

**Delaware Guidelines for
Young Children with Communication Delays**

**Sponsored by
Department of Health and Social Services
Division of Management Services
Birth to Three Early Intervention System**

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Table of Contents

I.	Introduction	1
II.	Eligibility Guidelines	3
III.	Intervention Guidelines	5
IV.	Enhanced Watch and See Protocol	11
V.	Frequently Asked Questions (FAQs)	12

Introduction

Overview

This document is designed to facilitate the implementation of consistent practices in Delaware, in accordance with the provisions of the Individuals with Disabilities Education Act, for determining children's eligibility for early intervention services based on delays in communication, and to assist IFSP teams in considering a variety of factors as they make individualized intervention decisions based on the priorities, needs and desired outcomes for individual children and families.

The guidelines are written using recommended practices from recent research and set the tone for the family to be an instrumental part of early intervention. The guidelines are intended to be flexible, not prescriptive or limiting, and are expected to result in assistance to families and caregivers for enhancing their child's language development and provision of supports and services for delays in language development when appropriate.

This document is intended to be used as a working draft from July 1, 2004 through June 30, 2005. For preparation of the final version, revisions will be made based on feedback from various perspectives, including administrators, early interventionists, evaluators, therapists, service coordinators and parents, about the implementation of the new practices as well as the results of using them to answer the question: are the needs of young children with expressive language delays being met?

Process for Developing Guidelines

In January 2003, a stakeholder group, comprised of individuals from Child Development Watch, the Department of Education, local school district staff, parents, early intervention providers, and speech-language pathologists, were invited by the Delaware Birth to Three office to participate in a meeting. They examined a broad array of challenges and made recommendations about how to change the system so that children with communication delays would receive appropriate interventions and parents and caregivers would receive the necessary support to enhance the child's speech and language development.

An outgrowth of the meeting was the development of a strategic work plan, the first step of which needed to be the development of state communication guidelines. Subsequently, a smaller group, called the Communications Guidelines Work Group, was established for the purpose of developing the guidelines. Over the course of a year, the Work Group reviewed the research literature and guidelines from several other states, assessed the current status of early intervention services for children with communication delays across the state, and considered the potential effects on the system if changes were to be made, resulting in proposed guidelines for Delaware.

Anticipated Outcomes

When effectively interpreted and implemented, the eligibility and intervention guidelines have several important outcomes. First, and most important, children who need intervention to support their language development promptly receive it. Second, unnecessary referrals to the Part C early intervention program, which result in inefficient use of personnel time and paperwork burdens that translate into dollars, are avoided. Third, uncalled-for determinations of eligibility are not made, again burdening the system as well as increasing parent anxiety. And finally, through the Enhanced Watch and See protocol, language development of a wider group of children is enhanced and family's feelings of competence in meeting their child's developmental needs is improved.

Eligibility Guidelines for Infants and Toddlers with Delays in Expressive Language

Not all children who have delays only in expressive language will be eligible for Part C Early Intervention services. The revised guidelines (see attached chart) are intended to target “late talkers” who may not require direct intervention services to demonstrate significant gains in expressive language.

Children referred to Part C will be assessed in 5 domains (motor, cognitive, social/emotional, self-help, communication) by an assessment team consisting of a variety of professionals (pediatrician, developmental nurse, child development specialist, etc.) under the supervision of Child Development Watch (CDW). Children with an established condition are automatically eligible as are children with any delay in communication plus a 25% delay in any other domain.

For children with no delays in the other four domains, children with a 25% or less delay in communication are not eligible. However, children with a communication delay greater than 25% are referred for additional, specific speech and language evaluation as part of their eligibility determination. Children between 24 and 36 months will receive a formal communication evaluation by a speech-language pathologist. For children between 6 and 24 months, parents may complete the Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP) to identify concerns and/or the child may be referred for a formal evaluation. A formal evaluation consists of language tests, such as: Preschool Language Scale (PLS-4), Rosetti Infant Toddler Communication Scale, etc), oral motor/feeding/ swallowing evaluation, and articulation tests such as the Goldman-Fristoe Test of Articulation–2 (GFTA-2).

Regardless of the presence or degree of language delay, children with an oral motor disorder or apraxia of speech are eligible. If the child has a phonological disorder and 30% or greater delay in expressive language, he will be eligible. If the child has 30% or greater delay in receptive language and 30% or greater delay in expressive language, he will be eligible.

Children with a 30% or greater delay in expressive language and a significant family history may be eligible or may be referred to Enhanced Watch and See (EWS) based on clinical judgment. Similarly, children with a 30% or greater delay in expressive language only may be eligible or may be referred to Enhanced Watch and See (EWS) based on clinical judgment. However, those children with less than 30% delay in expressive language are not eligible for Part C services nor Enhanced Watch and See, unless determined otherwise based on clinical judgment.

There are risk factors that should be taken into consideration when determining eligibility, including partial delays in other domains, child older than 24 months, preemies born 34-36 weeks gestation, and cultural/environmental factors. Clinical judgment may be employed in all cases.

**Delaware's Part C Eligibility Guidelines for
 Infants and Toddlers (birth to three) with Delays in Expressive Language
 (as of 7/1/04)**

WITH OTHER DOMAIN DELAYS

Child Assessment	Established condition	→	ELIGIBLE
Child Assessment	Any delay in communication with 25% delay in another domain:	→	ELIGIBLE
	➤ Motor	→	NOT ELIGIBLE
	➤ Cognitive		
	➤ Social/emotional		
	➤ Self-help		

NO DELAYS IN OTHER DOMAINS →

Child Assessment	Up to and including 25% delay in communication	referred for more testing
Child Assessment	Greater than 25% delay in communication	

CSBS screening or Communication Evaluation	➤ Apraxia of speech	a working diagnosis of verbal apraxia	(regardless of delay in ELD)	→	ELIGIBLE	
	➤ Oral motor disorder	a diagnosed unresolved feeding or swallowing disorder	(regardless of delay in ELD)	→	ELIGIBLE	
	➤ Phonological disorder	moderate to severe based on standardized instrument or clinical analysis [preferred Kahn Lewis/ Goldman Fristoe]	and	30% or greater delay in Expressive Language	→	ELIGIBLE
	➤ Receptive delay	30% delay in receptive	and	30% or greater delay in Expressive Language	→	ELIGIBLE
	➤ Family history	parent or sibling (1 st degree relative) who had speech/ language therapy as a child	and	30% or greater delay in Expressive Language	→	“WATCH & SEE” OR ELIGIBLE (based on clinical judgment)
	WITH EXPRESSIVE DELAY ONLY			30% or greater delay in Expressive Language	→	“WATCH & SEE” OR ELIGIBLE (based on clinical judgment)
	WITH EXPRESSIVE DELAY ONLY			Less than 30 % delay in Expressive Language	→	NOT ELIGIBLE

Risk factors that may trigger eligibility:

- partial delays in other domains
- child older than 24 months
- family history of language problems
- preemies born 34-36 weeks gestation
- cultural/environmental factors

Early Intervention Guidelines for Infants and Toddlers with Speech and Language/Communication Delays

Early Intervention should help enhance the child's overall language development and lead to better long-term functional outcomes. No one type of speech intervention is the best for all young children. It is recommended that the type of intervention for each child be based on an assessment of that child's and family's specific strengths, needs and cultural background. It is important to assess the child's development and communication functioning prior to determining intervention.

IMPORTANT INTERVENTION CONSIDERATIONS

Focus of Intervention

1. For a child to make progress in a particular component of communication (such as pronunciation or grammar), intervention focuses directly on that problem, since improvement in one area may not necessarily generalize to improvement in other areas.
2. Goals for each individual child are clearly identified and defined with measurable results and clear markers for mastery.
3. For most young children with communication disorders, intervention should focus first on increasing the amount, variety, and success of verbal and nonverbal communication and then, if necessary, on intelligibility or articulation.
4. A child's progress is facilitated by focusing on communication skills that are appropriate to the child's particular age or developmental level.
5. Ongoing assessment of the progress of the intervention is used to modify intervention strategies as needed.
6. Therapy documentation illustrates the effectiveness of intervention.
7. The intervention approach is modified when any of the following occur:
 - Goals have been achieved
 - Progress is not evident
 - Regression is noted
 - An unexpected change in the child's behavior or health status
 - A change in the intervention setting or the child's environment

8. A comprehensive evaluation, including appropriate standardized tests, should be performed at least yearly to compare the child's individual progress to age-expected development.
9. All intervention approaches facilitate long-term goals for communication interventions such as expressing basic needs, establishing functional use of language, interacting socially, and acquiring knowledge.
10. Interventions in the child's natural environment are more useful in increasing spontaneous language and generalization than intervention that is provided in "clinic settings".
11. The choice of setting for speech/language therapy will depend on a variety of factors relating to the individual child's needs and family situation. These might include age and developmental level, the type and severity of the communication disorder, other developmental concerns or medical problems, the family's interest in and ability to participate in the intervention, the culture of the child and family, and the language used by the child and family.

Considerations of the Language and Culture of the Child and Family

It is always essential to consider and respect the culture and primary language of the family when providing interventions for children with communication disorders.

Although it is important to consider the family's preference in determining the language used in the intervention, it is strongly recommended that intervention be conducted in the primary language used in the home. Family education and counseling, including written materials, should be in the primary language of the family.

It is recommended that a professional who is fluent in the language of the child and the family conduct any direct speech/language therapy.

Because family involvement is such an integral part of the development of speech and language, it is important for interventionists to be competent in the language of the family and familiar with its culture.

If a professional fluent in the child's primary language is not available, it is recommended that a specially trained interpreter for the interventionist who is providing the intervention.

If the interventionist providing the intervention is not familiar with the culture of the family, it is important to have a cultural informant to advise the professional on issues that may cause misunderstanding during the course of intervention. A person familiar

with the culture and language of the family needs to review intervention techniques and materials to determine if they are culturally sensitive and appropriate.

It is important for any interpreters assisting in the intervention process to be trained by the professional providing the intervention to ensure that interpretations of the child's behaviors are culturally and linguistically accurate. It is recommended that interpreters participate in the specific intervention program.

INTERVENTION APPROACHES

Speech and language intervention for young children with communication disorders include a variety of methods and approaches. Interventions should focus directly on the child and on teaching intervention skills to family members or caregivers who interact with the child.

The preferred approach is *naturalistic* and typically include the following three characteristics:

- Providing learning opportunities in the day-to-day environment of the child rather than structured learning sessions
- Following the child's focus of attention or interest
- Using an incentive and a reinforcer that are naturally associated with a particular communication response.

Naturalistic interventions use specific techniques that create opportunities for the child to learn. This approach utilizes aspects of adult-child interaction that promote language learning in the child's many natural environments. This approach differs from a direct approach where focus is on the structural aspects of language and speech. Deciding which techniques to use for an individual require the interventionist to draw upon knowledge about normal language learning and to be aware of the needs of the particular child. Intervention may be a mix of both techniques and depend on the needs of the child, the individual characteristics of the child, and the child's stage of language development.

Applications of Therapy

No one specific speech/language therapy technique or approach is best for all young children. When selecting an intervention technique or approach, it is important for the professional providing the intervention to consider the individual characteristics of the child, including the child's stage of language development.

When choosing the strategy for therapy, it is important to consider:

- The child's chronological age and developmental level
- The stage of language development
- The type and severity of the child's communication disorder
- Other developmental concerns or medical problems
- Strengths and interests of the child
- Other services the child is receiving
- The family's interest in and ability to participate in the intervention
- Language used by the child and the family
- Communication partners
- Community resources

The specific techniques used in intervention are often similar for both individual and group settings.

Of the interventions that focus directly on the child, some involve working with the child in *individual* therapy sessions in which the interventionist works one-on-one with the child and family or caregiver. This type of intervention can occur in the home or at some other location.

Individual therapy may be especially important at the beginning stages of intervention as specific intervention objectives are established and as the child becomes familiar with the interventionist and the use of particular techniques. However, individual therapy as the only intervention method may produce less generalization of language skills to other situations.

Other interventions involve working with children and adults in a *group* setting in which there are other children that offer multiple conversational partners. Group interventions may occur in a variety of settings and may involve small groups of two or larger classroom size groups.

Family Involvement in Intervention

Family involvement in intervention is critical to the child's progress. To understand the child's communication disorder, family members and/or caregivers need to be involved in the child's assessment. They should be actively involved in determining intervention options, goals, methods, and be able to identify how daily routines that help promote their child's progress. Family (or caregiver) involvement in intervention can be facilitated and enhanced by assuring that the interventionist provides adequate time for family training and adequate ongoing direction and support to the families.

It is important to include families in speech/language group interventions for young children. Including families in these group interventions provides families with support,

information, and education to enhance communicative development. It will also facilitate generalization of the child's language skills to other settings.

Contemporary best practice incorporates the view that interventionists and service providers need to consider themselves more as advisors, counselors to families than as direct care providers. This concept is more like being a coach or personal trainer than a hands-on provider. Research suggests that service providers should "move to a different position", alongside the family as a coach rather than a lead player. (Suzanne Campbell, 1977).

It is important that all interventionists collaborate with each other and with the family and child when coordinating and integrating techniques and approaches for working with the child and family.

It is recommended that the interventionists have expertise and experience with infants, toddlers, and their families and be qualified, trained appropriately, and have the appropriate credentials under the professional practice acts of the State of Delaware.

Family Education Programs

Training and education of the Family is an intervention that can result in improvement in the child's communication since families (or the child's primary communication partners) are key to creating learning opportunities in day to day involvement. The purpose of the training is to teach families ways to help improve a child's communication. The training includes demonstrations and discussion of various strategies and techniques designed to facilitate children's emerging communication and language skills. Families learn to interact and communicate with their child during everyday activities and routines in ways that promote social communication and language learning. Programs such as these are appropriate for a wide range of ages, including infants, toddlers, and preschool children.

Evaluating Specific Intervention Techniques

Many different specific intervention techniques have been shown to be effective in improving speech/language skills in children with communication needs. Specific techniques that will prove to be most effective for an individual child will depend upon many factors, including the type of communication need, the child's personality, and whether or not the child has other areas of developmental needs.

It is recommended that the objectives for each child be clearly identified and defined with clear criteria for success. It is important to evaluate the effectiveness of the speech/language interventions on a regular basis. When a child is receiving speech/language therapy, it is important to assess behaviors and communication skills

at the beginning of intervention and to document progress at the end of each intervention session.

When a child is receiving a communication intervention that is integrated within the child's daily activities (rather than in separate sessions), it is still important to periodically monitor and document the child's progress.

It is important to assess the extent to which the communication skills acquired are generalized and to modify interventions to promote generalizations.

It is recommended that the interventionist providing the intervention use information gathered regularly about the child's progress to assist in choosing and modifying intervention strategies as well as the intensity, frequency, and duration of the intervention.

ENHANCED WATCH AND SEE

Protocol

The purpose of Delaware's "Enhanced Watch and See" (EWS) protocol is to provide a safety net for children who do not currently qualify for Early Intervention services under Part C of IDEA, but who may benefit from a "boost" to their communication skills, particularly in the area of expressive language, through environmental and/or language enrichment. An additional purpose is to reassure most families that their children are developing normally by providing them with materials that will help them track their child's developmental progress and stimulate the development of their child's language and beginning literacy skills.

To accomplish these goals, the EWS protocol has several components; not all children and families will need all parts depending on the child's development and family priorities. All components focus on language and pre-literacy skills, using materials that are culturally appropriate for referred children and families. Children are referred to EWS by the Early Intervention Assessment Team for enhanced surveillance of their expressive language skills.

COMPONENTS

1. **INFORMATION PACKET.** An initial packet of information, including home-based language/literacy activities, is provided to families by members of the Assessment Team.
2. **HOME ACTIVITIES.** The types of home activities and other follow-up that is appropriate for each child and family is determined by members of the original Assessment Team, including the family. These could include, but would not be limited to: parent education, parent support groups, play groups, materials, informal activities. A member of the Assessment Team will make a follow up phone call to families after their initial assessment to answer any questions.
3. **MEDICAL HOME.** All children have a link to a medical home. The medical home is notified of all test results.
4. **FOLLOW-UP.** CDW will designate staff to contact the family for the re-evaluation.
5. **RE-EVALUATION.** Re-evaluation of the child is conducted generally every 6 months in areas or domains of reported concern. This may occur more often if recommended by the original Assessment Team. As part of the re-evaluation, family members may be asked to complete a screening of the child's expressive language development, using such instruments as the MacArthur Communicative Development Inventories (CDIs) (Words and Gestures or Words and Sentences, depending upon the child's age). Written information on their child's progress will be shared with families.
6. **CHILD PARTICIPATION.** The child's participation in a language-rich environment in one or more of the following settings is recommended: child care, Head Start/Early Head Start, and community activities. Access to specific curricula, training, and/or resources to stimulate the development of the child's language and pre-literacy skills is given to the family and other providers.
7. **PARENT PARTICIPATION.** Parents' participation in one or more of the following activities is recommended: parent education, parent support groups, play groups (e.g., PAT, Early Head Start).

FAQ

These “frequently asked questions” were developed by the Delaware Communication Guidelines Working Group based on work group discussions as well as Connecticut’s Birth to Three System Service Guidelines #3 (May 1998) related to children referred for speech delays. They are intended to provide more clarity for interpreting Delaware’s eligibility and intervention guidelines.

- 1. Q:** Is it acceptable to use criterion referenced tests now?
A: *Standardized (norm referenced) tests must be used to establish eligibility unless the child has an established condition or a condition exists that precludes the use of a standardized tool (i.e., cerebral palsy with oral motor needs, hearing impairment, etc.).*
- 2. Q:** Does a speech-language pathologist have to be on the evaluation team?
A: *A speech-language pathologist should be available for consultation to the evaluation team.*
- 3. Q:** Does a speech-language pathologist have to be on the treatment team when communication delays occur with delays in cognitive skills?
A: *It is acceptable for a speech-language pathologist to be either on the treatment team or available to the treatment team for consultation.*
- 4. Q:** How does the evaluation team decide which children receive the Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP) and which receive a full communication evaluation?
A: *For children up to 24 months of age, when a five-domain assessment indicates a communication delay, it is appropriate to use the CSBS DP to determine if a referral for a full communication evaluation is needed.*
- 5. Q:** If a child has a greater than 30% delay in expressive language and significant frustration or behavioral concerns or self esteem issues or a combination is he eligible?
A: *The child would not be eligible based solely on a 30% delay in expressive language. Referrals can always be made for behavioral support services. Additional options include: (1) referral to Enhanced Watch and See or (2) eligible based on clinical judgment with appropriate documentation.*

6. **Q:** What about a child who has many phonological errors, but has less than a 30% delay in expressive language?

A: *That child would not necessarily be eligible for Birth to Three. The eligibility guidelines indicate that a speech-language pathologist would need to formally document behaviors that indicate the presence of a phonological disorder, or clinically judge the child as eligible. These children may also be judged as eligible for Enhanced Watch and See.*

7. **Q:** Most of the children with expressive language delays are not talking at 24 months or are only using a few words. How do you assess for verbal apraxia or phonological disorders in that case?

AND

Q: I am uncomfortable diagnosing verbal apraxia at such a young age. Do we have to?

A: *The intent of the eligibility guideline is to determine which children should indeed be eligible. A formal diagnosis is not necessary but the speech-language pathologist should document which behaviors were observed that may be indicative of verbal apraxia (i.e., disordered vowel productions, reduced consonant repertoire, favored syllable, etc.) or phonological processes that are abnormal or late in resolving (i.e., backing to velars, deletion of initial consonants, etc.).*

8. **Q:** What about a child who had more than 10 words but now uses none of them?

A: *This could be an indication of other developmental issues. A full developmental evaluation would be required to determine eligibility and to report on the child's current level of functioning.*

9. **Q:** What exactly is meant by "clinical judgment"?

A: *The Delaware eligibility guidelines recognize that certain characteristics of a child or family may play a role in a team's recommendations regarding eligibility for services despite standardized test scores. When eligibility is established based on "clinical judgment" the risk factors considered should be documented and explained (i.e., family history, partial delays in other domains, child's age, cultural/environmental factors, etc.).*

- 10. Q:** If a child is found ineligible for Part C services when can the family request that another eligibility determination be made?
- A:** *Children who are not eligible for any CDW services are typically evaluated every six months at the request of their family.*
- 11. Q:** Some children will not be eligible for Child Development Watch (Part C) services; however, their families may wish to pursue speech-language pathology services privately. Will Child Development Watch (Part C) offer information about or referrals to private therapy services?
- A:** *Supportive information will be provided to families regarding other services (local school district information, American Speech-Language-Hearing Association, Delaware Speech-Language-Hearing Association, Primary Care Providers, etc.).*
- 12. Q:** What options are available to families who are eligible for Part C services but who do not wish to participate in the program?
- A:** *Options available to such families include: closure of case, “Watch” category, or information to assist in seeking other services and/or private service providers (i.e., American Speech-Language-Hearing Association, Delaware Speech-Language-Hearing Association, Primary Care Providers, etc.).*
- 13. Q:** What is the expectation of family members in meeting the communication needs of their children?
- A:** *It is expected that families will be made an integral part of the service provision team by being provided the necessary supports to fully embed their child’s communication goals into daily activities and family interactions.*
- 14. Q:** Is an IFSP needed for “Enhanced Watch and See”?
- A:** *No. Children in Enhanced Watch and See are not eligible for Part C services.*

15. **Q:** How will children in Enhanced Watch and See be formally monitored for Part C eligibility?
- A:** *The Enhanced Watch and See coordinator determines follow-up. The Enhanced Watch and See coordinator is expected to do this in consultation with the consulting speech-language pathologist or original assessment team members. The Enhanced Watch and See coordinator will be responsible for scheduling follow-up Child Development Watch evaluations.*
16. **Q:** How will children in Enhanced Watch and See be monitored for progress?
- A:** *Follow up plans and monitoring are tailored to individual child and family needs. Follow up evaluations may include parent report tools or criterion referenced assessment instruments in addition to standardized tests.*
17. **Q:** For children participating in Enhanced Watch and See, how will transitions or determination for school eligibility be made?
- A:** *The EWS coordinator will be monitoring for possible school district eligibility. The EWS coordinator will support families in making a referral to their local school district if the family so chooses.*
18. **Q:** What if a child is eligible for Part C based on adaptive/social/emotional domain but also has some delays in language development? Can he be referred to EWS?
- A:** *Children who are eligible for Part C may not participate in EWS. The assessment team may decide that other tests are needed to get a more accurate determination of a child's delays.*
19. **Q:** What information should be given to parents about expectations for their child's development since there is a wide range of typical development? Some parents might be concerned if their child is at the lower end of the range.
- A:** *The EWS staff will be trained to discuss developmental ranges and reasonable expectations for children. They will also have materials about development and language stimulation available for parents.*
20. **Q:** How many children do we expect EWS would affect? Would it be a significant number?
- A:** *Because this is a new program, the incidence in DE is not available at this time. Monitoring will take place to determine how many children are*

participating in the EWS program. It is anticipated that 5% to 10% of children previously eligible for Part C will now qualify instead for EWS.

- 21. Q:** Will children be included in EWS as they approach their 3rd birthday?
- A:** *It is appropriate for children over 30 months to be designated to receive EWS. These families will be asked to participate in child tracking procedures once their child enters school.*
- 22. Q:** What is the best approach for evaluating and providing services to children in bilingual households?
- A:** *It is essential to consider and respect every family's culture and primary language when providing intervention services. To enhance natural interaction and communication between the child and family, services should be provided in the primary language of the household. If an interventionist fluent in the primary language of the home is not available, a specially trained interpreter may interpret for the interventionist providing services.*