

Prematurity and Low Birth Weight Understanding the Need & Implementing Early Intervention: A Local, State & National Perspective

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Disclosures

- **Dr. Hussey-Gardner** receives funding from the Baltimore City Infants & Toddlers Program (BITP) to support Maryland's PRIDE. In addition, she received funding from the Maryland State Department of Education (MSDE) to develop web-based learning modules related to prematurity. Finally, she received honorariums for presentations related to prematurity that she provided to local jurisdictions in Maryland. Dr. Hussey-Gardner is the Chair of Maryland's SICC.
- None of the author presenters have disclosures to make.

Outcomes

To understand prematurity, associated developmental delays and the benefits of intervening early.

To become familiar with one model of collaboration between a NICU and a local Part C program, along with the impact of this model on program outcomes.

To consider the implications of serving this population at the State level.

To become aware of the draft potential DEC Position Statement on LBW.

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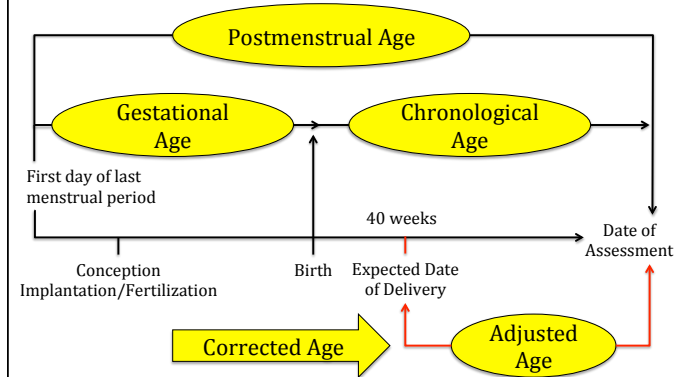
LOW BIRTH WEIGHT, PREMATUREITY & EARLY INTERVENTION: OVERVIEW





Definitions

PERINATAL AGE TERMINOLOGY



Prematurity Classifications

Perivable:
20 to 26 weeks



Extremely
Preterm:
<28 weeks



Very
Preterm:
28-32
weeks



Moderately
Preterm:
32-36 weeks



Not
preterm:
≥37 weeks

Preterm Infant: <37 weeks

Birthweight Classifications

High Probability
Criteria: <1,200 grams



Extremely
LBW:
<1,000g
(<2.2lbs)



Very LBW:
1,000-1,499g
(2.2-3.3lbs)



Moderate
LBW:
1,500-2,499g
(3.3-5.5lbs)

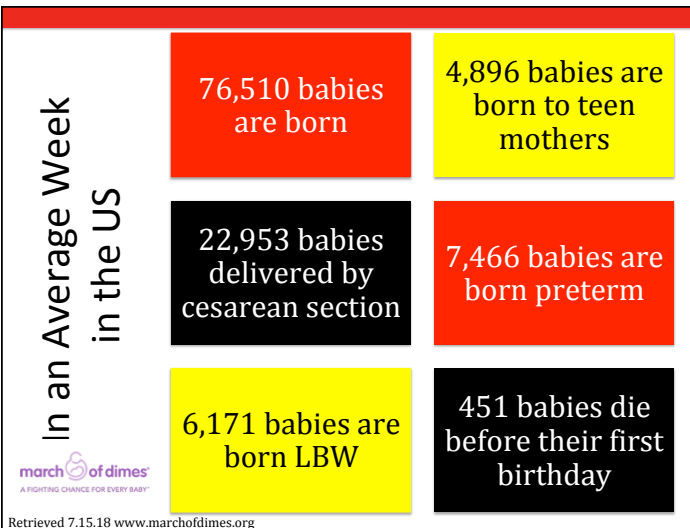


Not LBW:
≥2,500g
(≥5.5lbs)

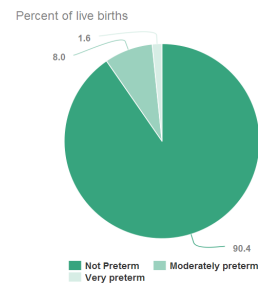
LBW: <2,500 grams



Prevalence & Survival



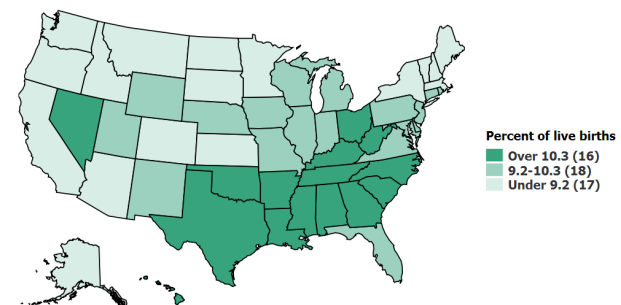
Distribution of GA: US, 2015



Not preterm is greater than or equal to 37 weeks gestation. Preterm is less than 37 weeks of pregnancy. Very preterm is less than 32 weeks. Moderately preterm is 32-36 completed weeks of gestation.
 Source: National Center for Health Statistics, final natality data.
 Retrieved July 15, 2018, from www.marchofdimes.org/peristats.

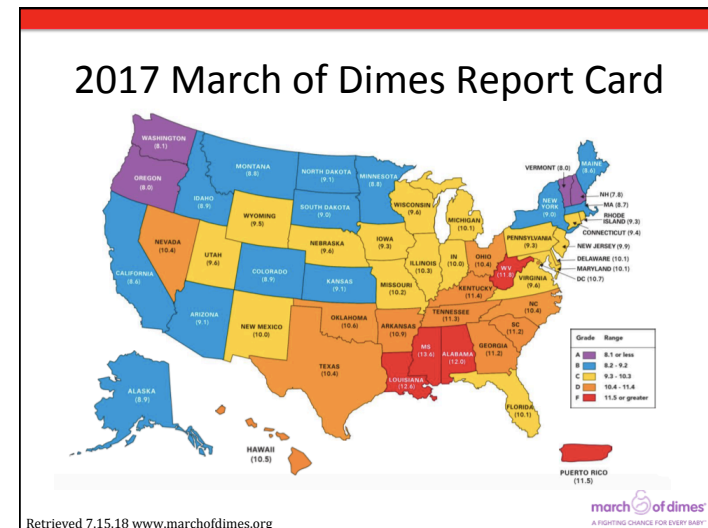
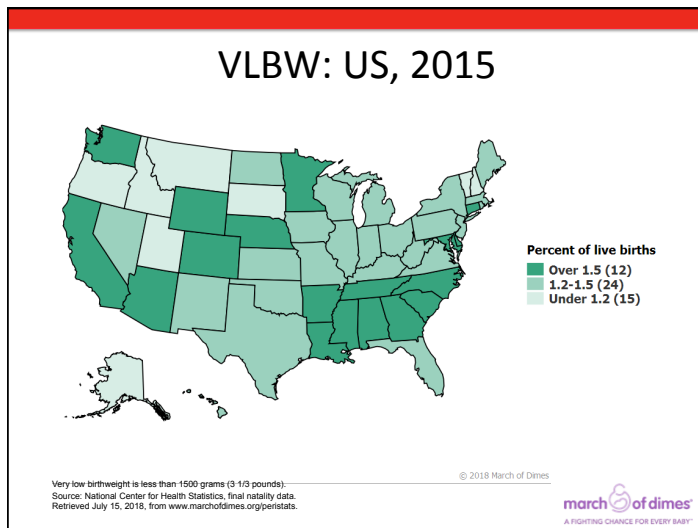
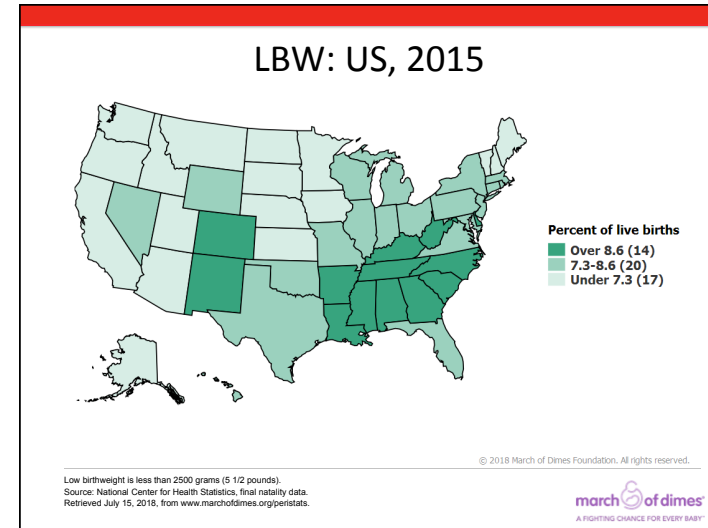
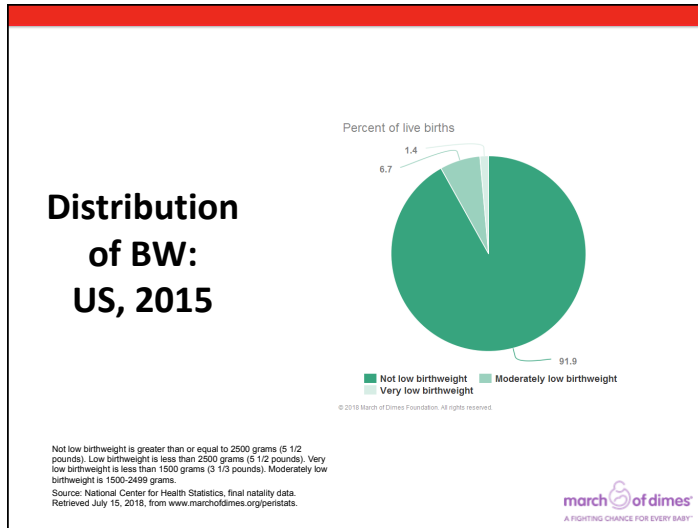
A FIGHTING CHANCE FOR EVERY BABY®

Preterm: United States, 2016

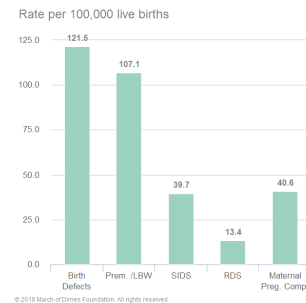


Preterm is less than 37 weeks of pregnancy.
 Source: National Center for Health Statistics, final natality data.
 Retrieved July 15, 2018, from www.marchofdimes.org/peristats.

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Mortality: US, 2013



SIDS is Sudden Infant Death Syndrome. RDS is Respiratory Distress Syndrome. Maternal Preg. Comp. stands for "Maternal Complications of Pregnancy." Cause of death for 1995-1998 is based on the Ninth Revision, International Classification of Diseases (ICD-9). Cause of death for 1999 is based on the Tenth Revision, International Classification of Diseases (ICD-10).
Source: National Center for Health Statistics, period-linked birth/death data. Retrieved July 15, 2018, from www.marchofdimes.org/statista.

march of dimes
A FIGHTING CHANCE FOR EVERY BABY



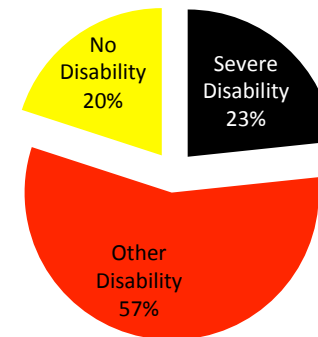
Neurodevelopmental Outcomes

Morbidity at 18-22 Months of Survivors (61%) Born at 22-26 Weeks



NICHD Neonatal Network (Vohr et al., 2005)

Risk of Death or Disability Survivors (29%) at 6 Years: Infants Admitted at 22-25 Weeks Gestation



EPICure Study (Marlow et al., 2005)

Delays Associated with Prematurity & LBW

- Expressive and receptive language *(Barre, Morgan, Doyle, & Anderson, 2011)*
- Cognition and later school achievement (e.g. reading and math, grade retention, placement in special education) *(Hack, Klein, & Taylor, 1995; Klebanov, Brooks-Gunn, & McCormick, 1994)*
- Executive functioning *(Zelazo, Blair, & Willoughby, 2016)*
- Social-emotional development *(Mathewson, et al., 2017; Msall & Park, 2008; Institute of Medicine, 2007; Bhutta, et al., 2002; National Research Council and Institute of Medicine, 2000)*
- Motor development *(Vohr et al., 2005)*
- Vision & hearing impairments *(Vohr et al., 2005)*

Promising Review of Outcome

- Premature birth incidence & survival rates increasing due to advances in obstetric & neonatal intensive care
- Those born at limits of viability at high-risk of adverse neurocognitive function
- Data from earlier generation cohorts, born in substantially different eras, cannot be relied on to predict outcome today
- Review, by birth cohort year, shows a changing developmental trajectory in which today's extremely preterm survivor likely to have fewer severe medical complications, better neurological outcomes & fewer adverse cognitive effects

(Baron & Rey-Casserly, 2010)

Evidence of Benefits of EI: Infant Health and Development Program (IHDP)

First Multi-Site RCT

- Effect of early childhood development and family support services with pediatric follow-up
- Preterm & LBW infants

Intervention

- Year 1: weekly home visits
- Years 2 & 3: monthly home visits, full-time center-based educational program & family support

Outcomes at 36 Months

- Significantly higher IQ scores
- Significantly lower behavior problems
- Significant increase in maternally reported minor morbidity
- No evidence of increase in serious health problems

(Gross, Spiker, & Haynes, 1997; Mallik & Spiker, 2016)



Medical Conditions Associated with Prematurity

Intraventricular Hemorrhage

IVH

IVH Grades

Bleeding into ventricular system of premature brain

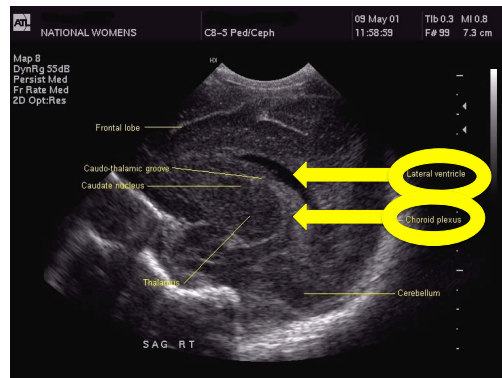
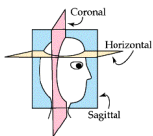
I.
Germinal Matrix
Bleed

II.
Ventricular
Bleed

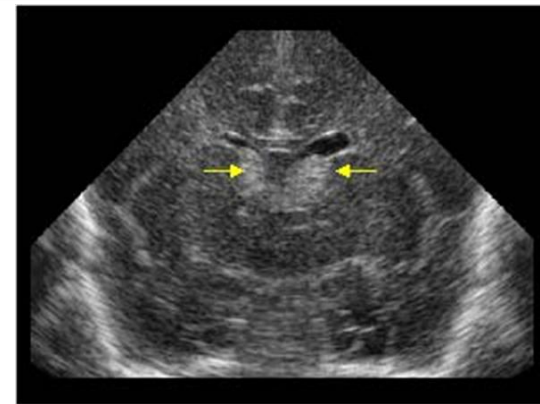
III.
Ventricular
Bleed + dilation
of ventricle

IV. Parenchymal
bleed

Normal Head Ultrasound

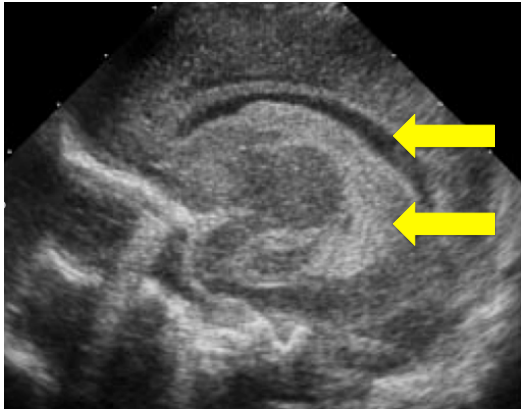


Grade I IVH



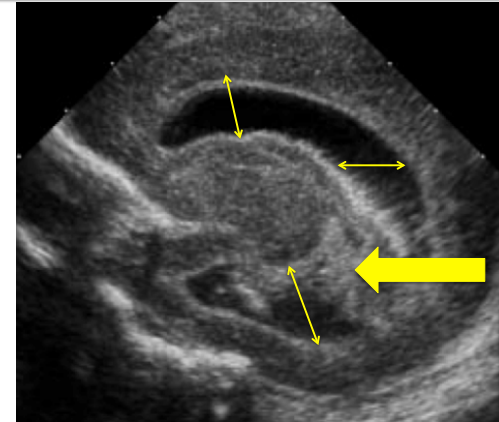
No blood in the lateral ventricles and the ventricles are not dilated

Grade II - IVH



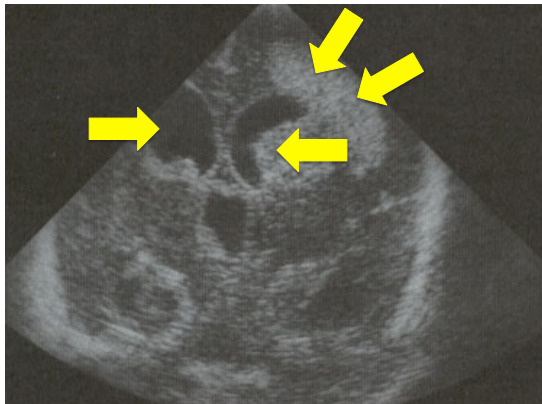
Blood almost filling R lateral ventricle
Lucent/darker area part of ventricle not filled with blood

Grade III IVH



White area is bleed. Black area dilated ventricle pushing against adjacent brain, possibly destroying brain cells

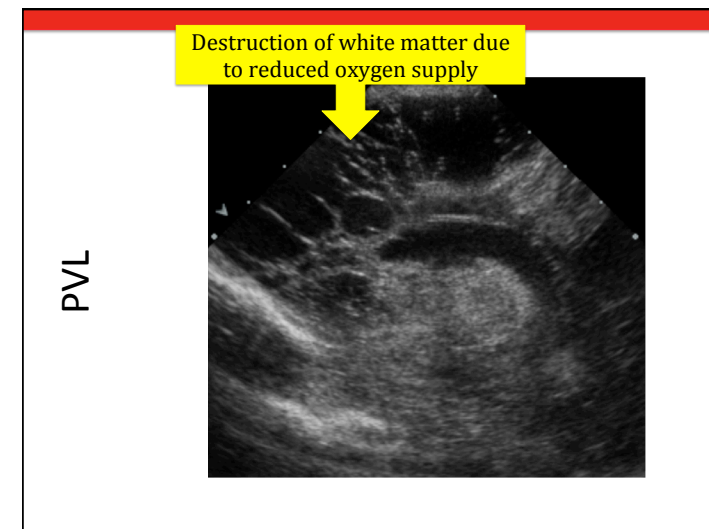
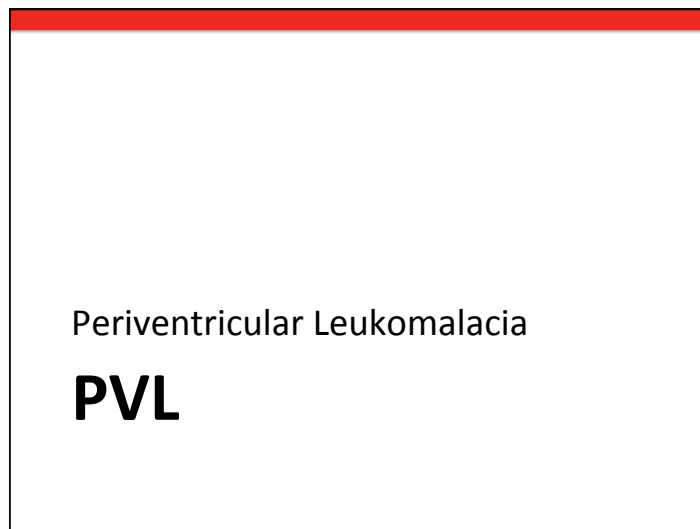
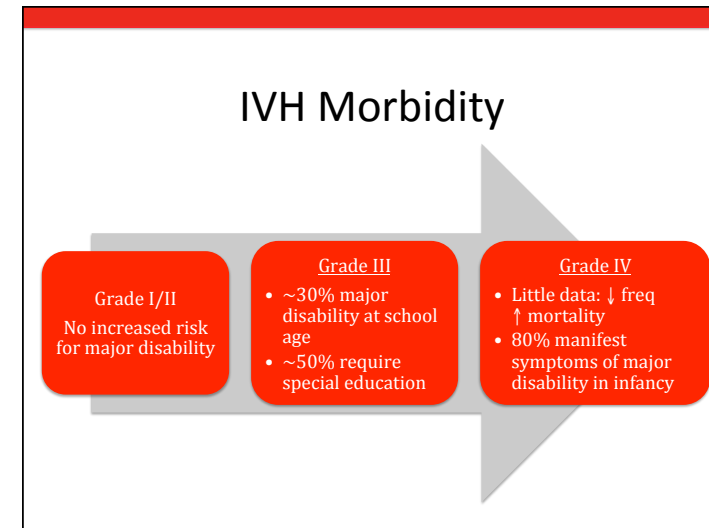
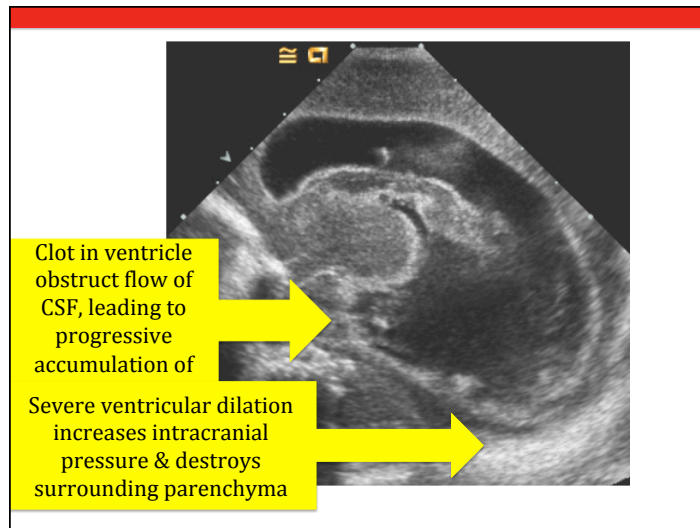
Grade IV IVH



Blood L ventricle, extending to surrounding brain tissue--cells destroyed replaced w/ cysts
R Grade III IVH

Post Hemorrhagic Hydrocephalus

PHH



Chronic Lung Disease

(Also known as BPD: Bronchopulmonary Dysplasia)

CLD

CLD

- Need for oxygen on DOL #28
- Need for oxygen at 36 weeks PCA



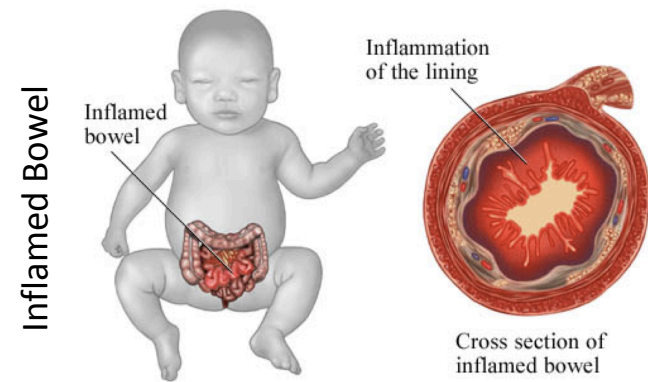
Normal lung x-ray



X-ray depicting CLD

Necrotizing Enterocolitis

NEC



http://www.prayersforpoop.com/s/cc_images/cache_2926041604.jpg?t=1336077157

Premature Infant with NEC



Breastmilk

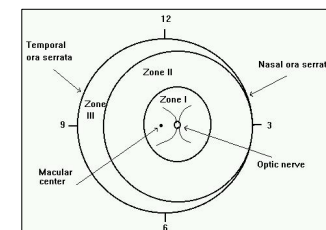


<http://www.fda.gov/ucm/groups/fdagov-public/documents/image/ucm335265.jpg>

Retinopathy of Prematurity

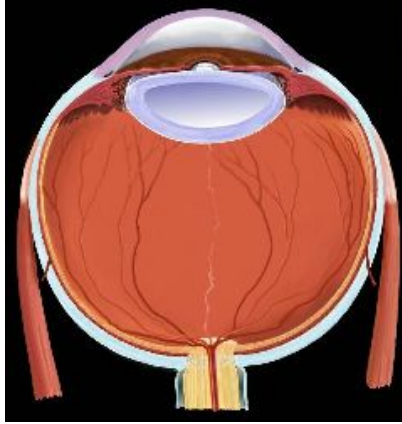
ROP

Diagnosing ROP



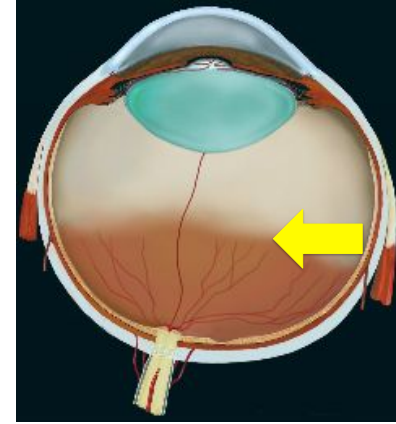
http://www.aapos.org/client_data/files/2011/_135_retinopathy1.jpg

Vascularized Retina



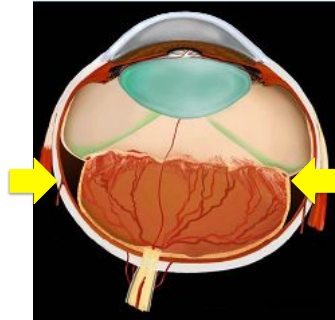
http://telemedicine.orbis.org/bins/content_page.asp?cid=1-1809-1874

Preterm Infant



http://telemedicine.orbis.org/bins/content_page.asp?cid=1-1809-1874

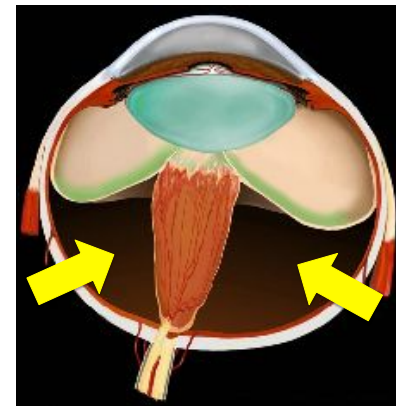
- Concerns exist if infants develop threshold disease
- Infant has a 50% chance of developing retinal detachment
- Serial eye exams done
- If threshold disease reached, laser surgery performed to prevent Stage 4 (partial retinal detachment) or Stage 5 (retinal detachment)



Stage 4 ROP

http://telemedicine.orbis.org/bins/content_page.asp?cid=1-1809-1874

Stage 5 ROP



http://telemedicine.orbis.org/bins/content_page.asp?cid=1-1809-1874

Outcomes

- Strabismus — **Crossed Eyes**
- Amblyopia — **Lazy eye**
- Myopia — **Nearsightedness**
- Thinning of the retina
- Retinal tears
- Glaucoma — **Abnormally high fluid pressure can result in hardening of eyeball & loss of vision**
- Visual field loss
- Reduction in contrast sensitivity
- Nystagmus — **Involuntary movement side to side**

Hypoxic Ischemic Encephalopathy

HIE

HIE: Diagnosis

- Profound metabolic acidosis
- Apgar 0-3 for > 5 minutes
- Neonatal neurologic manifestations (seizures, coma, hypotonia)
- Multi system organ dysfunction (CV, GI, renal)

Treatment: Therapeutic Hypothermia



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One Model Of Collaboration Between a NICU and a Local Part C Program: Maryland's PRIDE



Goals

Facilitate identification and referral of preterm and medically fragile infants

Expedite access to EI services by streamlining the evaluation process

Foster collaboration between the hospital and BITP

Educate medical professionals about development and early intervention.

History

- State Demonstration Model Grant ended
- Maryland's PRIDE formed contractual relationship with BITP
- \$30,000 to support a full-time position

- Under recent budgetary constraints, program currently operating with two service coordinators, developmental specialist & program director
- Current budget \$200,955

1994

- \$15,000 State Demonstration Model Grant
- Facilitated collaborative relationship between BITP and UMMC NICU and NICU Follow-Up Program
- Consisted of one part-time service coordinator who also served as the program's developmental specialist and director

1997

2018

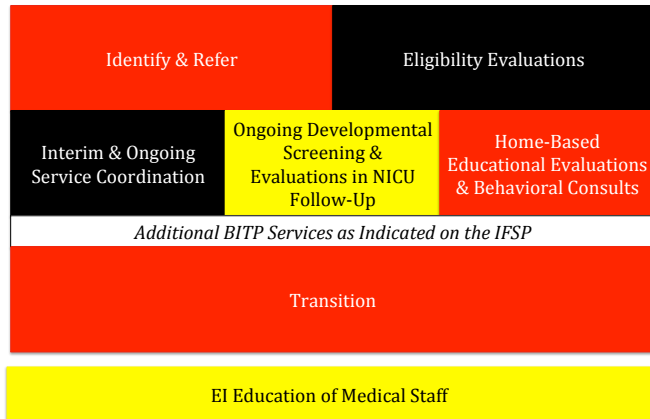
Eligibility Criteria

Attending UMCH NICU Follow-Up Program

Baltimore City Resident

Eligible for EI in Maryland

PRIDE Components



Locations

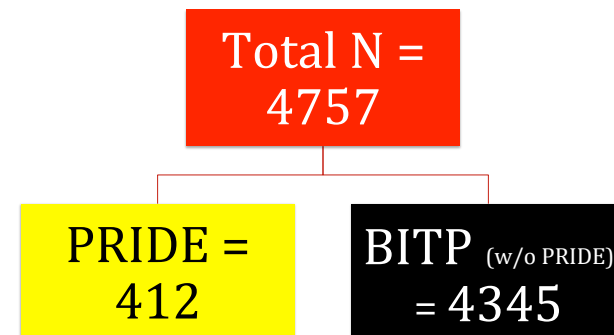


Gloria Valentine, M.S.
Director
Baltimore City Infants & Toddlers Program

Maryland's PRIDE: Impact On Program Outcomes



PRIDE Compared to BITP¹



¹From online IFSP database, FY 2013-2018

Eligibility

Variable	PRIDE % (N)	BITP % (N)	Significance Level
<1 year	73.1% (301)	31.4% (1368)	p<0.0001
High Prob	66.5% (274)	26.3% (1143)	p<0.00001



Eligibility

Age at Referral	PRIDE (Mean)	BITP (Mean)	Significance Level
Overall	8.39 mos	17.28 mos	p<0.0001
High Prob	4.82 mos	9.93 mos	P<0.0001
25% Delay	18.27 mos	20.67 mos	P<0.0037
Atypical Dev	8.44 mos	14.93 mos	P<0.0002



Other

Variable	PRIDE % (N)	BITP % (N)	Significance Level
Parent Withdrawal	.04% (15)	10.8% (470)	p<0.00001
Exit Program- Child Deceased	.02% (9)	.001% (5)	P<0.00001

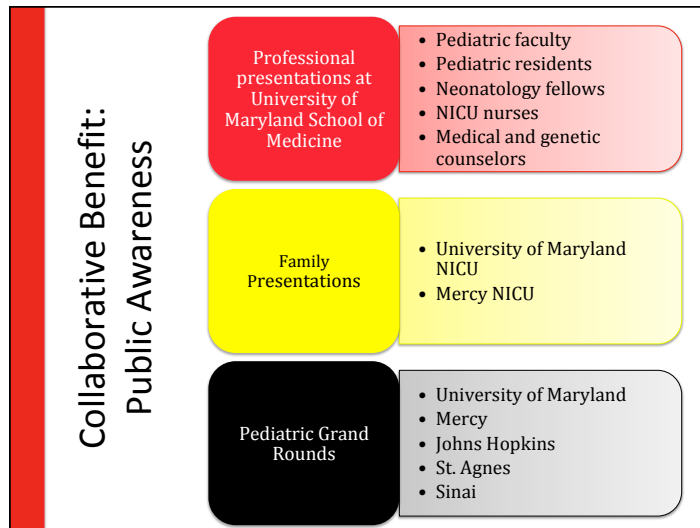
Indicator of medical
fragility of this
population

Service Coordination an Important Key

Service coordinators in the NICU develop a relationship with families

Allows interventions and supports as soon as needs arise

Equips families to provide care for their child and have the resources they need to participate in their own desired family outcomes



Funding & Sustainability

Utilize developmental evaluations conducted as part of routine care in UM NICU or NICU Follow-Up Program

MA billing for reimbursement offers a way to provide additional support & sustainable funding through unpredictable funding environments

Collaborative partnership offers “in-kind” supports that help sustain the program

Pamela Miller, Ed.D.
Maryland State Department of Education

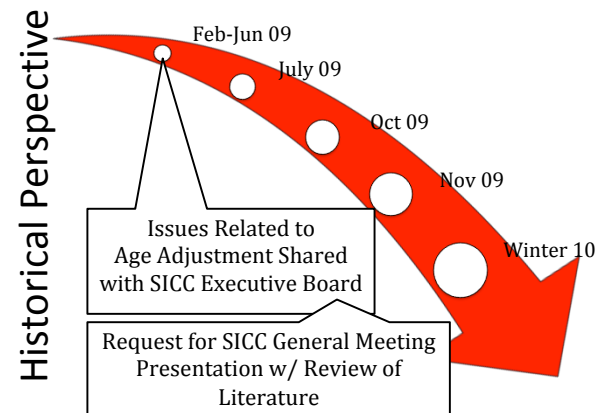
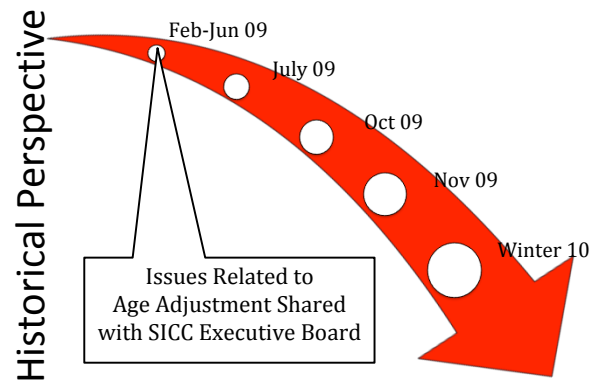
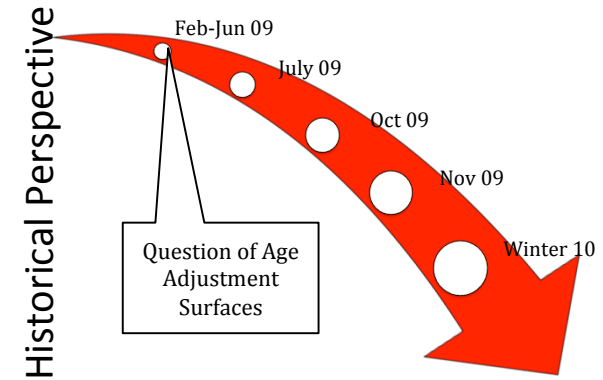
Implications at the State Level

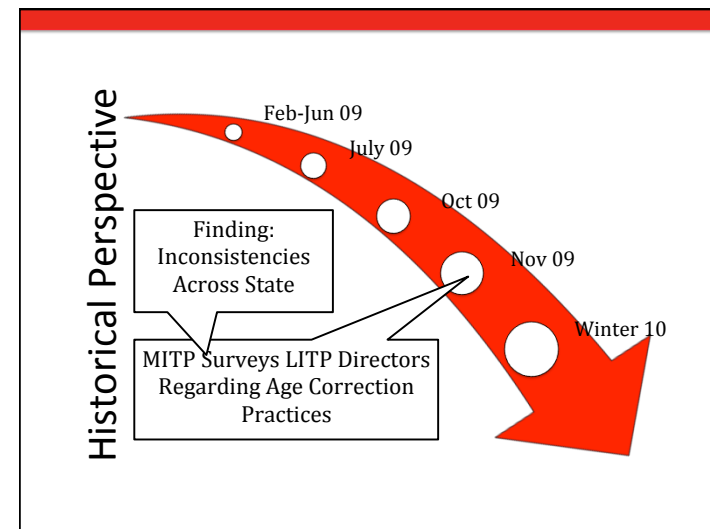
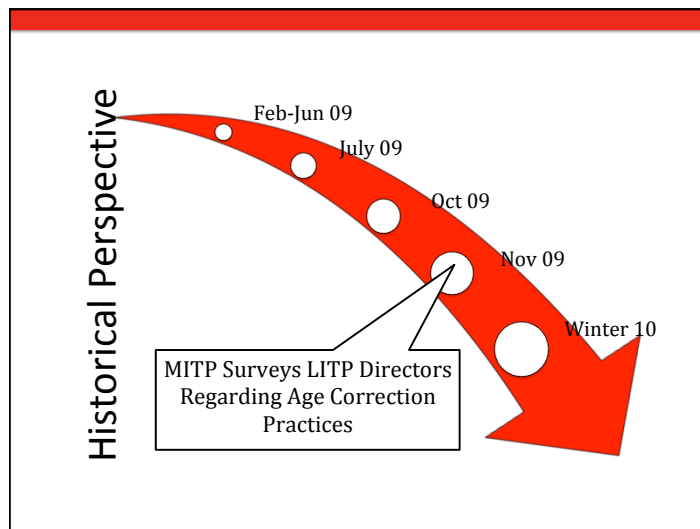
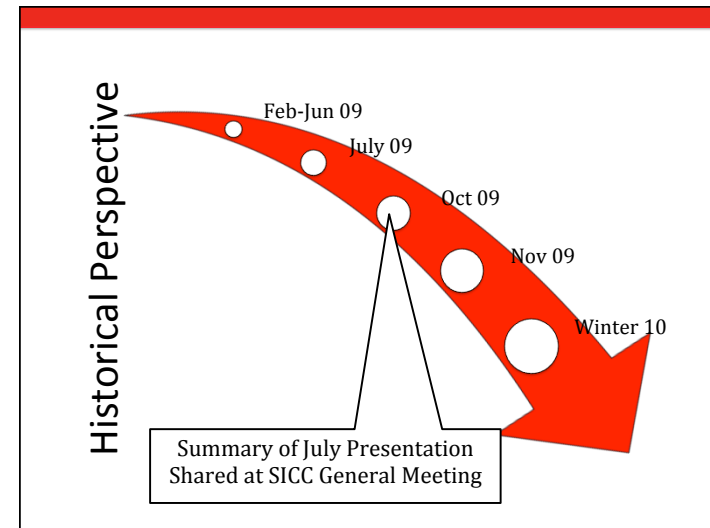
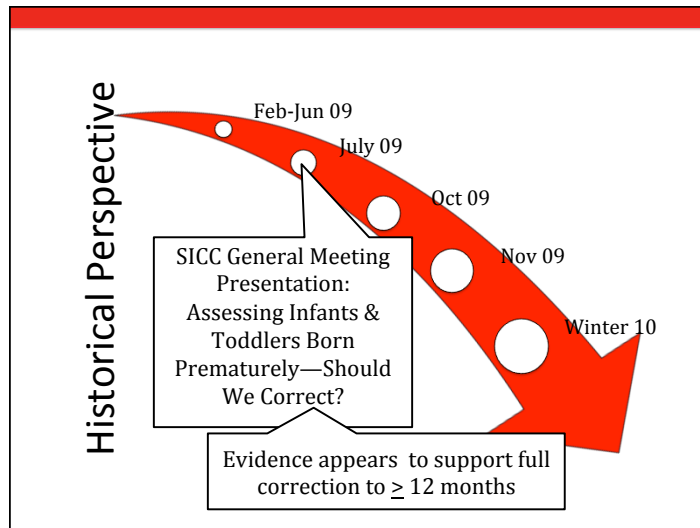


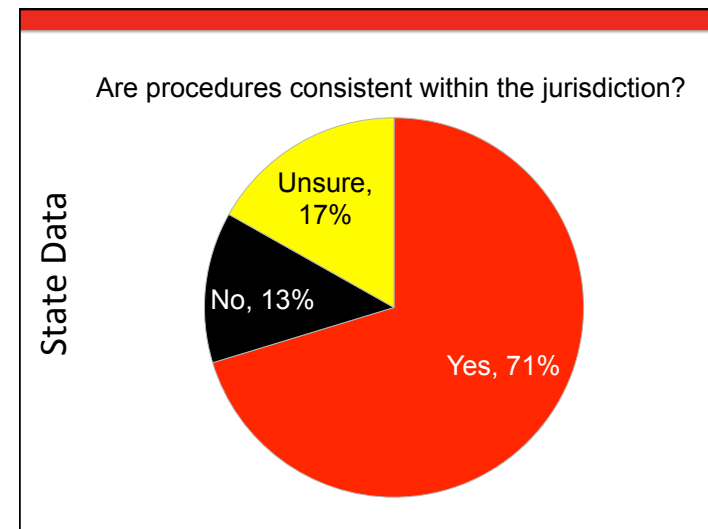
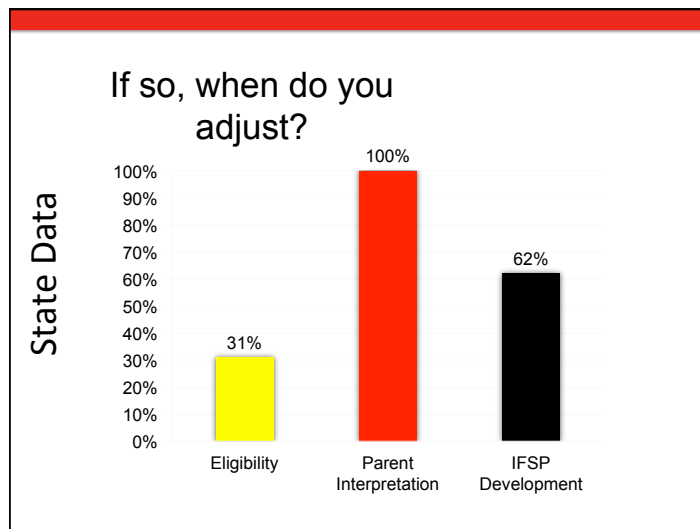
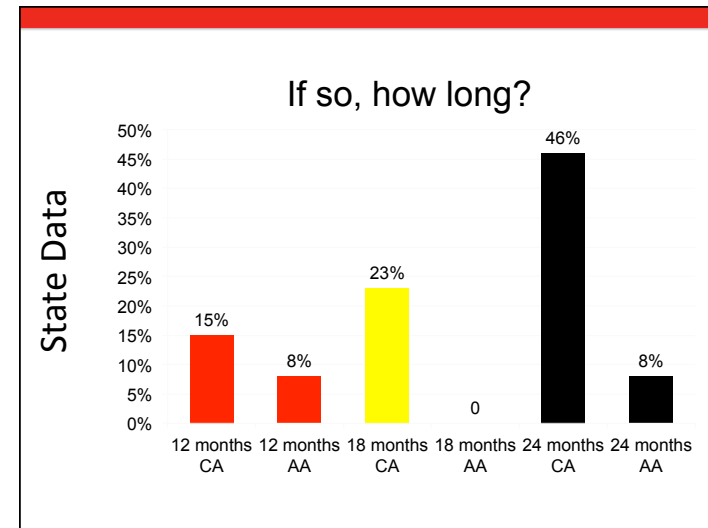
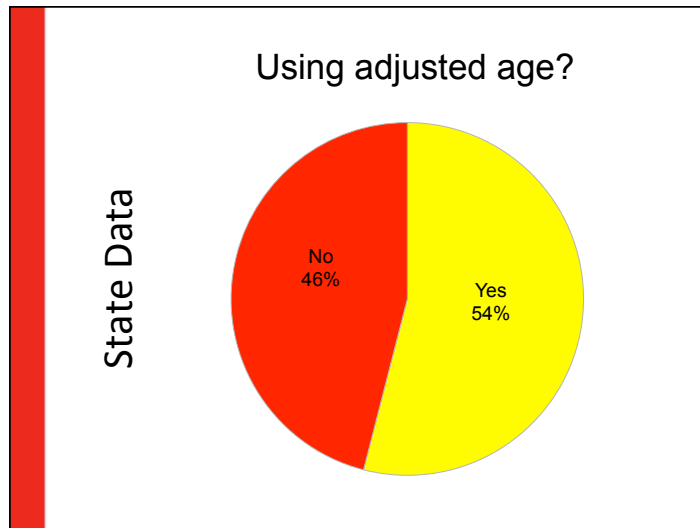
Implications in Maryland

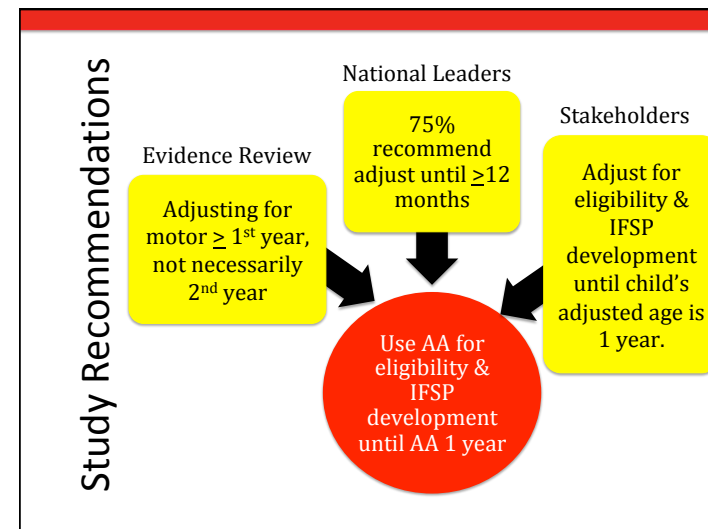
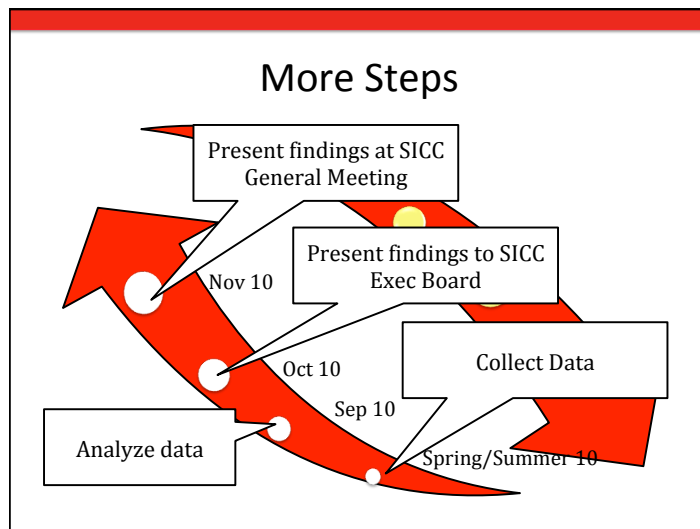
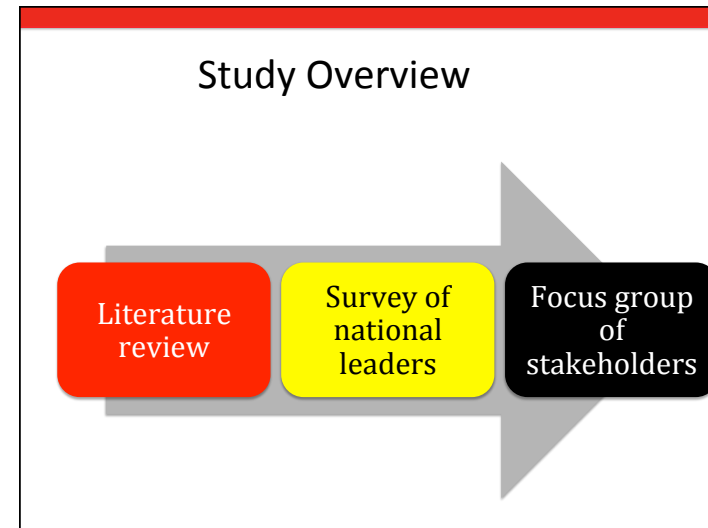
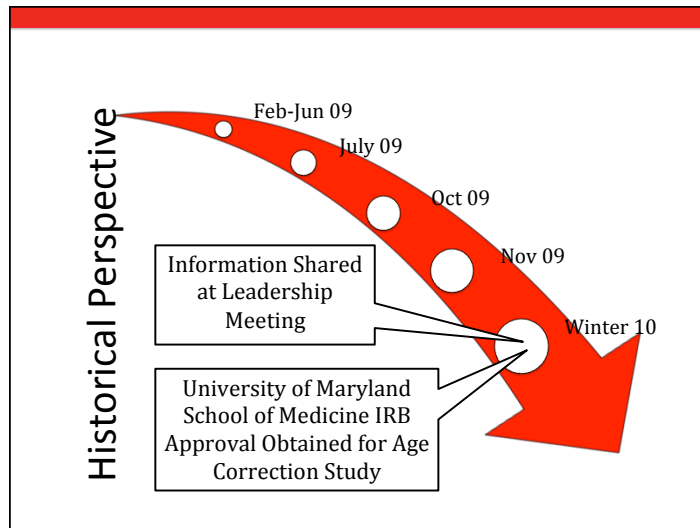


Age Adjustment Regulation









Public Comment

- 16 of 25 public comments mentioned adjusting for prematurity
 - 15 recommended using adjusted age:
 - Families, including parents, grandparents, etc. (7)
 - Citizens (4)
 - Hospital Representatives (1)
 - Private Agency (1)
 - Service Coordinator for an LITP (1)
 - SICC (1)
 - 1 Public Agency simply requested consistency in State

Adjusted Age for Prematurity

COMAR 13A.13.01.03B(2) and (12)(a)

(2) “Adjusted Age” means, for children born before 37 weeks gestation, the number of weeks born prematurely subtracted from the infant’s chronological age. An infant’s adjusted age is used until the infant’s adjusted age is twelve months.

(12) “Developmental Delay” means the presence of:

(a) A 25 percent delay, using a child’s adjusted or chronological age, and as measured and verified by appropriate diagnostic instruments and procedures, in one or more of the following developmental areas:

- (i) Cognitive development,
- (ii) Physical development, including vision and hearing,
- (iii) Communication development,
- (iv) Social or emotional development, or
- (v) Adaptive development;

Eligibility Criteria

UMB Study

Explore trends in follow-up of infants born prematurely

Understand patterns of EI & special preschool services received by children born prematurely

UMMC NICU Follow-Up Program & BITP

Hussey-Gardner B, Sulc W, Miller M, Baugh C. Neonatal predictors of the need for early intervention services. Poster presentation at the Society for Pediatric Research meeting: San Francisco; April 2004.

Method

- Retrospective reviews UMMC NICU Follow-up Clinic's & BITP databases
 - All infants born in 1997, 1998, 1999
 - Baltimore City residents
 - Gestational age < 37 weeks
 - Referred to UMMC NICU Follow-up Clinic
- 154 followed until age 3 years

Diagnoses Correlated with Specific Services

	Any	PT	OT	SI	SLP
CLD	.254**	.182**	.194**	.186**	.162**
PHH	.002	.061	.124*	.129*	-.079
Hypothyroidism	.152*	.045	.054	.083	.156*
IVH III-IV	.245**	.239**	.230**	.101	.144*
SNEC	.151*	.144*	.180**	.116	.178**
PVL	.085	.089	.183**	.192**	.105
ROP	.259**	.238**	.234**	.166**	.157**
Seizures	.088	.122*	.061	-.038	-.053
Tone Abnormal	.087*	.132*	.105	.041	.081

*Significant at the .05 level. ** Significant at the .01 level.

Diagnoses Predicting Services, Above & Beyond Birthweight (<1200g)

	Any	PT	OT	SI	SLP
CLD	X		X		
PHH				X	
IVH III-IV	X	X	X		
SNEC			X		X
PVL			X	X	
ROP		X	X		
Seizures		X			
Tone Abnormal	X	X			

X denotes multiple regression significant at $p < .05$.

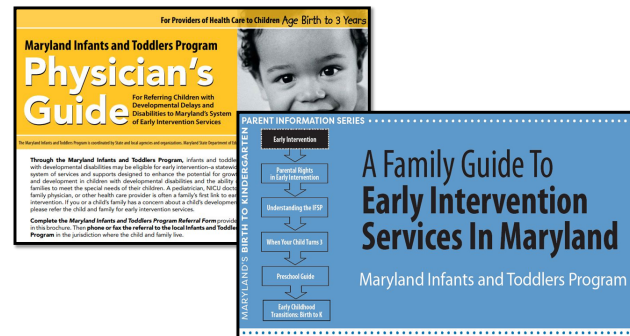
Conclusions

MITP inclusion of high probability conditions as eligibility criteria is supported by results of this study

CLD & SNEC was added to existing eligibility criteria

OUTREACH EFFORTS

State-Local Outreach: *IT TAKES A VILLAGE*



State-Local Outreach: *IT TAKES A VILLAGE*

Public Awareness			
Data Analysis			
Directions: Complete the data table below with data points relevant to indicator(s) 5 and/or 6. Utilizing System Considerations Table-Public Awareness Plan (included in directions) and a data analysis using the following: Why? (determine needs and assets)			
Describe how the local early intervention system will inform the public about the local infant and toddlers program and the overarching goal and include links to websites or local infant and toddlers program information.			
Data Points			
Child First Birth to One Indicator 5			
The percentage of children birth to one identified as eligible _____ (State Target 3.33%)			
Child First Birth to Three Indicator 6			
The percentage of children birth to three identified as eligible _____ (State Target 3.11%)			
Number of Referrals/Evaluations/New ISPs			
Current Year	Number of Referrals	Number of Evaluations	Number of Initial ISPs
Previous Year(s)	Number of Referrals	Number of Evaluations	Number of Initial ISPs
Underserved Populations			
The percentage of children from underserved populations who are identified as eligible compared to the overall population of infants and toddlers designated by underserved population			
Underserved Population	% of Total	% of Total B, C, D, and E	
Identify underserved populations served in locally program as compared to the majority/underserved population in the local jurisdiction; minority/underserved populations where readiness data are complete; other populations or other county data source			
Minority/Underserved Population	% of Total	% in Local Jurisdiction	Other Data Source (in School Readiness Data)
Root Causes			

Plan		
Focus Area	Infrastructure Development Strategies	Personnel Development Strategies
Public Awareness Materials		
Indicator 5: Children birth-1 with ISPs		
Indicator 6: Children birth-3 with ISPs		
Number of referrals, evaluations, ISPs		
Underserved Populations		
Other		

Items in the "Personnel Development Strategies" column must be included in your CSPO Plan.

TRAINING & WEB-BASED TUTORIALS

Online Series

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Prematurity and Atypical Development Professional Learning Series

This site is designed to equip early intervention professional learning facilitators with the information and materials needed to deliver a 5-module training series on prematurity and atypical development.

Modules may be delivered one at a time (taking approximately 1 hour to deliver each module) or all together during a single 4-6 hour professional learning event.

Overview

- [Module 1](#)
- [Module 2](#)
- [Module 3](#)
- [Module 4](#)
- [Module 5](#)

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Prematurity and Atypical Development

Module 1: The ABCs and 123s of Prematurity


This training module will take approximately 45 minutes to deliver to your staff. To begin, download and review the **Facilitator's Guide** in the callout box to the right.

Facilitator's Guide
Module 1: The ABCs and 123s of Prematurity (guide)

Learning Objectives

Upon completion of this training module, early intervention staff will be able to:

- Identify prematurity rates for the United States and Maryland;
- Describe statistics related to infant mortality and morbidity for the United States and Maryland; and
- Define important terms related to prematurity and birthweight.



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Prematurity and Atypical Development

Module 2: Diagnoses Associated with Prematurity and Developmental Implications


This training module will take approximately 60 minutes to deliver to your staff. To begin, download and review the **Facilitator's Guide** in the callout box to the right.

Facilitator's Guide
Module 2: Diagnoses Associated with Prematurity And Developmental Implications (guide)

Learning Objectives

Upon completion of this training module, early intervention staff will be able to:

- Identify diagnoses associated with prematurity;
- Identify the potential developmental impact of those diagnoses;
- Describe the importance of developmental monitoring; and
- Describe the purpose and role of NICU Follow-Up programs as a linkage service.



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Prematurity and Atypical Development

Module 3: Understanding and Using Adjusted Age with Infants Born Prematurely


This training module will take approximately 45 minutes to deliver to your staff. To begin, download and review the **Facilitator's Guide** in the callout box to the right.

Facilitator's Guide
Understanding and Using Adjusted Age with Infants Born Prematurely (guide)

Learning Objectives

Upon completion of this training module, early intervention staff will be able to:

- Describe the CONAR changes related to adjusted age that went into effect on July 1, 2013; and
- Calculate adjusted age.



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Module 4: A Potpourri of Interventions for After the NICU


This training module will take approximately 60 minutes to deliver to your staff. To begin, download and review the **Facilitator's Guide** in the callout box to the right.

Facilitator's Guide
Module 4: A Potpourri of Interventions for After the NICU (guide)

Learning Objectives

Upon completion of this training module, early intervention staff will be able to:

- Teach parents how to read and respond to their baby's approach, coping, and avoidance signals;
- Educate parents about the importance of back to sleep and tummy time;
- Show parents how to massage their baby to facilitate relaxation; and
- Provide anticipatory guidance to foster development of upcoming skills.



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Module 5: Atypical Development--Increasing Awareness


This training module will take approximately 60 minutes to deliver to your staff. To begin, download and review the **Facilitator's Guide** in the callout box to the right.

Facilitator's Guide
Atypical Development--Increasing Awareness (guide)

Learning Objectives

Upon completion of this training module, early intervention staff will be able to:

- Describe how atypical development may adversely impact the overall development of all infants and toddlers (those born prematurely, full-term, with complex medical histories, and those who have always been healthy);
- Identify characteristics of atypical development across multiple areas of development; and
- Determine when atypical development warrants further evaluation and/or early intervention services.



Acknowledgements

The training modules presented on this site were developed by Brenda Hussey-Gardner, PhD, MPH at the University of Maryland School of Medicine. Special thanks to Dr. Hussey-Gardner for sharing her work and for her dedication to serving Maryland's young children and their families. Funding was provided through a U.S. Department of Education, Office of Special Education Programs IDEA Part C grant awarded to the Maryland State Department of Education's Division of Special Education/Early Intervention Services.

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From Roots to Results

NEXT STEPS: CONTINUE PARTNERING WITH MEDICAL COMMUNITY TO SUPPORT EVIDENCE-BASED PRACTICES IN EARLY INTERVENTION

Brenda Hussey-Gardner, Ph.D., M.P.H.
Associate Professor of Pediatrics
University of Maryland School of Medicine

LESSONS LEARNED



Lessons Learned

- Don't wait until delays are present
- Establish statewide high probability conditions related to prematurity
- Implement statewide age correction policy
- Determine strategies to identify and refer in the NICU
- Importance of collaboration between NICU and NICU Follow-Up and early intervention program
- Value of on-site service coordination
- Essential to educate medical staff, fellows, residents, nurses and other medical team members

A Video Montage

PERSPECTIVES OF STAKEHOLDERS

Donna Spiker, Ph.D.
Center for IDEA Early Childhood Data Systems

Draft Potential DEC Position Statement on Low Birthweight





Draft Potential DEC Position Statement on Low Birth Weight

Donna Spiker, DaSy Center

Improving Data, Improving Outcomes Conference
Arlington, VA
August 2018

Purpose of the potential statement....

- * This is a product of DEC in draft form.
- * It is about the identification and eligibility for Part C early intervention (EI) services of children born low birth weight (LBW) and/or preterm in the United States.



Development process

- * DEC position statement workgroup made up of DEC members who are mainly researchers and EI TA providers who began work to develop the statement by reviewing literature on:
 - LBW development and health and
 - effects of early intervention on LBW.
- * Workgroup followed DEC guidelines: <https://www.decdocs.org/position-statement-guidelines>



Development process (cont)

- * Draft potential statement put out for DEC member and partner review.
- * Workgroup is revising draft statement.
- * Draft potential statement is now pending review and approval by DEC Executive Board.



Workgroup members included.....

- * Patricia Blascoe, Chair
- * Serra Acar
- * Kristi Atkins
- * Evelyn Foard Shaw
- * Jane D. Smith
- * Donna Spiker
- * Jane Squires



LBW terminology

- * LBW = < 2500 grams or 5.5 pounds (about 10% of population)
 - very low birth weight (VLBW) = <1500 grams
 - extremely low birth weight (ELBW) = < 1000 grams
- * Preterm birth is defined as <37 weeks gestation of a 40-week pregnancy
 - moderate to late preterm = 32 to <37 gestational weeks
 - very preterm = 28 to <32 gestational weeks
 - extremely preterm = < 28 weeks



What did literature say about LBW?

- * Able to keep smaller and smaller and earlier gestation infants alive.
- * Many LBW spend 2-6 weeks in NICU.
- * Parents experience stress and uncertainty and need support during the transition home.



What did literature say about LBW? (cont)

- * Medical and health conditions in first year of life and can continue to later ages.
- * Many show early difficulties with:
 - motor development including oral-motor difficulties
 - language acquisition, processing, and communication
 - engagement (e.g., exploration, initiative),
 - emotional regulation (e.g., persistence, frustration, competence),
 - social-emotional competence (e.g., joint attention, imitation/play, empathy, prosocial behaviors)



What is known about LBW in Part C eligibility definitions?

- * The criteria used to define LBW as a condition for eligibility varies greatly from state to state.
- * Only a few states include prematurity as a diagnosed condition to be considered for automatic EI eligibility.



What is known about LBW in Part C eligibility definitions? (cont)

- * For most states, LBW infants need to have a significant medical condition or demonstrate observable developmental delays before being eligible for Part C early intervention services.
 - In assessing EI eligibility, the use of corrected age (i.e., age the child would be if they had been born on their due date) may overestimate their abilities.



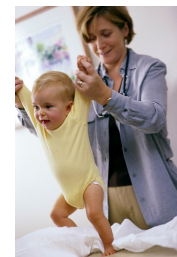
Conclusions about LBW eligibility

- * There is abundant evidence that this is a population at high risk for poor outcomes and the origins of their poor outcomes begin prenatally and in infancy.
- * The costs of the poor health, learning, behaviors, school achievement, and long-term life outcomes of LBW and/or preterm are substantial.
- * These data support identifying and providing EI services early on to reduce the long-term costs and poor outcomes.



DEC product in draft form recommends that.....

- * LBW and/or preterm should be considered an established condition to automatically make an infant eligible to receive EI services.
- * There is no need to wait to provide EI services until full blown delays and functional deficits are present.



DEC product in draft form recommends that.....

- * Across the range of LBW, there is strong research evidence to support the contention that all LBW infants born ≤ 1500 grams are high risk for delays, and this weight should be the definition for the national standard for automatic EI eligibility.
 - In addition, children born < 37 weeks should be considered for EI services.



DEC product in draft form recommends that.....

- * Some states may want to expand their eligibility criterion to include the full range of LBW (≤ 2500 grams) because the full range of LBW clearly confers risk status as well.
 - Especially for LBW children from low income families and who have cognitive and/or behavioral concerns that can manifest later at school-age.
- * States can also use informed clinical opinion to determine eligibility for many LBW infants.



Other considerations....

- * In the DEC product in draft form, the workgroup recognized that expanding eligibility may create challenges for many states.
- * But the DEC product in draft form suggests that:
 - states review their eligibility policy and consider how their eligibility criteria align with the most current research.
- * The workgroup recognized that there is a need for collaboration and data tracking across health care and EI professionals to facilitate referrals, track children's outcomes over time, and research interventions.



Questions and more information.....

- * If you want more information or have questions about the potential position statement, please contact:
 - Peggy Kemp, DEC Executive Director - peggy@dec-spel.org



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Thank You

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SMALL GROUP DISCUSSIONS



Questions?

