New York City Department of Health

CULTURALLY AND LINGUISTICALLY APPROPRIATE EVALUATIONS: WHAT EVERY EI EVALUATOR IN NYC NEEDS TO KNOW

Module 1: What EI Requires According to Laws, Regulations, and Policies

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These modules address evaluations that:

Primarily rely on the results of standardized and criterion-referenced tests to identify a child's functional levels;

Describe a child's functioning level primarily by listing the child's performance on test items;

Fail to include and/or consider the child's background and prior experiences; and

Fail to show how the evaluator analyzed the data collected using informed clinical opinion.

These modules are also intended to:

Clarify what makes an appropriate evaluation;

Increase understanding in the clinical practice on what culturally and linguistically appropriate evaluations involve; and

Emphasize that the skills of quality evaluators are needed in and sought by NYCDOH EI.

Culturally and Linguistically Appropriate Evaluations:

- Bring the child to life;
- Analyze acquisition of behaviors and skills that reflect the child's prior experiences;
- Consider reliability, validity and bias issue in evaluation materials;
- Demonstrate understanding of the threshold level for eligibility;
- Synthesize appropriate data using quality informed clinical opinion to determine child's functional levels.

WHY DOES THIS TRAINING MATTER?

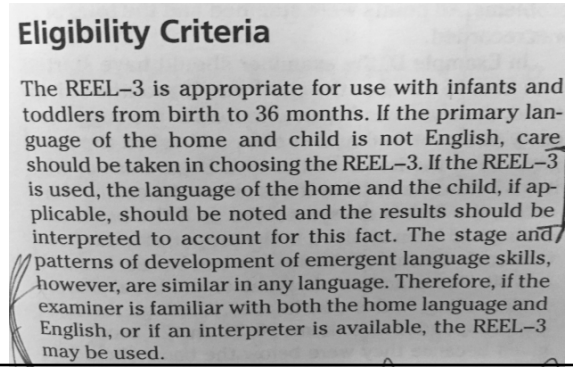
We want to increase the quality of EI evaluations so children who are eligible receive the appropriate services.

What would we want for our own children?

A problematical internal agency evaluation requirement

"My agency insists that the therapists use the REEL-3 for bilingual Yiddish/English-speaking children. My supervisor, an evaluator with over 30 years of experience, understands the weaknesses of standardized assessment tools and encourages me to rely on my knowledge of what is considered typical development in the community we are servicing. However, she complies with the regulations of the agency and continues to provide test scores. As a CFY, I have been doing the same. Today, I administered the REEL and it qualified for services a kid I was going to discharge!"

How could an evaluator give the REEL in any language based on this statement?



Eligibility Criteria

The REEL–3 is appropriate for use with infants and toddlers from birth to 36 months. If the primary language of the home and child is not English, care should be taken in choosing the REEL–3. If the REEL–3 is used, the language of the home and the child, if applicable, should be noted and the results should be interpreted to account for this fact. The stage and patterns of development of emergent language skills, however, are similar in any language. Therefore, if the examiner is familiar with both the home language and English, or if an interpreter is available, the REEL–3 may be used.

Any internal agency evaluation requirements must be consistent with culturally and linguistically appropriate evaluations

The majority of us have been working in EI for more than 11 years

Things have changed

The majority of us have been working in EI for more than 11 years

Laws and regulations have changed

The majority of us have been working in EI for more than 11 years

The people in EI have changed

The majority of us have been working in EI for more than 11 years

Appropriate clinical practice has changed

The majority of us have been working in EI for more than 11 years

Even the children we see are **different**

More **racially and ethnically diverse**

More **culturally and linguistically diverse**

More **bilingual**

What you may be asking…

<u>Question 1</u>: Will BEI accept MDEs in which there was no standardized test used to establish a development delay?

YES. However NYSDOH EI regulations and guidance state that an evaluator should use a standardized instrument when it is appropriate to the child's culture, language and developmental concern and the instrument has appropriate levels of sensitivity and specificity. It is incumbent on the MDE team to determine whether specific instruments meet the above requirements in relation to the unique characteristics of the child.

NYCDOH BEI Q and A, March 2016

<u>Question 1 (con't) :</u> Will BEI accept MDEs in which there was no standardized test used to establish a development delay? YES.

Regardless of whether a standardized instrument is used or not, all evaluators must

- Provide detailed clinical observations, informed clinical opinion and parent perceptions and observations about their child's development and any other pertinent information such as medical history, family history, etc. to support the child's reported level of functioning and developmental domain status.
- Reference developmental milestones and clinical clues/risk factors from *NYSDOH Clinical Practice Guidelines*.

NYCDOH BEI Q and A, March 2016

<u>Question 1 (con't) :</u> Will BEI accept MDEs in which there was no standardized test used to establish a development delay? YES

When a standardized instrument is used, scores should not be used in isolation to establish a child's eligibility status. Special attention should be given to whether test/instrument items or skills presented are appropriate to assess given specific knowledge of the individual child's prior experiences, the relevance for the individual family's culture and background and the functional relevance and the individual child's ability to acquire skills.

NYCDOH BEI Q and A, March 2016

Question 2: Are evaluators required to use a standardized test for an English speaking child?

No. If an evaluator determines that a standardized test is not appropriate to the child's culture, language and developmental concern, or the instrument does not represent the child's developmental level, evaluator should provide written justification in the evaluation report why such instrument or instruments are not appropriate or available for the child.

NYCDOH BEI Q and A, March 2016

Question 2: Are evaluators required to use a standardized test for an English speaking child? No.

Evaluators should provide detailed information based on informed clinical opinion, parent interview and behavioral observation to support the child's developmental level and developmental domain status.

Evaluators must document procedures and methods of how developmental delay status and eligibility is determined in accordance with NYSDOH regulations and guidance documents.

NYCDOH BEI Q and A, March 2016

"What EI wants . . ."

is what is in this training.

Some of us may need simply to go back to how we were trained to do evaluations in graduate school

A smaller group of EI evaluators may need to completely retool

Others will be empowered to continue to do appropriate evaluations

This NYCDOH training is based on the following:

IDEA 2004 Part C
EI Regulations 69-4
Memorandum 1999-02– Diagnosed Conditions
Memorandum 2005-02 and addendum to Memo 2005
Clinical Practice Guidelines:
- Communication, Motor, Down Syndrome, Autism, Hearing, Vision

Provider Agreement (Evaluation Section – B[LYF1])
Interim List of Developmental Assessment Instruments – Revised 5/12
NYCDOH Policy and Procedures Manual

Current law, regulations, and policies for EI evaluations reflect current best practices.

Too many NYCDOH EI evaluations do not reflect current best practices.

New York State Definition of Developmental Delay

"In New York State, consistent with federal requirements, a child must be experiencing a delay in an area (i.e., domain) of development that is significant enough to require early intervention." (emphasis added)

https://www.health.ny.gov/community/infants_children/early_intervention/memoranda/2005-02/eligibility_criteria.htm

To be initially eligible for the EIP based on developmental delay, the following criteria must be met:

a child must be experiencing a 12 month delay in one or more functional areas; or,

a 33% delay in one functional area or a 25% delay in each of two areas; or,

a score of at least 2 SD below the mean in 1 functional area or a score of at least 1.5 SD below the mean in each of 2 domains.

INFORMED CLINICAL OPINION

Informed clinical opinion means the best use of quantitative and qualitative information by qualified personnel regarding a child, and family if applicable.

NYSDOH 2010 Regulations. Sec. 69-4.1(x) Definitions

INFORMED CLINICAL OPINION

When using informed clinical opinion in the evaluation process, practitioners draw upon clinical training and experience; standardized instruments, as available and appropriate; recognized clinical assessment procedures. . .; experience with children of different cultures and languages; and, their ability to gather and include family perceptions about children's development.

https://www.health.ny.gov/community/infants_children/early_intervention/memoranda/2005-02/multidisciplinary_procedures.htm#opinion

Informed Clinical Opinion does not correlate to the number of EI evaluations an evaluator has completed.

How do evaluators develop quality informed clinical opinion?

1. By being on top of the research and understanding the statistical base o any assessment tool they use;
2. By identifying biases in assessment materials and in many current "developmental milestones";
3. By spending time assessing typically developing children from the sam age and cultural and linguistic background as the ones they are evaluating for EI; and
4. By ensuring that they have a deep understanding of ate developmental milestones.

Five characteristics that strengthen EI evaluations based on the law/regulations/policies, and best practice.

1. Include data on each child's family, cultural, and linguistic background
2. Illustrate a child's functioning level by gathering a wide range of data appropriate for the child's age and experiences.
3. Bring this particular child to life (aka: vignettes/holograms).
4. Determine functional levels by using informed clinical opinion considering the child's background and prior experiences.
5. Distinguish a significant delay sufficient to qualify for EI services.

What is "*SIGNIFICANT ENOUGH*" to be eligible for EI services?

Some clarity from the 2010 Amendments (a)(2)(iv)

[F]or children who have been found to have a delay only in the communication domain . . . if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department, including the following:

What is "*SIGNIFICANT ENOUGH*" to be eligible for EI services?

Some clarity from the 2010 Amendments (a)(2)(iv)(a)

[F]or children **18 months of age or older**;

(i) a severe language delay as indicated by no single words by 18 months of age, a vocabulary of fewer than 30 words by 24 months of age, or no two-word combinations by 36 months of age; or

What is "*SIGNIFICANT ENOUGH*" to be eligible for EI services?

See, TABLE 2 in Clinical Practice Guidelines, Report of the Recommendations, Practice Guidelines Communication Disorders, p. 18

"For example, if the evaluation team uses a standardized language test, and the child receives a subscore of 2 standard deviations below the mean in expressive language, but shows no, or a less significant delay, in receptive language, the child would ***not*** be eligible for the EIP, *unless* the results of the evaluation also substantiate the existence of a preponderance of clinical clues/indicators of problems in language and communication development."

Evaluators must know how to "dig deeper" than simply counting words.

Some clarity from the 2010 Amendments

Even if a child has no single words at 18 months, the child still may not have a developmental delay "significant enough" to be eligible for services. For example, that child may have good imitation skills, strong gestural skills, some word approximations, good communicative intent, age-appropriate comprehension, an age-appropriate phonological system, good play skills, and no family history of speech-language problems.

What is "*SIGNIFICANT ENOUGH*" to be eligible for EI services?

Some clarity from the 2010 Amendments

[F]or children younger than 18 months of age,

documentation that the child has attained none of the normal language milestones expected for children in the next younger age range, and none for the upper limit of the child's current chronological age range, and the presence of a preponderance of established prognostic indicators of communication delay that will not resolve without intervention, as specified in clinical practice guidelines issued by the Department.

NORMAL LANGUAGE MILESTONES

"For example, if the evaluation team uses a standardized language test, and the child receives a subscore of 2 standard deviations below the mean in expressive language, but shows no, or a less significant delay, in receptive language, the child would not be eligible for the EIP, unless the results of the evaluation also substantiate the existence of a preponderance of clinical clues/indicators of problems in language and communication development."

EI and the wide range of "normal"

NYSDOH Clinical Practice Guidelines: Communication

Three month ranges: 0-3 mths; 3-6 mths; 6-9 mths; 9-12 mths

Six month ranges: 12-18 mths; 18-24 mths

Twelve month range: 24-36 months

www.LEADERSproject.org

Grammar Fundamentals for a Pluralistic Society

Differential Diagnosis in a Preschool Evaluation

Disorder, Difference, or Gap? A School-Age Disability Evaluation

Model Speech-Language and Psychological Evaluations

Test Reviews of most commonly used tests

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Reference this material as:

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Additional Video Tutorials, Materials, and Resources Available From:

www.LEADERSproject.org