The Hearing Loss Association signed on to comments sent by the deaf and hard of hearing alliance to the Department of Education on IDEA Part C - early intervention programs for infants and toddlers.

The Hearing Loss Association is a member of the Deaf and Hard of Hearing Alliance a coalition that works on issues of concern to people with hearing loss.

Comments of the Deaf and Hard of Hearing Alliance to the U.S. Department of Education on the Notice of Proposed Rulemaking for Early Intervention Program for Infants and Toddlers With Disabilities
July 23, 2007

The Deaf and Hard of Hearing Alliance hereby submits comments to the U.S. Department of Education on the Notice of Proposed Rulemaking for Early Intervention Program for Infants and Toddlers With Disabilities, 72 Fed. Reg. 26456-26531 (May 9, 2007). DHHA comprises a wide range of professional and consumer organizations that promote quality of life and well being for deaf and hard of hearing persons. The DHHA organizations that sign on to this document are:

American Society for Deaf Children
Conference of Educational Administrators of Schools and Programs for the Deaf
National Association of the Deaf
TDI, Inc. (formerly Telecommunications for the Deaf, Inc.)

DHHA has long advocated for and followed the progress of early hearing detection and intervention (EHDI) systems. Research shows that deaf and hard of hearing babies who are identified early and enrolled in early intervention with qualified providers specializing in addressing the needs of deaf and hard of hearing children by age six months have significantly better language outcomes than later enrolled children. The goals of EHDI systems are to screen all babies by one month, confirm hearing status by age three months, and have the child and family enrolled in early intervention by age six months. As of 2005, 36 states were screening more than 95 percent of their babies in hospitals. However, serious gaps in follow up remain. Out of the 36 states responding, only 55 percent of babies who were referred for follow up evaluation as a result of the screening received an audiological evaluation by age three months (National Center for Hearing Assessment and Management (NCHAM), 2004 State EHDI Survey, www.infanthearing.org). Fifteen states did not know how many babies received the evaluation by three months. Further, of the babies identified as deaf or hard of hearing, only 49 percent were enrolled in early intervention by age six months. Fifteen states did not report any data on this measure. And the status was unknown on 32 percent of eligible babies.
Once babies are enrolled in early intervention they face a system that is not prepared to address their needs. While the research demonstrates the efficacy of early intervention with specialized providers, there is no research to support the use of “generic” early intervention providers with this population. Yet one study showed that early intervention programs are not up to this challenge. Out of 388 early intervention sites in 19 states serving deaf and hard of hearing children surveyed, only 48 percent had services providers with a degree in deaf education. Brown, Stredler-Brown, A., & Arehart, K.H., Universal Newborn Hearing Screening: Impact on Early Intervention Services, The Volta Review, Volume 100(5) (monograph), 2000, 85-117, p. 91). Only 33 percent of sites reported that they shared information with families about deaf culture (p. 95). As time goes on, more very young deaf and hard of hearing children will be identified and enrolled in early intervention. Without significant leadership from the Department, early intervention gaps to children and families in this low-incidence category will be exacerbated.

While there is still far to go, we are encouraged by some of the proposals in this NPRM, including those specifically addressing the language needs of deaf and hard of hearing infants and toddlers.

Our comments are written in the order these items appear in the NPRM. The DHHA thanks the Department for the opportunity to comment.

§ 303.13 Early intervention services.

Proposed (a)(4)(iii) Communication development;

Recommendation: Change to “Language and communication development;”

Rationale: “Communication” is a broad term referring to various language based and non-language based means of conveying information. “Language” is specific, referring to American Sign Language, English, etc. Children need both language and communication.

Proposed (b)(1) Assistive technology device and services.

Recommendation: The Department should make clear, through regulation, a letter to Part C lead agencies, policy statement, or other means, that hearing aids and appropriate related audiological services are included as assistive technology devices and services.

Rationale: Timely access to hearing aids and appropriate related audiological services is problematic. According to the Office on Disability, U.S. Department of Health and Human Services:

"Hearing aids are the primary tools that allow infants and children with hearing loss to have access to spoken language. Currently, the majority of infants with hearing loss in the United States identified through universal newborn hearing screening programs do not have timely provision of appropriate personal hearing aids. Delays can be months or a year or more until an amplification funding source is identified and the application process completed."
The Report recommends that Federal agencies should ensure that infants and toddlers with hearing loss have access to appropriate hearing aids.

**Proposed** (b)(11) Special instruction includes –

(iii) Providing families with information, skills, and support related to enhancing the skill development of the child;

**Recommendation:** Before “skill” insert “physical, cognitive, communication, social or emotional, and adaptive”

**Rationale:** This would provide guidance as to the skill areas that must be addressed through early intervention services.

**Proposed** (b)(12) Speech-language pathology services includes –

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

**RECOMMENDATION 1:** The DHHA recommends a change in the speech-language pathology services listed under §303.13(12) (iv). Separate out the services related to provision of sign language and cued language and the interpreting services, currently included in the proposed definition of speech-language pathology services into two different types of services: 1) Services for infants and toddlers who are deaf or hard of hearing and 2) Interpreting and transliteration services, as follows:

§303.13 (10) (subsequent numbering in this section will change)

**Services for infants and toddlers who are deaf or hard of hearing**

(i) **Provision of sign language (including American Sign Language), cued language, and auditory/oral language services, which, as used with respect to infants and toddlers with hearing loss, includes services to the infant or toddler to facilitate age appropriate language development, and family members to facilitate their interactions with their children in sign language, cued language, and auditory/oral language, as appropriate.**
(ii) **Infants and toddlers who are deaf or hard of hearing should receive services from qualified providers who have skills and training for this population and for the services they are providing.**

(iii) **Services for families of infants and toddlers who are deaf or hard of hearing should include information and counseling regarding hearing loss, amplification, communication opportunities, and the potential effects of hearing loss on social-emotional development, family and other social interactions, academic performance, and other behaviors.**

**Rationale:** When a family learns that their infant or toddler has significant hearing loss it is critical that they have access to a knowledgeable provider who can help them access, understand and cope with new information regarding the type, degree, and etiology of hearing loss and the variety communication choices that are available to them. Early timely information and support will help the family make informed choices.

**Rationale for “including American Sign Language:”** American Sign Language (ASL) is the signed language used in the United States. The regulation should be clear ASL should be available to the child and family, if appropriate.

**Rationale for “deaf and hard of hearing:”** In Part B “hearing impairment” (34 C.F.R. § 300.8 (a)(5)) and “deafness” (34 C.F.R. § 300.8 (a)(3)) are used to define two discrete categories of hearing loss. Using “hearing impairment” here could be interpreted to mean that children with “deafness” are not included.

Further, the term “hearing impairment” is outdated and many believe offensive. Part B refers to children who are “deaf or hard of hearing” (IDEA (d)(3)(B)(iv) and 34 C.F.R. § 300.24 (a)(2)(iv)), and this term is favored by the deaf and hard of hearing community.

The terms “hearing loss” or “deaf and hard of hearing” are preferred to “hearing impairment” because they are more descriptive and less value laden. We recommend changing the language throughout the regulations whenever hearing impairment is used to hearing loss or deaf and hard of hearing.

**Interpreting/transliteration services**

*Includes oral transliteration services, sign language (including American Sign Language), and cued language interpreting services for families of infants or toddlers who are deaf or hard of hearing when needed.*

**Rationale:** Provision of sign language, cued language, and auditory/oral interpreting/transliteration services is the purview of interpreters and transliterators. Typically speech-language pathologists are not trained to provide oral transliteration services, sign language, or cued language interpreting. Therefore, we recommend that these services be removed from the speech-language pathology services section and moved to a separate section.

Sign language and cued language interpreting services should not be used with infants and toddlers for purposes of language development. There is no evidence to support their efficacy with this population.
Infants and toddlers need direct communication with service providers to help them acquire language.

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

Therefore, it is recommended that these services be listed in a separate section rather than being included as part of speech-language pathology services.

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

Interpreting services involve the translation of language from one modality (e.g., speech) into another (e.g., sign language).

Transliteration services convey spoken information into more clear and accessible form (e.g., spoken language to cued language) or voices over difficult to understand speech into more clear speech (oral transliteration).

RECOMMENDATION 2: Add auditory habilitation or rehabilitation to the list of speech-language pathology services as indicated by the bolded language below and changing the numbering to §303.13 (12) (v):

(v) Provision of auditory habilitation or rehabilitation services for infants or toddlers who are deaf or hard of hearing.

Rationale: The provision of auditory habilitation and rehabilitation services may be considered a speech-language pathology service when the SLP is appropriately trained and practices in this specialty area and should be recognized as such within this section. Although speech-language pathologists typically do not teach sign language or cued language, they, as well as audiologists, may provide auditory habilitation or rehabilitation for infants or toddlers who are deaf or hard of hearing.

Proposed § 303.13(c)(11) Special educators, including teachers of children with hearing impairments (including deafness) and teachers of children with visual impairments (including blindness).

Recommendation One: Change "teachers of children with hearing impairments (including deafness)" to "teachers of deaf and hard of hearing children."

Recommendation Two: Move "teachers of deaf and hard of hearing children" to (12), move “teachers of children with visual impairments (including blindness)” to (13), and re-number current (12) and subsequent sections.
Rationale: These are separate fields and should be listed as such.

§ 303.21 Infant or toddler with a disability.

Proposed (a)(2) Has a diagnosed physical or mental condition that –

(ii) Includes conditions such as . . . severe sensory impairments . . .

Recommendation: Delete "severe."

Rationale: Even mild hearing losses can result in consequences such as poor academic performance. (Blair J, Peterson M, Viehwed S. The effects of mild sensorineuroal hearing loss on academic performance of young school-age children. The Volta Review. 1985; 87:87–93.) Children with hearing loss of any degree should be eligible for early intervention services.

§ 303.25 Native language.

Recommendation: DHHA strongly supports this section, which defines native language.

Rationale: Use of the child’s and/or family’s native language is a well-established concept under the current Infant and Toddler regulations. This section provides a definition for this important term.

§ 303.105 Positive efforts to employ and advance qualified individuals with disabilities.

Recommendation: Maintain and strengthen, perhaps by requiring a State plan and/or hiring and advancement goals with specific benchmarks.

Rationale: Without a plan or goal there is no assurance states will follow this provision and no way to measure what progress has been made.

Proposed § 303.126 Early intervention services in natural environments.

Recommendation: Add “(c) Nothing in this section is intended to preclude the provision of services in a combination of a natural environment and another setting, such as a center-based program, if such an arrangement is necessary to help the child and family meet the IFSP goals.”

Rationale: This will help clarify the dichotomy of offering services in one setting or another. For many children and families, providing services in a “natural environment” and a center based program is appropriate. IFSP Teams should be able to feel confident that making this choice is supported by the regulations.

Proposed § 303.301 Comprehensive child find system.
(a)(3) Ensures rigorous standards for appropriately identifying infants and toddlers with disabilities for services under this part that will reduce the need for future services;

**Recommendation:** Delete “that will reduce the need for future services.”

**Rationale:** Eligible infants and toddlers should have access to necessary early intervention services regardless of whether services are expected to be needed in the future.

(c) Coordination. (1) The lead agency . . . must ensure that the child find system . . .
(ii) Is coordinated with the efforts of . . .

**Recommendation:** Add (J) Early Hearing Detection and Intervention (EHDI) systems.

**Rationale:** Every state has established newborn hearing screening, and one of the biggest challenges these programs are facing is ensuring that deaf and hard of hearing children are enrolled in early intervention programs. EHDI and early intervention systems should collaborate more effectively in order to serve children and families better.

**Proposed § 303.302 Referral procedures.**

**Recommendation:** DHHA opposes elimination of the two day referral timeline. We appreciate the Department’s concerns related to the brevity of this time frame and the Department’s lack of authority over some primary referral sources. However, the phrase “as soon as possible” leaves this time frame with no limits at all. While referral for evaluation and assessment may sometimes be complicated, other times it is fairly straightforward. For example, if a child is suspected of having a hearing loss, the established protocol is that the child should undergo medical evaluation and audiological assessment. (Joint Committee on Infant Hearing, Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs) If a hearing loss is confirmed, the child should be referred to early intervention immediately (Joint Committee). While we acknowledge that the process does not always move as quickly as this implies, we think the better plan is to hold to the two day time frame and provide assistance and support to systems so that the two day timeline may be met to the fullest extent possible.

**Proposed §303.320 Evaluation and assessment of the child and family and assessment of services needs.**

(a)(3) All evaluations and assessments of the child and family must be conducted by qualified personnel, in a nondiscriminatory manner, in the child’s or family’s native language (as appropriate), and selected and administered so as not to be racially or culturally discriminatory.

**Recommendation:** Support.

**Rationale:** This maintains current requirements.
Proposed § 303.320 (e)(1) Timelines. Except as provided . . . the evaluation of the child . . . as well as the initial IFSP meeting, must be completed within 45 days from the date the lead agency obtains parental consent to conduct an evaluation of the child.

Recommendation: Retain current requirement that public agency shall complete the evaluation and assessment activities and hold an IFSP meeting within 45 days after it receives a referral, as outlined in current 303.321 (e)(2).

Rationale: The rationale given by the Department for having the 45 days start at the time of parental consent is that often it takes some time to obtain consent. However, DHHA believes this reason is not sufficient. If obtaining parental consent is difficult or time consuming, the lead agency should find more effective and efficient ways to obtain parental consent. For example, it can use its primary referral sources to ask parents for consent for evaluation. Primary referral sources, such as pediatricians or other medical or health care professionals, can explain the purpose of the evaluation, and can help facilitate the family’s participation in evaluation and early intervention activities. In order for this to work there needs to be collaboration between primary referral sources and early intervention systems – which we believe has been and continues to be envisioned in the Part C statute and regulations.

§ 303.342 Procedures for IFSP development, review, and evaluation.

(d) Accessibility and convenience of meetings.

Recommendation: Support.

Rationale: This provision supports families.

§ 303.342 Procedures for IFSP development, review, and evaluation.

Recommendation: The September 5, 2000 Notice of Proposed Rulemaking for the Early Intervention Program for Infants and Toddlers with Disabilities, 65 Fed. Reg. 53807-53869, included a "special factors" provision related to IFSP development that was patterned on the special factors provision related to IEP development in Part B (§ 300. 324(a)(2)). We recommend a modified version of this provision, to read:

(2) Consideration of special factors. In developing each child's IFSP, the IFSP team must--

(i) In the case of a child whose behavior impedes his or her development, consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior;
(ii) In the case of a child of a family with limited English proficiency, consider the language needs of the child and the family as those needs relate to the child's IFSP;
(iii) In the case of a child who is blind or visually impaired, if appropriate, provide for exposing the child to pre-literacy or readiness activities related to the use of Braille (e.g., through tactile stimulation and the use of "raised" picture books);
(iv) Consider the communication development needs of the child, and in the case of a child who is deaf or
hard of hearing, consider –
(A) The appropriate use of communication and language development opportunities including spoken language, signed language, including American Sign Language, tactile signed language, and cued language.
(B) Opportunities for direct communication with peers, professional personnel, and deaf and hard of hearing adults in the child's language and communication mode consistent with the developmental level of the child, and full range of needs related to the child's language and communication mode or mode(s).
(v) Consider whether the child requires assistive technology devices and services.

**Rationale:** When Congress authorized IDEA in 1997, it included special factors provisions, thereby providing guidance to IEP Teams about how to address the needs of these populations. Extending the special factors provisions to Part will help ensure that the children in these groups receive appropriate services to meet their language, literacy, and other needs from the start.

§ 303.344 Content of an IFSP.

(c) Results or outcomes. The IFSP must include a statement of the measurable results or measurable outcomes expected to be achieved for the child (including pre-literacy and language skills, as developmentally appropriate for the child) and family, and the criteria, procedures, and timelines used . . .

**Recommendation:** DHHA supports this provision.

**Rationale:** DHHA supports the language and literacy focus in the statute.

§ 303.421 Prior written notice and procedural safeguards notice.

(c) Native language. (1) The notice must be –

(ii) Provided in the native language, as defined in § 303.25, of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

**Recommendation:** Support.

**Rationale:** This maintains current requirements.