Policy Brief: Introduction to Early Intervention & Recommendations for Future Directions

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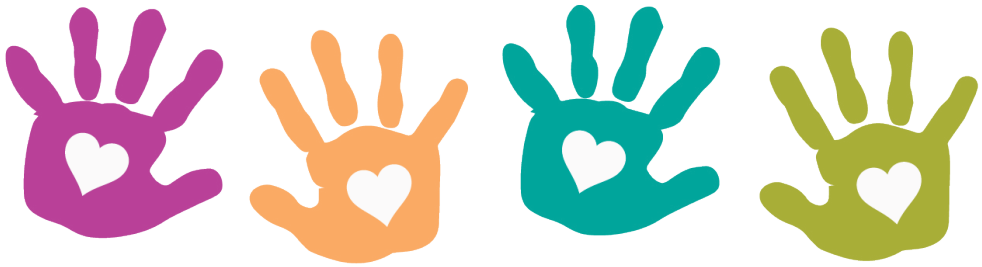
What is Early Intervention?

The **Individuals with Disabilities Education Act** (IDEA) is legislation that secures individualized and developmentally appropriate services for children with disabilities.[1] Through IDEA, **Early Intervention** (EI) services cover a multitude of childcare programs and interventions (e.g., social and motor evaluation, speech, and language therapy) geared towards advanced detection of developmental health delays in children under five years of age, regardless of their household income.

Part C of the Individuals with Disabilities Education Act (IDEA) emphasizes discovery of disabilities or risk of delay in infants and toddlers from birth to age three, with the goal of meeting their individual needs to enhance development. Though EI programs employ a mandated framework, funding levels and much of the program implementation are guided by the state, leaving room for variation in service provision.

Mississippi has the fourth lowest Part C enrollment rate (3.2%) in the nation, and 31% of young children, from birth to age five, experience poverty.[2,3] Poverty places children at increased risk of developmental delay by affecting their immediate environment through parental stress, familial strain, food insecurity, lack of access to healthcare, and a plethora of other adverse experiences.[4,5] In some states with child poverty rates comparable to Mississippi's, Part C enrollment is among the highest nationwide. For example, New Mexico retains the highest rate of age-eligible children enrolled in Part C (21.9%) and has a 28% child poverty rate. Similarly, West Virginia has 13.8% of age-eligible children enrolled in Part C and a 22% child poverty rate.

Part B special education services are provided to children from ages 3 to 21. Part B and Part C must work closely to promote harmonious transition from Part C early intervention programs to Part B special education programs, which are provided through public school districts. Approximately 25% of children exiting Part C programs are found to be eligible for Part B programs in Mississippi, as well as in West Virginia and New Mexico. These states differ in enrollment continuation rates (WV-11.69%, NM-10.3%), however, with Mississippi retaining the lowest percentage (8.9%) during the transition from Parts C to B.



Marking Milestones Early is Key for Referral to Part C.

Early detection of developmental delays is essential for Part C referral and service provision. Key factors in this process are surveillance and screening.[6]

Surveillance

Developmental surveillance primarily refers to monitoring a diagnosed condition or a child's advancement toward developmental milestones.[7] Surveillance for developmental delay consists of observing child behavior, accounting for parental concerns, and considering environmental factors that may promote or adversely impact children's developmental health. Parents may informally observe their child's behavior using tools such as the Ages and Stages Questionnaire to ensure their child is meeting milestone.[8] This service is typically completed by a health care provider who may refer a child for more formal screening in the health care setting.

Screening

Developmental screening is employed to identify early symptoms or risk of compromised health with the goal of timely intervention to prevent the progression of any health challenges. This process is more formal and health care providers who initiate this process may examine a child and determine a need for Early Intervention services such as more thorough assessment.

Though these services differ, both screening and surveillance are integral parts of IDEA and are vital to prompt intervention for optimal health in children. The timing of developmental surveillance and screening is crucial and warrants further attention, as the rates of families who receive timely intervention within the Part C 45-day window vary among these states. The most recent data from 2019 indicates that percentages of eligible infants and toddlers receiving timely assessment after referral to Part C programs varied by state, as well, with Mississippi assessing 88.81% in a timely fashion, New Mexico assessing 94.06%, and West Virginia assessing 99.25%.[9] Children who receive earlier services may have better outcomes, as detection in earlier stages is associated with improved health.[10]

Policy Recommendations

Expand Early Intervention (EI) Eligibility Criterion. The expansion of eligibility criteria for Part C programs to include risk factors, or occurrences that could have negative implications for health, such as abuse or neglect, could increase the number of children receiving services. For example, maltreatment rates per 1,000 for children are 51.9 (MS), 86.6 (NM) and 119.1 (WV).[11] In New Mexico and West Virginia, eligibility requirements are broader than Mississippi's and include children who are "at risk" for a delay among children who do not have an established delay or disability. This "at risk" criterion typically includes low birthweight and prematurity but varies from state to state. The inclusion of risk factors in Part C eligibility requirements supports more proactive referral to EI from healthcare providers, resulting in more children receiving needed services that support their development at an earlier age. This is especially important as early detection and treatment of developmental delays improves children's lifelong trajectories and promotes more cost-effective strategies in the special education system.

In Mississippi, 12.3% of babies were born with a low birthweight in 2021, making it the state with the highest rate of low birthweight children born in the nation. The cumulative percentage of children under age three receiving EI services in Mississippi, however, was 3.2% in 2021. Mississippi's low birthweight criteria for diagnosed/established conditions or at-risk classification used to determine eligibility for EI services is <1,500 g (about 3.31 lbs.), while low birthweight classification is <2,500g (about 5.5. lbs) in both New Mexico and West Virginia.[12]

Mississippi does not currently serve "at-risk" children under federal Part C policies. Increasing the criteria for low birthweight classification could increase the number of children who receive Part C EI services, while also including children who are at risk for delay.

Increse State Fund Allocation to Early Intervention (EI). As federal funding is geared toward program coordination and administration in existing state EI services, increases in state and/or local fund allocation can supplement these funds. In the highest performing EI states with similar child poverty rates to Mississippi, state funding successfully supplements federal funding. For example, in Mississippi, 23.2% of program funds are sourced from the state, while 90.2% of state funds in New Mexico and 78.2% in West Virginia are allocated from the state to supplement Part C programs.

Provision of Surveillance and Screening. While surveillance is imperative to marking children's milestones and promoting healthy development, it is not a holistic indicator of health and must be supported by regular developmental screenings to increase the rates of early detection of developmental concerns. In proactively implementing screening, healthcare providers can prompt advanced referral to EI services. For example, in states with higher EI enrollment, the developmental screening rate of children aged nine to 35 months in 2018-2019 was approximately that of half of the population in West Virginia (47%), a little lower in New Mexico (31%), and even lower in Mississippi (28%).[8]

Provision of Timely Assessment Post-referral to EI May Reduce Costs Associated with Special Education. A plethora of research finds that provision of health services once a challenge is detected is associated with more optimal health throughout the lifespan, beginning in childhood. Thus, once the need for EI services is assessed and determined, timely assessment following referral is essential. Nationally, 6.8% of children under 5 receive Part C services on average. Thus, if Mississippi increased current enrollment rates from 3.2% to match the national average, there is a projected savings rate of $3.5 million per year in special education services.[13]

Offer Services in Children's Natural Environments and Include Accessible Materials in Early Intervention (EI) Visits. Natural environments can refer to community, home, or any normative environment for the child that could allow for more individualized services. Provision of funding that is catered toward appropriate training to offer services in a natural environment may result in improved family engagement in EI services. For example, in states with the highest Part C enrollment, almost all Part C services are provided in natural environments (99.7%-WV, 98.8%-NM), compared with Mississippi's rate of 88.19%.[14] To increase the rate of children receiving services in natural environments, appropriate training for providers and adequate funding to expand these services is needed. One of the benefits of providing EI services in natural environments is that it allows for inclusion of families' own materials in EI visits. Using readily accessible materials in the child's home increases the ease with which the family can continue supporting the child's development in the absence of the provider. Prior strategists have referred to this tactic as the Bagless Approach, which emphasizes usage of items in the child's home that would be conducive to their routine once the EI visit has concluded, as opposed to bringing items to the home to conduct the visit.[15] That is, by increasing deliberate efforts to include materials that are readily available to the family (i.e., toys), the effectiveness of Part C services may be enhanced.

Offer Competitive Salaries to Retain and Recruit Qualified and Experienced Providers. Increasing funding for EI services would afford more competitive salaries to qualified and experienced providers, which could address concerns around health care provider retention and recruitment. When services are provided by qualified staff who are well-versed in skills to support young children's developmental health, families may engage more thoroughly in services, and interventions may be more effective. Therefore, increasing salaries and/or offering incentives through recognition and reward for performance may help ensure that contracted health care providers remain in the early childhood developmental health systems in Mississippi.[16]

Expand Medicaid Coverage. Implementing expansion of Medicaid eligibility criteria may increase enrollment rates, as states with higher enrollment rates and similar poverty rates (New Mexico and West Virginia) include this benefit. That is, including this benefit would afford more families in Mississippi eligibility for Medicaid-covered IDEA services.

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