Michigan P3 Policy Agenda-Setting
Executive Summary: Early Intervention Action Team Responses

Number of Conversations Held*	17
Number of Action Team Participants*	230
Number of Survey Responses*	17

*as of 11/1/19

In Michigan, there are currently 167,000 infants and toddlers in families who live at or below 200% of the federal poverty level ~ 12,567 of them currently receive early intervention services. (CEPI FY17, MDE and U.S. Census)

Overall themes:

- Parents report receiving most effective referrals to Early On at birth and/or from pediatric staff at the hospital; parents identified inconsistencies in referrals to Early On in other settings.
- Inconsistent visit frequency, long delays between appointments were common concerns.
- Perceptions and/or misperceptions about eligibility deterred families from utilizing Early On.
- For those who have utilized Early On, parents say the lack of non-traditional hours is a barrier (with the exception of stay-at-home parents).
- For both families who have utilized Early On and those who have not, there is a high level of confusion about what is available: lack of understanding about Early On is and what's provided.
- What services you receive depends on where you live; several families report moving from one county to another to access early intervention services (higher quality, higher frequency, etc.).
- Parents note that while it is a positive that Early On is free, many families do not understand the value of the service, in part, because it's free.
- Program staff/administrators cite workforce shortages and lack of funding as top needs, noting several challenges with hiring OT, PT and Speech therapist positions.
- Several program staff and administrators describe the system as fragmented, highlighting the need for a uniform framework for delivery of visits and universal marketing.
- Challenges within the referral processes were also common, and many program staff talked about how families "reject" Early On services.

Recommended Policy Solutions:

1. Increase early intervention funding gradually over five years to adequately serve 100% of eligible children and examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in early intervention services to ensure equitable access statewide.
2. Set a minimum standard regarding responsiveness and frequency of early intervention visits and services, ensuring all counties statewide can provide consistent, quality services.
3. Include early intervention in broader advocacy efforts to promote workforce development and increase early childhood workforce compensation.
4. Strengthen and streamline data sharing between early intervention services and other supports to remove barriers to accessing care.

Early Intervention Action Team Responses – Full Text

Parent Responses

1. **If you have a child with a disability or a developmental delay, or if you have concerns about your child's development, have you used Early On services?**
    - Yes
    - The majority of participants asked had used Early On services. One parent who had not said it was because they could never get a call back/response from Early On.
    - Yes, Micro-preemies automatically enrolled at discharge from the NICU and added services/providers as more diagnoses were made. Weekly visits from 3+ providers and were very satisfied with our experiences. Eventually moved to a toddler group which was also a wonderful experience to get her ready for preschool. In addition to early on, connected with EHDI, mi hands & voices, guide by your side, great start playgroups, sign language classes, Michigan alliance for families, and a program at the university of Toledo for deaf children/families. Our providers were the best! We received OT, PT, speech, and teaching consultant for deaf and even 10+ years later I am still in contact with some of them for updates and just general friendship from the relationship we formed.
    - 3 out of the 4 parents had participated or are currently participating in Early On. All 4 parents are participating in a playgroup run by Early On providers that welcomes any interested family in the community.

2. **If yes, how did you find out about Early On?**
    - Through Great Start
    - Nurse practitioner
    - Through Great Start Early Learning Groups
    - Through friends/neighborhoods
    - Community awareness of developmental knowledge
    - Share parent to parent information of informal supports
    - Connections to preschool teachers
    - Pediatricians
    - Healthy Futures Home Visitors
    - Allow for support for transportation
    - Ensure that they know the service is home based/transportation not required
    - DHHS perspective – even when not substantiated child abuse, thinks that the families are likely referred
    - Change perception that there might be punitive services
    - Preservice for new workers may be helpful DHHS/GSRP
    - Younger siblings may be connected to services or families through GSRP
    - Standard Packet or information that may be available to be shared with families – resource guide?
    - 2 found out through their doctor, and 1 through Early Head Start

- Hospital that diagnosed gave information and received several pamphlets from different sources. Early intervention contacted at about 3 months old. Excellent experience. Wonderful team. Special education teacher and DHH teacher consultant. Really appreciated all of the tools, but switched out of Lake Orion Early On to the Center Based Program in our county to get group experience vs. 1:1. Wanted more connections in the community, exposure to kids who were DHH and to ASL.
- Yes, my pediatrician told me about it. Early On person was very kind, but she didn't know to require hearing testing when my child was behind in speech and language. I wish she would have provided a referral for a hearing test right away. Child was a late diagnosis
- Fliers at diagnosis, from Hands & Voices, also contacted by Early On program staff.
- Foster Care

3. What was your experience?

- Wonderful
- Loved it
- “So-so”
- Didn’t particularly like the assigned worker but she gave us good resources so in the end it was a success
- Took me a long time to get the external services I needed from Early On, my experience with the workers wasn’t awesome
- Mixed reviews, some felt ambivalent about their experience, others felt well-served. Still others had not remained with the program because they felt their needs were not being met.
- One parent talked about the visit frequency not being what their family needed.
- Another spoke about the approach “It felt like it was always a bunch of paperwork and not spending any time with my son.”
- Two parents spoke of feeling like their child was not prioritized because they were ‘not as delayed as other children in the program’. Less frequent/useful visits because their children were not showing signs of extreme delay. “Put on back-burner”, “checking a box” [Facilitator note that this issue could be unique to Flint because of the Flint expansion to include all children exposed to Flint water. This could account for their children being ‘not as delayed as other children in the program.’]
- Multiple parents talked about change of staff being frustrating.
- Most said it was easy to access Early On
- All report positive experiences. One commented “I look forward it”.

4. Why did you not use Early On?

- Families didn’t sign up for Early on because they have a medical marijuana card and didn’t want to be judged or reported (they also don’t sign up for WIC or other services)
- Parents don’t sign up because they don’t want dad nailed for child support when signing up for services
- “I didn’t think we were qualified.”

- One parent knew they were qualified under the “Flint expansion” and attempted to be in contact with the program but never was connected/early on never came out to the house/evaluated the child.

5. **Were you satisfied with your Early On experience? (The approach, the frequency of services, the interactions with you and your child, etc.?)**
   - At the playgroup, it seemed like I was an afterthought. They got everyone else set up and then they checked in but didn’t spend as much time with him.
   - Son in it for speech, however the worker that was assigned to me, did not have an expertise in speech and the things she was suggesting we already did. The services that he needed were not matching what he was getting
   - In my case it seemed like my worker was diagnosing my child which was bothering me. She referred me to a specialist and the specialist said everything was ok

6. **If no, why not?**
   - Felt like we were an afterthought
   - Didn’t get enough one on one time with a plan of action
   - Took a really long time to get evaluated and to get the speech therapy set up - the speech therapist is awesome but the Early On worker wasn’t giving me anything that was helpful

7. **What services other than Early On did you use to support your child?**
   - Mine went into a specialist referred through Early On - I didn’t seek out separate services
   - Friends have looked into private services because they are not happy with Early On
   - Most of the families had utilized home visiting models. Some used center-based and home-based childcare and almost all have worked with the Michigan Department of Health and Human Services (MDHHS).
   - private speech, private PT/OT, audiologists

8. **What barriers, if any, made it difficult for you to access Early On services? (Consider every step of the process: the referral, the Early On evaluation, developing an Individualized Family Service Plan, and receiving services.)**
   - Wait time between referral and evaluation - took 6 months to be evaluated the first time
   - Having a job made it difficult to make the time for paperwork and appointments.
   - Had a baby - had a 2 year old being evaluated and a baby that made it difficult to make it to playgroups
   - The biggest is the proximity to downriver area in MI Wayne County and not enough services throughout the entire county
   - The parent who was not able to receive services was referred at least 2 times by another early childhood program and a physician and still was not connected with services.
   - Barriers with adoptive mother having to have bio Mom sign off on everything.
   - Timing for one parent made it seem like another thing to have to juggle.

- Time was a barrier - especially for parents working full time. Providers were excellent at working their schedules to fit with early morning appointments and working with grandparents on days parents not available.
- No barriers for stay at home mom.
- Didn't tell me about Michigan School of the Deaf or Center Based Program.
- Didn't review all of the options.
- Wanted to manage my case without discussing other options.
- How can we make educated informed decisions if we don't have all of the information?
- Guides from Guide By Your Side program through Michigan Hands & Voices (parent to parent support) are hearing from parents that "[Early Intervention/Early On] can't do anything for me." Don't understand that Early On is there to train them to recognize milestones, etc. Parents assume it's another therapy session for their child. Don't see the value because their baby is so young. Don't see the value in tools. Early Intervention teachers need to "Teach you how to teach and engage with your child," and communicate that purpose clearly to the families they serve.
- Need list of ALL options available for D/HH children. What are the possibilities? What should we try?
- Flexibility (with IFSP interventions).
- Transparency.
- Early Intervention team needs to be the expert. Hold our hand. Provide guidance.
- If it's not working/not making progress, make specific recommendations. Change the plan. Don't keep trying the same things if improvement isn't happening.
- Needed access to ways to learn sign language from an actual sign language teacher or deaf person.
- Parents want government to set up an information-sharing agreement between Early On and the Michigan Early Hearing Detection and Intervention program like other states have, so that deaf/hard of hearing children can be tracked through the system. We are trained parents who know that this is a major hold-up to tracking which children are enrolled, and families then fall through the cracks.
- Families I've talked to have had to wait weeks/months for services to start because Early On personnel were waiting for reports from medical staff (ENT, audiologist, hospital clinic). Maybe Early On could move forward more aggressively with evaluations based on parent concern?
- Once children are enrolled in Early On and have a confirmed diagnosis of hearing loss, whether it is bilateral or unilateral, mild/moderate/severe/profound, families need a professional on their team who is trained in educating children who are deaf or hard of hearing. When families don't have access to that person, they actually have negative feelings about the experience with Early On and will be more likely to drop services.
- As a supporting parent, I've seen Early On tell families of children with unilateral hearing loss or single-sided deafness that because the child isn't developmentally behind they do not need services. This inhibits the family being able to integrate the child's needs associated with hearing loss into their lives. Unfortunately, these kids are at risk for delays later. At a minimum, best practices from the Joint Commission on Infant Hearing (JCIH) states that these children should have check-ins every 6 months. https://www.audiology.org/sites/default/files/publications/resources/2019_JointCommiteeInfantHearing_Principles_Guidelines4EarlyHearingDetectionInterventionProgrs.pdf

- and Principles and Guidelines for EI for Children who are DHH https://pediatrics.aappublications.org/content/131/4/e1324
- Families I know have said that they can't meet during the day, and they miss what's happening if visits happen at daycare. Perhaps some Early On staff could have work schedules that allow them to meet with families in the evenings if that's the only time families have available.
- There were no barriers experienced by these parents. In fact they all commented on the ease of access. Their doctor or Early Head Start asked if they would like a referral to Early On. They said yes, and Early On called them and got things going. Suggestion for improvement – sending a reminder text for their home visit appointment or text when playgroup is cancelled (like for snow days).
- Those that attended report that other families may have transportation issues that keep them from coming to playgroups. Recommendations were to have a car pool list or take public transit, although the public transit has limited routes and times they travel to the more remote areas in this region.
- The families stated that the main things they do when trying to seek information is to search on the internet and go to Facebook events.
- One parent stated that when they started questioning if their child had a delay, they didn’t know what to do so started asking people and professionals they knew as well as their doctor, which led to their Early On referral. That parent wondered how other people would find out if they didn’t have an extended support system. Other parents in the group suggested WIC, Drs office, flyers in the community, or in packets at events.

9. **What suggestions do you have that might help remove or reduce the barriers you faced?**

- Quicker timelines
- knowing as a parent the timeline and how long to expect
- More information on the website, so parents can get a better idea of what exactly to expect.
- Is there a way to “triage” the referrals coming through to move “higher risk” families through faster
- More communication
- Share waitlist information so new parents will know that it is a longer wait
- Updates during the process to know where they stand in the process so that the parent doesn’t feel like they have been forgotten
- Not comfortable with new and strange people coming into our home - during the first phone call, find out how the family feels and if they would be more comfortable meeting somewhere else instead of in their home
- Do not require the visits to be in the home - allow options to be outside the home - advertise that it can be done where you as a parent are most comfortable
- Transparency in what Early On can provide. Consistency county to county. Parents SHOULD NOT HAVE TO MOVE TO GET SERVICES. TCs who are educated in D/HH.

10. **If you have used early intervention services, did you feel that the service providers who worked with you were knowledgeable and respectful of your family culture?**

- All felt that service providers were respectful of their family culture.
- One parent with adopted children felt very supported by workers with experience in similar situation.
- Everyone in the groups felt like their cultures were respected.
- Yes (all)

11. **From your perspective, what's working well in your community for Early On and other early intervention services?**
    - Very resourceful and knowledgeable specifically for children with special needs.
    - Compassionate.
    - Awareness about the program; people know that you can just call and don't necessarily need a professional referral.
    - Never made you feel inadequate; supportive.
    - Great at resource sharing.
    - Not sure as it's been 10+ years and it appears there has been a lot of staff turnover. Specifically moved back to Lenawee County for elementary school because we received such good services in early on! Great, caring providers.
    - There are some really stellar people in some counties who go above and beyond for their families, creating play date events for families of children with similar diagnoses/situations
    - Most families don't feel like they are getting anything from Early Intervention. They don't understand the value. Weighing the perceived benefits against the invested time. Spread thin with so many appointments. Most end up dropping or refusing services. Our kids don't show physical or easily recognizable gaps until 12 months +. Their needs aren't as obvious. Need Early Intervention staff that are trained to support D/HH kids and current with changes in practice.
    - There is no charge for any of the services
    - Access to both home visits and playgroups
    - They make it easy to get the services

Provider Responses

1. **What's working well for Early On in your community?**
   - Parents accept services
   - Delivered services – well trained people, capable training and support network, strong partnerships with ECE SE, starting to get state level support for additional funding and add quantity.
   - Statewide program – baseline to "catch" various children
   - Outreach to physicians has positively increased referral from Dr/ stronger collaboration has been improving between Early on and MMSE staff
   - Referral process – enter through many doors and is working quite well, especially referral system at the state level.
   - Connection to Higher Ed

- In our community what works well is TOTE is in Woodhaven School District in our TGC Service Center and parents think it is too far. Early On is a part of Wayne RESA it's the proximity of Downriver Families that benefit and maybe not so much for others throughout Wayne County.
- Multiple services, EHS, Early On, and Nurses doing NFP. Lots of diverse programs being offered. Home visits build familial relationships which are personal, and the relationships built are really special and have a positive impact on parents. Working with the parents pays off for the children by providing whole family services. More than two gen – grandparents and other family members are also being served who are surrounding the child.
- Preschools and community services as referral services are working well
- Excellent service providers, families get access to SE or non-SE services regardless of eligibility. Good word of mouth throughout community member and between families to get referrals. Pediatricians make lots of referrals. Good partnerships for referrals and services with EHS, CC providers. Districts value services. Families value services. Many students get exited because they no longer need services. Have a sense of urgency to meet timelines. Use an ISC model to manage referral process. Workgroups help support the work; problem solve to support our work and eventually families. Community playgroups are well attended and supported and run collaboratively and are inclusive groups. We have comprehensive teams to serve families (4 regional teams) and families get frequent, face to face great service.
- TCs that consistently go above and beyond, organizing communities and support. Playgroups, support groups, etc.

2. **What are your challenges?**

- Parents reject services
- Still lack of resources/ funds if we are to increase number of I/T numbers
- Finding staff to provide services (especially if there was an increase in number of children serves Lack of Funding – unable to hire specialized staff
- Inability to hire staff (OT, PT, Speech) due to lack of enough funding.
- Helping other comm. Partners see the value of EO – spec Local school district, medical providers, EHS, developing and sustaining partnerships as changes arise can be challenging
- Growing process can create growing pains (specifically for new people who do not have experience in EI) don't want EO to become to much like other services (become water down)
- Gaps that are missing some families – no eligibility criteria around domestic violence or abuse – not a qualifier if they are demonstrating on target skills
- Limited/lack of coordination of services for very high risk families – limitation of services that are available to families (Eaton county) if they do not qualify for EO
- **Distrust** of organizations for a new mom.
- Labelling that child or mom has issues.
- Too many hoops to jump through to get help for child. i.e. one more thing on an already over-taxed parent.
- **Navigation** through the system.
- If it's not happening at the Dr. office, where is it happening?
- The right partnerships are not in place.
- Doctors like to refer and refer and refer; parent is exhausted of referrals.
- Disparities in the way people view people; is the child delayed or is it parenting?

- People lie about a disability to get funding from SSI.
- **Lack of Resources:** not enough workers to handle all the cases.
- Babies are having babies.
- Re-train our lens and broaden our understanding.
- Families need a community advocate who is consistent; a warm hand off to walk alongside a family.
- The system doesn't work fast enough.
- Having enough staff to do them – bodies – posting positions and not finding qualified people. Such a shortage in staff. Trying to get creative in who is providing services by connecting them with mentors who are qualified staff.
- Workloads for staff that are doing this work, their loads are unrealistic and the compensation isn't balanced with their workload or the kind of work they are doing. With the populations that we are trying to serve, (special education) we get a referral and by the time we contact the family, we can't reach them – changed contact information, transitions in housing etc. Not able to reach families because in that short time, they have already moved or can't get in touch with them.
- In Wayne county case loads for Early On are really high – can't fit them in quickly. Need to go quickly when the parent is ready – if we wait too long they may not want it any longer. Poverty in general is a barrier and creates stress – trying to survive and adding on parent responsibilities to engage in these programs is hard. If they are working during the day and there are limitations related to poverty that impacts accessing services.
- Access can be challenging
- There is a persistent 3 year old gap
- Families don't have transportation to get to playgroups. Rural areas do not have access to resources/services, etc. There is confusion about geographic boundaries. Families cross boundaries (live in one county and have childcare in another county). Inconsistent childcare make services inconsistent. Families do not want to have staff go out of their way to make a visit.
- ELL, lack of interpreters, materials are not in native language. Ability to coach is reduced with ELL. Disparities in availability of services (e.g. interpreters may not have large availability). Do physicians refer ELL families enough? Public charge/immigrant status is a deterrent. Trust – immigrant families do not always trust outside providers, especially CC providers, which leads to inconsistent childcare and inconsistent services.
- Cultural representation in workforce, materials, etc. Grandparents/Intergenerational/Kinship care can make establishing consistent parenting can be a barrier to getting consistent services.
- Access to assessments
- Since way on stops at age 3 many children are too d to get help. The parents must now go through the local school district or find private help. Parents are having to spend more than they can afford out of pocket or are waiting for months.
- underfunded, under resources, not considered ion par with infant toddler special ed
- Parents willing to accept their child needs additional help
- Paperwork
- No centralized service provider, fragmented system

3. **What would it take to remove or reduce these challenges?**
    - More information for parents about benefits of services, services through agencies near where parents work in case child goes to childcare outside of their community
    - More funding.
    - Inclusive approach – support the whole family.
    - Education about/define what mental health looks like in infants/kids.
    - Broadening screenings because now we are seeing social/emotional being factored in.
    - Continuum of care.
    - Universal marketing for Early On for families throughout the county and downriver Pediatricians being more aware of what Early On is and early referrals.
    - Staffing – paying equitable pay for the work that they do. Staff in Special Ed (K-12) get paid more than Early On staff. Home visitors are on their own a lot and need an administration that supports them with reflective practice.
    - Family specific – learn better what are the barriers and address them! Some parents work throughout the night so that they can access services for their children during the day. If the child had comprehensive day care during the working day, they might be able to be served. With 0-3 there aren't many options.
    - Are there some quality assurance standards for case loads – with a recommended number of families and visits to help guide staffing issues for things like Early On staff who are required to serve families if they say yes. All things considered, when we run short on time, the visits run short. Can't always commit the frequency or duration needed.
    - Trying to find some type of uniformity – create a framework for the delivery of visits especially in Early On – because it really is open to the interpretation of the provider. If some kind of pipeline or regular training and PD specifically for home visitors there is the HV conference etc. every year, but it's a lonely field that isn't widely understood. When you try to hire, it's hard. Have had some who had a class that focused on what early intervention and HV actually looks like which was great – but it's rare.
    - More people, more playgroups. Education internally and externally with our approach to services; PSP and Coaching. We are educationally based and need to remind others that the delay needs to impact their education. If a child does not qualify for *Early On* we need more agency partners to serve families. Low income families – getting them to meet some of their everyday living needs (family needs) and also work on strategies to meet the child needs. Need to get families to the right programs – need connections with other community based organizations. Need a way to triage a family to the proper program. Level of service in the receiving programs when transitioning out of *Early On* is not sufficient to be successful. Staff needs more training on playing the role of a primary service provider – sometimes families are matched up with a primary provider who does not have the background that meets the family's needs. Need time to have meaningful dialogue and planning for the families we support. Need enough time to service coordinate. General family doctors need education on when to refer. Share that Early on services are free.
    - Better special needs training offered to early childhood educators. Every special needs training I go to teaches me nothing. The person who prepared the training speaks of just 1 child which every child with special needs is different or they are so nervous they jump all over the place and is hard to follow.

- The redundant paper work that ask the same question 5 different ways
- Streamlining of systems

4. **Does your community have sufficient resources to provide adequate Early On services to families and children?**
    - Yes, Early On through tote with a large number of participants or/and RESA but still needs more outreach. Family Day Cares can even have a gap in services.
    - Priorities come down to compliance, so the teacher has a caseload to manage and evaluations that have to be done in a quick timeline, so the caseload tends to be the service that has to be cut. Evaluation needs to take precedence because it's mandated.
    - With EHS, they have waiting lists – they are always full and the staff starts looking for subs to help support them in keeping up. We see that our staff need immediate support and skill development. We sometimes bring others in to sub under direction of the EHS teachers, so we can keep running. Not enough EHS! We try to refer and there are areas where I have no suggestions because there are no options – especially in Detroit. Parents should all have options.
    - Transportation is another serious issue for many of the families.
    - No (4)

5. **Does your community provide distinctly separate services to Early On-only children versus Michigan Mandatory Special Education children?**
    - Our services are very similar but the frequencies of services differ
    - Yes - Early On Oakland provides distinctly separates services/service delivery models for Part C and Part C + MMSE.
    - Yes the services differ in Genesee county. But we utilize the same providers for both.
    - Part C staff does not have qualifications of MMSE staff
    - Our services differ DRASTICALLY in terms of providers and frequency/intensity
    - Difference in frequency
    - Community based agency EO/ school district provides MMSE
    - We have part c staff and frequency is less than MMSE
    - Wayne County has community-based agencies providing services to Early On only and School Districts provide services to MMSE EO children. MMSE EO children receive weekly services where as EO only children receive monthly or bi-monthly visits. Staff vary in each agency program, MMSE programs have a more diverse staff, PT/OT/Speech etc.
    - Eaton RESA has one group of providers. Frequency and intensity depend on the needs of the child and family, regardless of C vs MMSE.
    - We have a range...
    - Frequency and intensity are determined by the IFSP but service delivery model is same for both.
    - No and this is/has been/could be a barrier to services for families and even confusing if they are even aware of these services. Increase collaboration with MI Alliance for education on the difference of the two services maybe an education branch.

6. **If so, do you feel that all children are getting the appropriate intensity/level of services they need? Why or why not?**

- No
- MMSE eligible children cannot be seen by some of our staff.
- Children who qualify for EO+ MMSE have needs met - Part C children who are only served through community org. are limited in frequency (once a month) due to limitations of funds and don't have as much access to providers – while gains are being made there is a need for funding to ensure all children's needs are met.
- Part C only do not get enough services and some of the MMSE get too much (because of FTE requirements)
- We have part c staff and frequency is less than MMSE
- MMSE eligible children do have their needs met due to the frequency in visits and diverse staff, but Early On only may not always receive the frequency of services that they may need. One hour per month is not enough to follow through on child and family outcomes/strategies during daily routines.
- I have worked in two other counties and 1 has vastly different service models for C vs MMSE and the other one group of providers with similar services, intensity based on needs. Neither of those counties are represented here today in this group.
- We have a team of service providers covering all disciplines. While caseloads are pretty high and recruitment of qualified staff is a challenge. All children are getting an appropriate level of services now.
- Because our Part C children have access to specialists/therapists and we are not collecting FTE for either C/MMSE I am finding we under identifying MMSE
- Frequency not enough. Some services not available to all. (Speech and ECDD teachers especially limited)
- MMSE eligible children do have their needs met due to the frequency in visits and diverse staff, but Early On only may not always receive the frequency of services that they may need. One hour per month is not enough to follow through on child and family outcomes/strategies during daily routines.
- We have a team of service providers covering all disciplines. While caseloads are pretty high and recruitment of qualified staff is a challenge. All children are getting an appropriate level of services now.
- More frequent services would definitely be helpful.
- In general, 80% of our Part C Only children do not have access to OT, PT, SLP support. The majority of providers have bachelor's in SW or PSYCH.
- I think there is enough. We are continuing to work on our dosage based on the needs of the child & family--not the eligibility (necessarily)--so that it is individualized.
- Our team is mostly social workers, 1 nurse, 1 special ed teacher
- We do not. Some families are not interested. Some families have other priorities. Some families we serve at childcare and it does not feel like we are serving families. Some families are served by multiple programs.
- No, Few direct services and interventions for social/emotional needs, challenging behaviors, trauma
- funding

7. If not, what would help mitigate this problem?

- Funding
- More direct services, fewer administrative positions

8. **Are you experiencing any challenges related to the workforce?**
    - Shortage across the board for statewide professionals working with children birth to five and there needs to be statewide programs/free college to support people who want to work with this population and more college options.
    - Substitutes – for a staff on leave, can't find someone to fill these positions. Not enough people considering Early Intervention as a career. Transitioning children out of the program to larger districts takes time and coordinating all of this takes time and many players. Staff turnover and communication with receiving teams is challenging on state and local requirements; receiving teams not always understanding the *Early On* system. Higher education does not seem to focus on Early Intervention Key Principles, especially in PT, OT and SLP programs.
    - workforce stress and feeling of being perceived as less professional
    - The time lines associated with Early On, by the time we receive the referral it is late

9. **Are you seeing staff turnover issues?**

10. **Would your community be able to hire new staff if Early On received additional funding?**

11. **What would it take to stabilize the Early On workforce?**
    - More administrative support, more training, opportunities to go on home visits while in training programs, more information about home visiting jobs while students are in college early childhood education programs
    - Funding – increased pay and benefits
    - Adequate resources might help

12. **Has your community developed local solutions, such as doing things to work around the system, local funding, etc., to help families who need early intervention services? What are those?**
    - Use as many outside resources (not funding) that we can – other agencies working with families, play group locations etc.
    - It helps that we have a healthy local special education millage that offsets the cost of MMSE services.
    - We have weekly team meetings where our Part C providers have access to OT, PT, SLP, SW, nurse for consultation or to schedule joint visits.
    - Our Early On and MMSE staff are both employed by our local ISD.
    - we use the community resources around us to support families - access to playgroups. We also try to provide EO staff with training from MMSE staff as needed.
    - Consultation from specialists through team meetings or 1;1 also ongoing.
    - It would be easier to follow a seamless model if the ISD employed the MMSE staff.
    - Not that I am aware of

- I would like to see partnerships with local universities to fill some of our needs – grad students who need practice hours – use them to create mutually beneficial relationships.
- To some degree but not adequately
- Public schools or private programs like Brainz or pine rest
- We have coordinators, but no additional direct service providers

Reactions to Policy Solutions

Solution One: Increase early intervention/Early On funding gradually over three years to adequately serve 100% of eligible children.

- Absolutely!
- Some of the challenge's ties to funding – impacts staff hiring (lack of qualified staff) and the needs of families – It is hard to attract qualified staff if we cannot pay them what they can make in other fields of service.
- Direct funding to programs, not administration
- Funding would need to be reliable for staff coming into EO - would help to retain qualified staff
- Just because it's offered, doesn't mean families know or want it. A broader understanding of professionals around the field of Home Visiting and what it looks like. So they might know if this is a field of interest before they are seeking work.
- Fully support additional funding through state investment - and the idea that it is gradual so that local service areas can build capacity.
- There also needs to be pay parity
- Last year we doubled our Early On Services due to the 54 D funds...I feel that student needs are much better met now that they have more services as well as access to certified staff who specialize in the child's area of deficit
- Meet with families in settings that are non-threatening or with someone who is already known and trusted by families
- Have a generalist interventionist that can talk to the range of services and are responsive to the needs of families (both emotional and with family's timeline or expectation of response)
- Collaboration with our local Great Start Collaborative and Local Leadership Group are helpful.
- Community outreach for identification; partner with other agencies and hold at their site. Screening teams at community events. Need more service providers: SSW, Psych, SLI, Teacher, PT, OT. Need access to a public health nurse or a nurse on staff. Need support for transition. A floating staff person depending on need on regional team.
- <u>If there's no understanding of the need, people won't take advantage of it - no matter how much funding the program has.</u>
- Invest in DHH Teaching Consultants, in-servicing and educating the early on team to low incidence, DHH kids. Many lack the knowledge and skills to work with our children.
- Facilitate bridging the language gap with basic sign language prior to interventions even with kids who are AVT (auditory/verbal therapy) focused - especially when the child has no access to sound (CI candidates).
- Coordinate services throughout the state and share resources so that all families have equal access to qualified resources.
- Speech therapy with people who are DHH trained.

- Audiologists involved.
- Specific service plans for our kids.
- Adult DHH mentorship/exposure for families.

Solution Two: Increase the availability of infant mental health services, both within the Community Mental Health system and other settings.

- We would have more SSW time to provide direct services. Existing staff work on IMH endorsement.
- Generally, no. Need IMH services for families who are not Medicaid eligible. Would need intentional coordination for programming if a family is enrolled in multiple programs and common goals/outcomes/and even a common service plan. Multiple programs collaborate and make joint visits.
- Imh offered OUTSIDE the CMH community is as important as within due to eligibility issues at CMH
- This is still great but doesn't impact D/HH kids who aren't D/HH Plus.

Solution Three: Explore postpartum visits for all women and their infants to identify prevention and intervention needs.

- Yea! Yes, I think that would be great – some hospitals offer that for moms but I think that it would be great for everyone to have access to.
- One of the pitfalls that surround every corner is that we tend to for needs of the grant and the biggest bang for the buck focus the attention on a targeted audience – while there is a recognized need that every parent at some point in their life needs some support – especially with a newborn. More and more evident now that people are more isolated and disconnected – especially due to social media. Almost like a disconnection between people.
- I think for my population – if people called and offered it many may turn it down and not see themselves as able to make an appointment – I would be curious if it was coming from a community based format with partnerships with other organizations that provide additional supports if it would bring people would help jump start the relationship.
- If I said I want to come for a home visit – bringing samples, might be more appealing.
- I think it would be fabulous. In the Netherlands they do it and I want to steal that. I also agree. It would be a great idea and the front-loading piece – education around normalizing post-partum and the experience of motherhood and giving birth. It's glamorized like babies latch on immediately and you are excited to have this baby and bring them home. Normalizing that it's hard would help more families to not feel so alone and depressed if they are not feeling connected to their baby.
- Even the safe sleep pieces. I have a MA in IMH and EC and on my best days I do great, but I can empathize - when your child doesn't sleep and cries all of the time, things like safe sleep isn't top of mind – is this a mom who hasn't slept, doesn't have resources to insulate her child? Its' different when you have resources, or you have slept. It's not reality.. We have a free drop of child care site for low income parents where twice a week they can drop off their baby and go home and sleep – take a shower, 2.5 hours twice a week. Those supports are invaluable! Families with higher incomes pay $5

- Medicaid guidelines don’t offer the full support. If parents live in a hotel and you are trying to help build capacities of the child, it’s nice to take them to Bob Evans or somewhere comfortable. To be able to have a little pot of money for roach treatment etc. People would not believe what we do to help families so that they can focus in. It’s not wasted money – it goes a long, long way, but most of us are spending our own money to provide this kind of support.
- Level of payment that home visitors receive as a salary – some are serving the Medicaid population and they are the Medicaid population. This is how we perceive the helping profession in our country.
- Interesting, does it stigmatize birthing or support it? Are we screening for areas of concern or lending a warm welcome to the family? to whom do we hand off post visit?
- This is great, but won't necessarily directly impact D/HH services.
- I had PPA and it took 9 months for me to get help

Solution Four: Increase earnings for the infant-toddler early childhood workforce.

- Funding issue is huge! We contract Early Intervention staff - no benefits.
- I feel fortunate in Eaton County that we have one group of providers and we are providing what services the child/family needs, regardless of C vs MMSE. We are adequately staffed.
- It is hard to attract qualified staff if we cannot pay them what they can make in other fields of service.
- Single tier along with additional funding to hire and retain highly qualified MMSE staff to serve all children would create a much more equitable system
- I think that a single tier is what we have to move toward. Keep this the focus vs. having too many initiatives.
- I don’t know that it would solve the problem– it’s a start, but one if the issues that I have heard lately is that in this field what is the opportunity for increases in pay do not exist for those that stay in their roles – like – making more based on years of services, (raises over time etc.), more benefits etc. Moving up in the administrative system doesn’t exist in the same way in this work as it does in the school districts. We have 20 people – so the size of the K-12 districts doesn’t match and those things aren’t in place.
- It would be one way to make it more attractive – I have had teachers that look at the pay and say they can’t afford to do the EC work.
- CRITICAL!
- More money would bring them in in the beginning – the soft benefits. But the work is so isolated and there is really no supervision – if there was more funding and the staff got more support, it might increase the emotional well-being of the staff and keep them in the role longer.
- For example, when they visit a home with bed bugs – they also need to pay for cleaning this up in their own home because they catch them, and they have to pay for this out of their pocket due to their position.
- The shortages in our fields couldn’t be met with additional earnings. There aren’t enough specific therapists – narrows the pool and we just don’t have people to hire!

Solution Five: Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in early intervention services.

- Yes, it would be helpful – Absolutely, I wish that we had more coordinated ways to screen at hospitals and have a consortium or something where we could track the needs I don't know what all of that would be but I wish that there was more coordination.
- Examine disparities.
- Not comfortable having people coming into their home. Difficult home situations.
- Lack of transportation and resources.
- Break down access barriers.
- Integrate with WIC visits? Success meeting at public places.
- How to reach transient populations? Hard to get a hold of these families.
- rural settings are so tricky to serve due to cost and access
- Fund local communities to do this work, not far away staff in urban centers.

Solution Six: Tell us your ideas! What policy solutions would you suggest?

- Collaborating with pediatricians – with this specific population I question if they are going, do they have a medical home, can they get there? Could we collaborate with Early On and HV – could we do a day where we bring the doctors to the families at a school or somewhere like the high schools do for sports physicals? We have done a lot with Early On trying to get pediatricians to refer children. We try to follow back up and then follow up to re-refer as needed but it takes time and building relationships.
- I like the idea of a community event way of connecting people with medical resources and it would be nice to also form relationships – with diapers and formula with advertisers that would make them attend for what they need and incentivizing them with food diapers, etc. being met by coming.
- Coordinate counties to have more similar services - sharing resources across counties
- Tailor programs for D/HH kids - Develop Michigan State Communication Plan (or use an existing plan like Ohio State's: https://deafandblindoutreach.org/storage/ocali-ims-sites/ocali-ims-outreach/documents/Outreach-Center-Communication-Plan-HH-2018.pdf) used to individualize each IFSP/IEP
- Communicate greater sense of value in resources for families.
- List of options - more transparency in what the benefits are. County to county is inconsistent
- Education and knowledge of D/HH kids
- Not discouraging families from enrolling - all hearing loss is eligible (unilateral, mild, etc.)
- Guideline on how to follow up with a family
- Coordinate resources all at once at first visit - set expectations of what you are going to receive from each group, who does what, support and services in one visit. DHH mentor, MI H&V, EI all go in one visit to minimize the amount of appointments. (Maine has a model for this.)
- Bridge the language gap that first year for kids with ASL especially those with no access to spoken language (CI candidates)
  - Safety
  - Basic words
- Increase teachers of the D/HH
- Increase ratio
- Consistency of services available county to county and sharing of services to allow all children to have the same access to education. Developing/Using a communication plan. Access to

language (cued speech, ASL, SEE) to bridge time without auditory input regardless of planned intervention. Coordinating services to reduce families being overwhelmed. Have Guide by Your Side, DHH Adult/Mentor and Early Intervention all visit for the first time to explain services available. Coordinate care. Collaborate. Information sharing with EHDI!! Can't improve enrollment in silos. Other states do this. We need to figure out a better way.

- Increase speech and language pathologists that specialize in D/HH. Inservice training.
- ASL and cued speech instructors for families and children who choose visual language
- Need more training for language development 0-5 years - need skills to teach DHH (ASL, cued speech or AVT)
- Consent to share information with Early Intervention/EHDI. Automatic enrollment in Early Intervention at diagnosis? Meet goals with transparency, information sharing, collaboration.
- Financial incentive for low income families to incentivize the time.
- Coordinate WIC and Early Intervention services.
- Lack of D/HH specific services
- Develop knowledge from Early Intervention vs. discouraging families from enrolling or unable to speak to benefits of Early Intervention.
- Counties are very inconsistent with what they call their LICC. It makes it hard for parents to get involved. Maybe Early On could make the names of the LICCs consistent across counties?
- There used to be a pamphlet that stated clearly the timing that Early On is supposed to respond to requests for service, write an IFSP, and so on. What happened to it? It disappeared off the website.

Change state policy so that all children eligible for *Early On* are also eligible for Michigan Mandatory Special Education

- Highlights the differences between communities – there is not equitable access to services across the state of MI. Two tier system is difficult to implement and justify and rationalize to parents on a day to day basis.
- Moving towards a more consistent systems – maintain key elements of early intervention: family centered, flexible
- Bringing Early On funding brought up to the level of MMSE to help to move to 1 tier system
- Then you would not have enough staff to serve all of the children eligible. What would be the percent delay that would make them eligible. I do support a single tier - but there would have to be thought into how to make that happen and further looking at the required hours to provide each child.
- The single tier would increase equity and access. More consistency throughout the state would be so helpful.
- I wonder about delivery methods...each therapist may have different training (OT, PT, SLP). How do we create a continued improvement around the delivery of Early Intervention?
- Eligibility criteria is for child but most of what is promoted in work (coaching, parent driven goals, family routines) seems to be at odds – family gets support through child's eligibility.
- I think that a single tier is what we have to move toward. Keep this the focus vs. having too many initiatives.
- I wonder about delivery methods...each therapist may have different training (OT, PT, SLP). How do we create a continued improvement around the delivery of Early Intervention.

Notes:

Group was interested in seeing/getting data on race, ethnicity, not age. Some mentioned an expert from Wayne State University that has this data. The Michigan League for Public Policy was also mentioned as possible data source for this info.

  - Why give Early On more money to increase services before ensuring the services they are currently providing are high quality?
  - “It might be a quality of care problem, not a pay problem.”
  - Ensuring services are quality when funding goes away.
  - Cost of Childcare so high and workers are paid so little; Need to educate community about prioritizing early education.
  - Mom’s mental health needs. Perinatal mood disorders and how they impact attachment and development. Need to help moms to help kids.
  - Connection with local school district; school of choice can’t get services because they have to go to their home district.
  - Getting the word out about services into the right hands of parents who want to be further involved in their child’s education
- A policy recommendation based on father’s mental health
- Add a word in #5, examine and address (migrant, tribal, poverty)
- Using trusted advisors to engage families in services
- Engagement of participants, culturally, postpartum