stressed daily by impoverishment- would require even more intensive services. This may be accomplished through the elimination of the Freedom of Choice waiver currently in the state's managed care plan or through another mechanism to allow LEAs direct access to the federal EPSDT funding. This funding mechanism would then be able to offset costs of any eligible service that is both medically and educationally necessary for students who are dually eligible under both Medicaid and IDEA entitlement programs. The Sub-Committee understands that such a review and potential change could necessitate a change in the state's managed care plan, consistent with the revision currently being completed regarding coverage for ABA, as well as the possible need to shift J-50 funding and other required components of Part C as appropriate to follow the shift in responsibility.

Alternately, if not needed to fully fund the proposed realignment of responsibility, these dollars could be redirected to improve pre-school funding, which has been seriously underfunded for years. Current J-50 program operators should still be available and eligible to serve these populations, but as a fully-funded vendor to DHCS, on a fee-for-service basis. This would ensure that the costs of services provided are fully covered, but also, cost-contained for the State, as MediCal sets statewide rates for billable services. As is the case for case management and collateral service codes availability to county mental health to bill under EPSDT, so should be the case for vendors under the Early Start Program under Part C.

This would fully enable the family medical home model, which is also aligned with Part C. Thus, the intent and historically provided services available through Early Start are honored, while combining J-50 state dollars, federal Early Start Part C dollars, private insurance and additional federal contributions through Medicaid all come together under one umbrella to better serve eligible children. Indeed, with the epidemic rise in the autism population (currently one in every 66 according to the Center for Disease Control), such an approach may be essential in getting the early intervention services necessary to all children who qualify, thereby maximizing the opportunity for school readiness when children are evaluated for eligibility at age 3 under Part B of the IDEA. As well, it would mitigate costs, long term, for the state of California for students who will need ongoing support through special education and other state agencies throughout the lifetime of these most vulnerable of citizens.

Issue #5: Parent Participation

Researchers have evidence for the positive effects of parent involvement on children, families, and school when schools and parents continuously support and encourage the children's learning and development (Eccles & Harold, 1993; Illinois State Board of Education, 1993). According to Henderson and Berla (1994), "the most accurate predictor of a student's achievement in school is not income or social status but the extent to which that student's family is able to:

1. Create a home environment that encourages learning
2. Express high (but not unrealistic) expectations for their children's achievement and future careers
3. Become involved in their children's education at school and in the community (p. 160)

More than one out of every eight students in America is classified as having a disability under the provisions of IDEA (National Center for Education Statistics, 2010). Yet nearly every metric used to measure post-high school success (employment, independent living, post-high school education/training) shows the majority of students with disabilities do not succeed (NCES, 2010). The chief safeguard for special education students are their parents, who are explicitly written into nearly every aspect of the special education process. Research shows that, as parents become more involved and empowered in the special education process, outcomes for students improve (Stoner et al., 2005), which underscores the importance of collaboration between parents and educators (Fish, 2006). Goodall and Bruder (1986) emphasized that educators seek and use parental knowledge because no one knows a child better than his or her parent. Unfortunately, parents in many cases do not possess the confidence with legal and procedural knowledge they need to assert their role in the special education process.

In addition to parents' involvement in the IEP process, there is no question that parental involvement in the use of effective and evidence-based practices (EBPs) results in better

outcomes for students. Dunst, Trivette, & Hamby,(2007) found in a meta-analysis of family-centered help-giving practices that parents who feel empowered about their parenting capabilities are more likely to provide their children with development-enhancing learning opportunities. This requires that parents are involved in trainings and are provided with hands-on support and coaching similar to what educators have, to master the use of newly-acquired skills for implementing EBPs.

Not only do research and evidence-based practices indicate that parent training and involvement is critical, the provision of service in IDEA specifically states that parent counseling and training can be provided as a related service: (i) parent counseling and training means assisting parents in understanding the special needs of their child; (ii) providing parents with information about child development; and (iii) helping parents to acquire the necessary skills that will allow them to support the implementation of their child’s IEP or IFSP.

SB 511, Children with Disabilities, CHAPTER 4.3: FAMILY EMPOWERMENT CENTERS ON DISABILITY outlined:

“56400. It is the intent of the Legislature, through enactment of this chapter, to the extent feasible, to do all of the following: (a) Ensure that children and young adults with disabilities are provided a free and appropriate public education in accordance with applicable federal and state law and regulations. (b) Ensure that children and young adults with disabilities receive the necessary educational support and services they need to complete their education. (c) Offer parents and guardians of children and young adults with disabilities access to accurate information, specialized training and peer-to-peer support in their communities. (d) Ensure that parents, guardians, and families of children and young adults with disabilities are full participants in their child’s education, school reform, and comprehensive systems change efforts. (e) Build upon existing local and regional service delivery systems to improve, expand, and offer coordinated technical assistance to the network of existing resources available for parents, guardians, and families of children and young adults with disabilities.”

While it is clear in the original legislation that the intent was to provide this mechanism of parent training and support through the Family Empowerment Centers across California, over 285,000 children and youth with disabilities live in counties that are not served by a Family Empowerment Center. That means that over forty percent (40%) of the families in California with children with disabilities receiving special education services are without access to the education, information and support provided through Family Empowerment Centers.

Conceptual Recommendations:

1. We recommend full funding for Family Empowerment Centers (FECs) statewide as legislated in SB 511. Currently only 14 FECs are funded while there are 32 FEC regions statewide. Funding for the remaining 18 Centers must be put in place by the legislature. In addition, we suggest consideration of an increase to funding support for the Family Resource Centers, who have not seen an increase in

funding since their inception even though they have seen a significant increase in the number of Early Start families receiving their services and supports. The Parent Training and Information Centers alone cannot adequately serve all of the families throughout California's diverse population and immense geography. The FRCs/FECs provide parents with parent-to-parent support, special education system navigation, trainings on the IFSP/IEP process and parent rights, and many other parent-friendly services and community collaborative supports.

2. We support the establishment of a data collection system to determine the outcomes and impacts that result from the work of the FRCs/FECs. Although this was not required in the original legislation, with the recent shift in focus from compliance to "Results Driven Accountability" (i.e., outcomes) it seems prudent to consider a system for looking at this related to the work of the FRCs/FECs.
3. We support increasing efforts for parent involvement and training as partners in the education of their child with disabilities. In addition to expanding and fully funding the FRCs/FECs to provide training to families in advocacy and navigation of service systems, we believe there must be efforts to involve families in training on the use of evidence-based practices (e.g. positive behavior supports, evidence-based reading/academic interventions, evidence-based practices for Self Advocacy, etc). We believe that this training should include follow up coaching and support for implementation. Through parent training, families will not only gain valuable information, techniques and strategies that they can use at home to increase progress, but parents and caregivers can also become valued assets and full participants in the IEP process and in the classroom as volunteers.
4. We support cross-agency and community-based trainings that are inclusive of families and providers across agencies (school personnel, regional center personnel and vendors along with parents sitting side by side receiving training in effective practices). Parents are often seeking help with academic skills/homework support, adaptive skills, behavior, communication and other challenges and often receive supports from schools and their Regional Center in isolation. The strategies that are suggested or in use may not be coordinated or even in agreement. Cross-agency, community-based training models will improve outcomes, relationships and help to build local capacity.