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# Navigating the Self-Assessment

The numbered necessary practices on the left come from the **Guidelines for Identifying Young Children with Special Needs.** Note that the necessary practices in this document represent a *subset* of the full guidelines to use during this reflection exercise. AU staff are expected to reference the full list of necessary practices in the Guidelines regularly.

This self-assessment is intended to help AUs reflect on their implementation of these necessary practices.

**Step 1** – Read through the **Necessary Practices - *Highlights*** reflecting on how they compare with the operations of your AU. Note that the complete list of necessary practices can be found in the [Guidelines for Identifying Young Children with Special Needs (PDF)](http://www.cde.state.co.us/early/childidguidelines).

**Step 2** – Answer the **Reflection Questions** on the right by describing the operations of your AU. These questions are intended to help you reflect more deeply about how the necessary practices are put into action.

**Step 3** – Complete the **Summary Rating** depicting your AU’s implementation of the necessary practices in each section. The reflection questions should help you with these ratings; answering ‘M’ (mostly) suggests that you have concrete answers for most (if not all) of the questions in that section.

**Step 4** – Select areas where your AU team can focus their improvement efforts. You may choose to focus on areas rated ‘S’ (somewhat) or ‘Y’ (not yet).

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# A. Leadership and Administration

AU processes and procedures to support an effective child identification system, including coordination with partners across the early childhood system who support young children with delays or disabilities, or have opportunities to identify and refer them.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Practice #1 Leadership and Administration**   1. Coordinate with System Partners    1. AUs nurture relationships with community partners to assure the implementation of a coordinated child identification system that is:       * Easily navigable by families and the community       * Available 12 months a year       * Follows legal mandates    2. AUs create and utilize written materials (protocols, procedures, and/or flow charts) to describe their local child identification process.    3. The initial screening and/or evaluation process provides an opportunity to allow parents to sign paperwork permitting communication back to the referral source (i.e., a Referral Status Update - RSU) | **Reflection Questions**   1. List and describe two meetings over the last three months that “nurtured relationships with community partners”.   Click or tap here to enter text.   1. What materials describe your child identification process? Who has received these materials?   Click or tap here to enter text.   1. How/when are you requesting parental consent to send referral status updates?   Click or tap here to enter text. |
| **Practice #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #1**  Click or tap here to enter text. |
| **Practice #2 Leadership and Administration**   1. Create Referral Intake System    1. AUs create a referral intake process that facilitates early and timely identification of children with educational disabilities. The referral intake process includes:       * Written materials for families in more than one language if needed, based on the most common languages represented in the community       * Staff capacity to leave telephone greetings reflective of the primary languages of those in the community       * Staff capacity to meet mandated timelines       * Opportunity to contact a local Coordinator, or designee, year-round, to ask questions and/or begin the process       * A mechanism for the AU to request and review information and records provided by referral sources to reduce duplication of services (e.g., previous screening, relevant medical records)    2. AUs develop a system for communicating with families about the need for ongoing rechecks and ongoing monitoring of children who are referred but do not qualify and who are at risk for developmental delays      * + - This system may include notifying the child’s primary care provider (with parental consent) about the potential delay and need for monitoring within the medical home | **Reflection Questions**   1. What written materials does your AU provide to families who indicate concerns about their child’s development?   Click or tap here to enter text.   1. Where do you document (e.g., staff handbook, onboarding materials, AU policies etc.) recommendations that should be made to families who do not qualify?   Click or tap here to enter text. |
| **Practice #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #2**  Click or tap here to enter text. |
| **Practice #3 Leadership and Administration**  3) Develop and Utilize a Public Awareness Plan   * 1. A written public awareness plan is in place and guides ongoing outreach. The plan is reviewed and revised as needed and includes:      + Outlines of the key messages shared      + Designated efforts to establish consistent messaging among early childhood partners and key referral partners      + Method, frequency, and locations of information distribution, including use of online and social media      + Quantity of materials to be produced, shared via technology, and/or distributed      + Strategies that are family friendly and reach culturally diverse populations      + Plans for routine personal contacts with key community partners | **Reflection Questions**   1. What public awareness methods (e.g., brochures, social media, newsletter, etc.) is your AU using to notify partners and families about your child find process? List methods:   Click or tap here to enter text.   1. Who updates your public awareness plan? Who carries out your public awareness plan?   Click or tap here to enter text. |
| **Practice #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #3**  Click or tap here to enter text. |

# B. Partnership and Collaboration

In the context of child identification, Partnership and Collaboration refer to the AU participation in the community’s broader early childhood system to ensure that all child serving organizations within the broader system work together to support young children with delays or disabilities to be identified and have access to needed services as early as possible.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Practice #1 Partnership and Collaboration**   1. Coordinate Across the Early Childhood System    1. AUs collaborate with community partners (as listed below) to clarify and establish pathways for identifying young children who may be eligible for IDEA services. This collaboration will often take the form of active participation in a cross-sector early childhood workgroup (referred to as Early Childhood Work Group below).    2. AUs share information about the child identification process with the following community partners, including organizations that reach out to traditionally under-served or at-risk populations, including families experiencing homelessness. These stakeholders are involved in local child identification workgroup meetings and activities, as necessary.       * Families with young children, including friends and neighbors of those who suspect a child may have a need for special education services       * Early Learning Programs (school district administered preschool as well as community based; licensed home and center-based programs)       * Local Coordinating Organizations (LCOs)       * Local Early Childhood Council (staff and members)       * Head Start and Early Head Start       * Community Centered Boards       * Home visitation programs       * Pediatric and family medical practices       * Community based organizations and programs that serve young children with special needs and their families (e.g., business community, family organizations, health care providers, public health, mental health, human services, social services, child welfare, advocacy organizations, and recreational programs)    3. The AU shares data with relevant stakeholders to inform the broader early childhood system partners about the effectiveness of the child identification system. | **Reflection Questions**   1. What local cross-sector early childhood workgroup(s) exist in your district/region? How often does an AU staff member attend workgroup meetings? What is the role of that staff member, and what components of the AU’s child identification process can they represent (e.g., “referral intake for X County”)?   Click or tap here to enter text.   1. How are referring agencies updated about the status of those referrals? Describe your RSU process.   Click or tap here to enter text.   1. What’s the proportion of referrals from each referral source that led to an eligibility determination? When did AU staff last discuss this proportion with referral sources?   Click or tap here to enter text. |
| **Practice #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #1**  Click or tap here to enter text. |
| **Practice #2 Partnership and Collaboration**   1. Generate Public Awareness    1. Public awareness activities are ongoing, sustained throughout the years, and:       * Provide information about developmental milestones       * State the purposes of the child identification process       * Provide information about how to access the child identification process       * Inform the community of the value of early identification       * Indicate that the identification process is at no cost to families       * Coordinated to present clear consistent messages about how to access the system    2. A variety of strategies are used to reach families, referral partners, and the community at large | **Reflection Questions**   1. According to your public awareness materials, how should families access your child identification system?   Click or tap here to enter text.   1. How do your public awareness materials increase knowledge about development and early identification?   Click or tap here to enter text.   1. How do you tailor your public awareness materials to reach culturally and economically diverse families?   Click or tap here to enter text. |
| **Practice #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #2**  Click or tap here to enter text. |
| **Practice #3 Partnership and Collaboration**   1. Support Community Screening Efforts   *Community screenings refer to screening efforts conducted by programs outside of the AU that are available to families, either universally to all families, or embedded into other early childhood programming, to identify potential concerns and generate referrals for further evaluation*   * 1. Community screening efforts are ongoing, proactive services for families that:      + Are conducted by primary health care providers, early learning sites, home visitation programs, and other community agencies involved in supporting early childhood development      + Occur year round      + Allow for periodic re-screening, as developmentally appropriate, and as needed      + Involve interagency coordination      + Take place during well-child visits, as a part of preschool enrollment, or embedded in home visiting or other child focused services   2. AU staff support the general community screening efforts by:      + Offering their knowledge on effective screening tools and processes      + Encouraging referrals (e.g., for early intervention or special education) when screening suggests delayed development      + Ensuring screening entities understand local referral procedures      + Using the Early Childhood Work Group as a forum for coordination among screening entities so that agencies agree that children would not typically receive multiple screenings within the same time frame | **Reflection Questions**   1. Which programs/agencies in your community are you aware of that use a standardized tool for developmental screening?   Click or tap here to enter text.   1. What communication has the AU had with these programs/agencies regarding what to do if the screening suggests delayed development? For example, when is the concern significant enough for a referral for special education, what other referrals might be appropriate, and when is re-screening needed?   Click or tap here to enter text.   1. How do AU staff support programs/agencies in implementing quality screening processes? What advice or input is offered (see examples under Necessary Practices)?   Click or tap here to enter text. |
| **Practice #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #3**  Click or tap here to enter text. |
| **Practice #4 Partnership and Collaboration**   1. Actively Locate and Identify Children for Referral    1. The local child identification process actively cultivates referrals of children who are suspected to have an educational disability by:       * Discussing the referral process clearly with community partners, so that they can accurately refer and explain the process to families.       * Providing community partners with accurate written documentation explaining the referral process (i.e. which form(s) to use, where parents should sign, what accompanying information to include), pertinent referral forms, and contact information for pertinent staff (e.g., intake line, Child Find Coordinator, etc.) | **Reflection Questions**   1. Compare your written materials to the documentation description (second ✓ in Necessary Practices). What content is well described in your materials and what is missing?   Click or tap here to enter text. |
| **Practice #4 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #4**  Click or tap here to enter text. |
| **Practice #5 Partnership and Collaboration**   1. Support Well Coordinated Systems    1. AU personnel are knowledgeable about services and programs in the broader early childhood community and connect families to other appropriate services before, during, and after their involvement in the child identification process.   Note: The following practices are considered “best practices,” as they are supported by early childhood literature but not required by law or Rules.   * + - The Early Childhood Work Group has developed shared values, mission and measurable goals related to child identification and referral | **Reflection Questions**   1. What home visitation and family education programs are offered in your community?   Click or tap here to enter text.   1. Does the Early Childhood Work Group attended by AU staff have a Team Charter, a Work Plan, agendas, or other “governing” documents to support effective meetings?   Click or tap here to enter text. |
| **Practice #5 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Practice #5**  Click or tap here to enter text. |

# C. Intake and Referral

General intake refers to the AU process for receiving referrals of children for whom a concern is noted. These referrals may be treated as a referral to special education (triggering an IDEA evaluation process) when the AU suspects the child to be a child with an educational disability. Please note, however, in instances when a referral is received where there is not adequate information to suspect that the child has an educational disability that Individualized Screening activities provide information to support a decision about whether a full evaluation for determining eligibility for special education is warranted. In this case, local procedures influence whether the referral is considered a referral to special education prior to conducting Individualized Screening activities. AUs are encouraged to consider specific and differing processes for intake and referral based on whether the child is currently attending public or private preschool and what may already be known about the child. For example, helpful information may be available for consideration when the child is already enrolled in a preschool program, versus if the child does not yet attend any formal early learning setting outside the home.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Practice #1 Intake and Referral**   1. Accept and Process Referrals    1. Permit referrals from any source, including private and public preschools (e.g., Head Start) and community-based childcare programs that suspect a child may be eligible for special education and related services.    2. AUs request parental consent for a special education evaluation as soon as possible when parents indicate that they have concerns about whether their child may need special education,       * If the AU suspects the child is not a child with a disability, they must either conduct Individualized Screening activities (with general consent) or issue IDEA Prior Written Notice refusing to conduct the evaluation. | **Reflection Question**   1. Do you regularly receive referrals from community-based childcare programs, physicians, and home visitation programs? What are your other sources for community referrals?   Click or tap here to enter text. |
| **Practice #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #1**  Click or tap here to enter text. |
| **Practice #2 Intake and Referral**   1. Follow Timely Processes    1. Upon agency receipt of referral information, family contact and scheduling for the next appropriate step takes place promptly.       * If there is a suspected disability, seek parental consent within a reasonable period of time after the referral for evaluation, if the AU suspects an educational disability       * Document actions taken, method of contact and date, following AU procedures regarding the number of times and various methods for contacting the family       * The timeline for completion of initial evaluation for special education for 3–5-year-old children is 60 calendar days from the date that the written parental consent to evaluate was received by the AU       * The meeting to develop the IEP must take place within 30 days of the date the child is determined to need special education and related services and up to 90 days from the date that the written parental consent to evaluate was received by the AU       * For children who are transitioning from Part C services, the initial IEP must be implemented on or before the child’s third birthday | **Reflection Questions**   1. Approximately how many days pass (on average) between receiving referral information and contacting the family regarding next steps?   Click or tap here to enter text.   1. Approximately how many days pass (on average) between a parent indicating concern about their child’s development and that parent signing consent for screening or evaluation?   Click or tap here to enter text.   1. What if the physician is expressing concern about a child’s development – how many days pass before your AU requests parental consent for screening or evaluation?   Click or tap here to enter text. |
| **Practice #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #2**  Click or tap here to enter text. |
| **Practice #3 Intake and Referral**   1. Engage Families and Provide Resources    1. Families are informed and understand their rights, responsibilities, and options before each step in the process begins. This includes providing:    2. Information about early developmental expectations and relevant community resources is shared with all families at pertinent times throughout the process | **Reflection Questions**   1. Which records (screening, evaluation, other) are routinely reviewed with families and when?   Click or tap here to enter text.   1. What community resources are shared with families and when?   Click or tap here to enter text. |
| **Practice #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Practice #3**  Click or tap here to enter text. |

# D. Individualized Screening

Individualized screening refers to screening conducted on individual children by the AU. This differs from community screening efforts that occur on whole populations of children as a part of universal screening and developmental monitoring efforts. Individualized screening is typically conducted for children referred to child find due to a known or suspected developmental or educational concern to determine whether further evaluation is needed and whether to initiate the special education evaluation process. Individualized screening differs from screening as described in 1 CCR 301-8 ECEA 4.02 (3), which refers to the practice of screening to inform instruction as part of a general education process.

In those instances when the information shared at the time of referral does not clearly suggest that a special education evaluation is needed, and when there is no general education data available, parents may consent to gather some preliminary standardized screening data prior to initiating the special education referral process, in order to inform that decision. At whatever point in the process AU personnel determine that more in-depth evaluation is warranted, the special education referral process should be initiated, which includes issuing IDEA Prior Written Notice obtaining parent consent.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Practice #1 Individualized Screening**   1. Define the Screening Process and Tools    1. Identify whether individualized screening has recently been conducted by other sources (e.g., medical practitioners, preschool providers, home visitors). Obtain permission to view screening tool(s) completed by other sources, if applicable.       * Previous screening results or information may or may not be sufficient to determine whether further evaluation is needed. The screening should inform your next steps (consider significance of delay, completeness of tool, areas screened, etc.).       * Gather brief birth/health/developmental history from caregiver(s) and referral source    2. Parent consent for individualized screening obtained before the initiation of the special education referral process occurs prior to triggering IDEA parent consent requirements. Therefore, AU policies and procedures dictate how this consent process occurs and CDE suggests that the consent be written.    3. Screening instruments:       * Are objective, reliable, valid, and used with fidelity       * Are culturally unbiased       * May be combined to screen all areas of development       * Are developmentally appropriate       * Support AUs in deciding whether further evaluation is needed (but not to determine special education eligibility)    4. Individualized screening activities may be conducted within the IDEA Part B special education evaluation process when, based on a review of existing information (such as previous screenings, referral and intake information), the individual child being screened is suspected of having an educational disability.       * In this case, screening would be conducted after issuing IDEA Prior Written Notice and obtaining parent consent | **Reflection Questions**   1. How does the AU ask families for permission to gather relevant information from a third party such as previous screenings and/or health records (on a form, orally, etc.)?   Click or tap here to enter text.   1. How does the AU decide when there is enough information to move forward with an evaluation? When do you issue IDEA prior written notice?   Click or tap here to enter text.   1. What is the full cadre of screening tools among which the AU chooses? Which combinations of tools are used together to ensure that all areas of development are screened?   Click or tap here to enter text. |
| **Practice #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #1**  Click or tap here to enter text. |
| **Practice #2 Individualized Screening**   1. Facilitate Family Engagement    1. AU personnel are sensitive to families and engage them during the screening process by:       * Including parent interview or information obtained from the parent about individual child and family strengths, concerns, routines, priorities, and needs       * Making screenings easily accessible to families (time, date, locations)       * Making every attempt to make the process culturally non-biased       * Supporting families as decision-makers       * Asking how they wish to participate and respecting their wishes (e.g., asking them to play with their child, trying a new skill with their child while being coached by a screener, etc.)       * Describing screening activities in the IDEA Part B Prior Written Notice, including a description of the purpose of screening and how screening results are used to determine further evaluation needs | **Reflection Questions**   1. How do AU staff adapt the individualized screening process based on families’ participation preferences? What options are offered to families?   Click or tap here to enter text.   1. Sometimes individualized screening occurs as part of an IDEA Part B special education evaluation. How are these screening activities described in your Prior Written Notice? (Paste applicable PWN wording below)   Click or tap here to enter text. |
| **Practice #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #2**  Click or tap here to enter text. |
| **Practice #3 Individualized Screening**   1. Share Screening Results    1. AUs share screening results with the family at the time the screening is completed    2. At the conclusion of the screening process, families are provided with information to assist them in selecting community services and support options best suited to their child and family needs. | **Reflection Questions**   1. Do parents receive their results in writing at the time of the screening? If so, how does the document help families make meaning of their screening results?   Click or tap here to enter text.   1. Is information about community supports (programs for children, parenting education, etc.) provided in writing AND elaborated on orally to help guide families’ next steps? If so, describe the conversation.   Click or tap here to enter text. |
| **Practice #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #3**  Click or tap here to enter text. |

# E. Initial Child Evaluation

Prior to engaging in child evaluation activities, the team determines and documents the evaluation plan in the Prior Written Notice and then gains signed consent from the parent. The purpose of the initial evaluation is to determine if the child meets the criteria for one or more of the disability categories under the Exceptional Children’s Education Act (ECEA 2.08), is unable to receive reasonable benefit from general education, and to identify the educational needs of the child. AUs are encouraged to develop and implement local procedures to implement evidence-based early childhood assessment practices, as appropriate. Evaluation teams encompass the professionals involved in initial child evaluation along with the parent(s), who are expected to be meaningfully included in each step described below.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Regulatory Requirement #1 Initial Child Evaluation**   1. Obtain parent consent to conduct the initial special education evaluation, through issuing Prior Written Notice. The Prior Written Notice will outline the evaluation plan which is developed through a review of existing information.    1. AUs Collect/review existing body of evidence, which may include:       * Community Screening       * Notes from referring entity documenting referral reasons/concerns       * Monitoring tools such as checklists and portfolios collected by early childhood teachers    2. Determine if additional screening measures will be conducted as part of the evaluation process, as appropriate | **Reflection Questions**   1. Consider your 10 most recent evaluations. What data sources made up the body of evidence gathered and considered when planning those evaluations? Describe the information your team most commonly includes in your body of evidence.   Click or tap here to enter text.   1. If you do conduct additional screening as part of the evaluation process, how is this screening described in the Prior Written Notice?   Click or tap here to enter text. |
| **Regulatory Requirement #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Regulatory Requirement #1**  Click or tap here to enter text. |
| **Regulatory Requirement #2 Initial Child Evaluation**   1. Conduct initial evaluation (see C.2(a) for timelines) activities identified in the Prior Written Notice.    1. Teams conduct additional assessment, including gathering meaningful input from families and other caregivers, including the child’s teacher(s), through a variety of means to add to the body of evidence initially collected and reviewed    2. Teams conclude with enough information to determine whether, or not, an educational disability is present:       * No single measure is used as the sole criterion       * All instruments are technically sound with strong validity and reliability for intended purpose    3. Teams use an evaluation process that is not discriminatory regarding racial or cultural bias       * All instruments are administered in the child’s native language or another communication mode (i.e., alternative and augmented communication) acceptable to yield relevant information (for very young children assessment reveals an understanding of what the child knows in all languages to which they are exposed)    4. Teams use an evaluation process that is sufficiently comprehensive to determine all needs for specialized instruction and related services. | **Reflection Questions**   1. How and when do you gather input from the child’s physician, teachers, and caregivers?   Click or tap here to enter text.   1. Suppose a child’s native language *differs* from the languages of your go-to evaluation instruments. What options does your AU utilize to ensure an accurate and non-discriminatory evaluation process? What personnel or processes are available to conduct the evaluation in the child’s primary language?   Click or tap here to enter text.   1. Name all the evaluation instruments commonly used in your AU. Rank the technical adequacy of each tool. Is that tool not well, somewhat, or well   suited for how it is being used in your AU?  Click or tap here to enter text.   1. Name all the screening instruments commonly used in your AU. Rank the technical adequacy of each tool. Is that tool well, somewhat, or well suited for how it is being used in your AU?   Click or tap here to enter text.   1. Combined, do these tools provide multiple options for ensuring a sufficiently comprehensive evaluation that covers all developmental domains and identifies unique needs?   Click or tap here to enter text.   1. Combined with the body of evidence gathered prior to the evaluation, do these tools ensure the evaluation process is “sufficiently comprehensive to appropriately identify all of the child’s special education and related services needs, whether or not commonly linked to the disability category in which the child has been classified.” [1 CCR 301-8 ECEA 4.02(4)]   Click or tap here to enter text. |
| **Regulatory Requirement #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Regulatory Requirement #2**  Click or tap here to enter text. |
| **Regulatory Requirement #3 Initial Child Evaluation**   1. Evaluation data is used to establish whether, or not, the child has an educational disability and a need for Special Education    1. Teams meet to review the body of information and establish if the child meets one or more of the disability categories, including demonstrating a need for special education.       * The multidisciplinary team making the eligibility determination includes:         1. Individuals knowledgeable about the child and able to interpret the meaning of the evaluation data         2. At least one teacher or other specialist         3. Other, appropriately qualified professionals, as needed (i.e., occupational therapist or other)         4. The parent/s and/or caregivers of the child         5. Special education administrator or his or her designee       * Teams have a process to make informed decisions about whether the underlying concern and its impact is a disability or delay, or a difference that maturation and exposure to experiences and materials may ameliorate | **Reflection Questions**   1. How does your AU identify who should participate in an evaluation?   Click or tap here to enter text.   1. Do your evaluation teams typically meet or exceed the bulleted requirements? If you are routinely exceeding these requirements (e.g., by including a motor specialist in each evaluation even if motor is not related to the suspected area of disability) consider revising the process in question #1 above.   Click or tap here to enter text.   1. What is your process for synthesizing evaluation data across sources and instruments? How do you resolve discrepancies if one source of information suggests eligibility while another does not?   Click or tap here to enter text. |
| **Regulatory Requirement #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Regulatory Requirement #3**  Click or tap here to enter text. |
| **Regulatory Requirement #4 Initial Child Evaluation**   1. Connect evaluation and eligibility determination results to initial individualized education program (IEP)    1. Evaluation results clearly link to and establish the present levels of academic achievement and functional performance (PLAAFP) section of the IEP    2. PLAAFP includes a statement of the child’s strengths and participation in appropriate activities and daily routines to determine the impact of disability    3. IEP goals identify services and service delivery in the Least Restrictive Environment (LRE) | **Reflection Questions**   1. Who determines whether evaluation results have been clearly linked to PLAAFP? Have you received any recent feedback on whether IEPs sufficiently bridge assessment data to the classroom? If you haven’t received any recent feedback, consider gathering information from ECSEs or classroom teachers. Alternatively, consider asking parents about their understanding of children’s strengths, needs, and goals. Both mechanisms provide can feedback on whether your AU is meeting this regulatory requirement.   Click or tap here to enter text.   1. Review with your Team the CDE document: [Making Least Restrictive Environment Placement Decisions for Preschool Children Ages 3 through 5](https://www.cde.state.co.us/cdesped/ta_lre). How does input from families assist in the determination of LRE?   Click or tap here to enter text. |
| **Regulatory Requirement #4 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Regulatory Requirement #4**  Click or tap here to enter text. |
| **Best Practices Guidelines Initial Child Evaluation**   1. Embed evidence-based practices for early childhood evaluation into local policies, procedures, and practices    1. Utilize a whole child approach       * Vision and hearing screening occurs as a priority first step in the evaluation process as a part of the overall assessment of physical development for each child       * Relevant background information is collected in an interview type format along with intake forms completed by the parent    2. Form interdisciplinary or transdisciplinary evaluation teams    3. Build capacity across team members of various disciplines for each team member to observe and evaluation developmental domains beyond the professionals’ specific areas of training in use of authentic assessment measures    4. The team values and implements family-centered practices throughout the evaluation process       * Evaluation occurs in the most natural environment for the child (e.g., the family home, classroom, childcare center, etc.)       * Evaluation includes people and materials familiar to the child and parent       * Strengths and assets of the child and family are used to plan interventions    5. Assessment results are linked to the preschool curriculum    6. Families receive appropriate referrals to a full array of community supports, where appropriate       * Formal, intermediate and informal resources are identified for each family and leveraged to enable the family towards self-sufficiency and improved family quality of life | **Reflection Questions**   1. How does your evaluation process account for areas of development that are not specifically related to the area(s) of concern? (In order to ensure that evaluation is sufficiently comprehensive).   Click or tap here to enter text.   1. Do you incorporate play-based assessments in your evaluation repertoire? If so, which tools do you use?   Click or tap here to enter text.   1. How does your team elicit information about people, materials, and activities that are familiar to the child and can be used in the evaluation process?   Click or tap here to enter text.   1. How do you help connect families to community supports?   Click or tap here to enter text.   1. Does your menu of community supports include offerings that reflect the cultural, linguistic, ethnic, and racial diversity of the population you serve?   Click or tap here to enter text. |
| **Best Practices Guidelines Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Best Practices Guidelines**  Click or tap here to enter text. |

# F. Continuous Quality Improvement

Continuous quality improvement refers to an ongoing and systematic utilization of data to proactively evaluate whether a process is effective, to identify needed improvements, and to engage in ongoing improvement activities. In the context of this document, Continuous Quality Improvement refers to the ongoing process of evaluating how an AU’s child identification process for children 3 through 5 years old can be improved and to continually strive towards improving the process. Analysis of effectiveness and opportunities for improvement of the child identification process for young children should be coordinated and intentionally intersect with the broader AU responsibility for evaluating the effectiveness of the special education system as a whole.

| **Necessary Practices – *Highlights*** | **Program Implementation** |
| --- | --- |
| **Practice #1 Continuous Quality Improvement**   1. Define the Process    1. The AU has a clear process for determining the effectiveness of the child identification process for children ages 3 through 5. Program evaluation should examine all components of the child identification process:       * Considers how well the process fulfills the core values, vision, and mission articulated in this document       * Provides families with access to services as early as possible       * Meets the criteria articulated in this document, as required by state and federal law and Rules       * Is easily accessible | **Reflection Questions**   1. Think about your child identification system in the context of your community (e.g., describe the population served, who are your referral partners, how is Child Find perceived). What THREE evaluation questions would you like to ask to better understand what is/isn’t effective in your child identification system? (Consider the evaluation components in Necessary Practice 1a)   Click or tap here to enter text.   1. How is existing data collected and reviewed? For each data source, answer the following:    1. What data is currently collected? List each data source/tool separately (e.g., family survey, child intake form)    2. Who records (or collects) data?    3. Who analyzes (or compiles) data?    4. How is data compiled (i.e. summary graph, annual report, tables, etc.)? 2. When is data reviewed? By whom?   Click or tap here to enter text. |
| **Practice #1 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #1**  Click or tap here to enter text. |
| **Practice #2 Continuous Quality Improvement**   1. Select Data Sources and Methods    1. Data to be collected includes:       * Data on each special education referral, including all data fields required by CDE as a part of the process for submitting Student Special Education Participation files which includes:         + Referral source         + Date on which the AU first learned of a potentially eligible child         + Date of parental consent for evaluation         + Individual screening date (if applicable)         + Child’s ethnicity/race         + Age of child at time of referral         + Referral outcome       * Whether children are identified as early as possible, or what barriers may prevent earlier identification       * Reason for referral (and whether that reason/concern is shared by the family)       * Documentation of completed follow-up activities (such as sending a Referral Status Update to the referral source)       * Family satisfaction data about their experiences with the child identification process       * Family attendance at any child identification events or general community screenings       * Internal and external stakeholder perceptions of the child identification process, specifically ease of referring families       * Proportion of children identified for special education compared to the general population (census data) | **Reflection Questions**   1. How do you collect family input about your child identification system? What proportion of families provide feedback (i.e., what is your response rate)?   Click or tap here to enter text.   1. How do you collect input from internal and external stakeholders/partners? Which external stakeholders/partners participate?   Click or tap here to enter text.   1. Consider the data in Necessary Practice 2a. What data elements are you not currently collecting?   Click or tap here to enter text.   1. Can any of these missing data elements be added to a current data collection tool? Describe which data elements will be added to which tools.   Click or tap here to enter text. |
| **Practice #2 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #2**  Click or tap here to enter text. |
| **Practice #3 Continuous Quality Improvement**   1. Use Findings for Continual Improvement    1. Qualitative and quantitative data is collected and made available to internal and external child identification stakeholders on a regular basis for discussion, review, and influencing system and process improvements. | **Reflection Questions**   1. How is your program evaluation data made available to external stakeholders (e.g., annual report, reviewing tables during meetings, etc.)? How often does this occur? 2. Does your AU facilitate conversations that allow child identification stakeholders to engage in meaningful discussions about program evaluation results? Describe these conversations (who participates, what feedback do they provide, etc.). |
| **Practice #3 Summary Rating Scale**  **C** – Complete (we meet these requirements all of the time)  **M** – Mostly (we do this most of the time)  **S** – Somewhat (we do this some of the time)  **Y** – Not yet (we don’t typically do this, but improving this practice is a current priority)  **N** – No (we don’t typically do this, and cannot currently prioritize this requirement) | **Rating Score for Reflection Questions Practice #3**  Click or tap here to enter text. |