Early Intervention Developmental Profile and its use in determining  
Early Intervention eligibility in Massachusetts  
Frequently Asked Questions, 10/15/03

How do you score items on the EIDP when a child refuses to perform?

In most cases, if a child refuses to perform an item, or has no response to administration of a particular item, the item should be scored as an (F) for fail. If the item is one that may be scored by parent report or interview or if the service provider has observed the child performing the requested item, these may be used to determine whether the item can be scored as a pass.

How is the adaptive (self-care) section scored?

For children under 12 months of age, this section will be comprised of feeding skills only. For older children, each section should be scored to arrive at an age level. The age levels of each section should then be averaged to arrive at a self-care age level.

How does one arrive at separate expressive and receptive language scores?

Receptive and expressive items should be scored separately and an age level arrived at for each. Those items identified as imitation should be included with expressive language.

When I score using the formula, I often get a score that is not a whole number, e.g. 6.3 months. How do I transfer this age level to the EIIS form?

Scores should be rounded to the nearest whole number. For decimals that are .5 or greater, the age level should be arrived at by rounding up. For decimals that are smaller than .5 the age level should be arrived at by rounding down. For example 8.4 would be rounded to 8 months, while 8.5 would be rounded to 9 months.

How should I determine the child's chronological age if it is not a whole number, for example 8.3 months?

A child is considered to be the chronological age he/she has attained on his last monthly birthday until the next monthly birthday. For example, a child who will be one on her birthday of October 4\textsuperscript{th} is considered to be 11 months of age on October 3\textsuperscript{rd}. 

How do you score when there is a great deal of scatter?

A basal score should be arrived at as with any child. Because of scatter, the ceiling may be difficult to acquire, but every attempt should be made to administer items in order to reach a ceiling. Then scoring using the formula should proceed as usual.

Because there is no test kit, may a child’s play materials be used to administer test items?

The EIDP materials list in Volume 2 and the Test Items Description section in Volume 1 provide examiners with suggested materials to be used in item administration. If a child’s play material are consistent with those suggested, they may be used. Care should be taken to ensure that the materials a child uses are consistent with those suggested. For example, if a child uses two inch blocks at home, but one inch blocks are suggested for stacking items, then blocks from the test kit should be used for those items. The Department of Public Health strongly encourages programs to use materials suggested in the EIDP manual.

Can other discipline specific tools be used in conjunction with the EIDP?

Additional testing materials may be used so that the team may gather additional information about a child’s performance or qualitative information about a child’s skills and knowledge. However, age levels used to determine eligibility should be those arrived at using the EIDP.

What if the EIDP consistently scores children as “not eligible” in certain domains even though in the clinical opinion of the evaluation team the children should be deemed eligible?

As has always been the case, the clinical opinions of the evaluation team members are valid determinants of eligibility status as long as they are based on observation and assessment of skill, qualitative aspects of a child’s performance or risk for developmental delay. A child may be deemed eligible under the classification of “clinical judgment” despite their age appropriate performance on the EIDP as long as such qualitative concerns exist. Please see the article “Informed Clinical Opinion” for more information on interpretation of clinical opinion under IDEA.

How many trials may a child be given to complete an item?

The Administration and Test Item Descriptions in Volume 1 give the examiner guidance related to numbers of trials for some items. Some items do not specify a suggested number of trials. However, it is generally accepted practice to offer a child two or three trials at most in typical assessment situations.
Early Intervention Developmental Profile and its use in determining 
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Frequently Asked Questions # 2 
11/17/03

1) Given that the state is trying to use one eligibility tool across the state so that the state 
could then be a benchmark for the rest of the country, there are concerns about 
scoring a child when a “baseline” has not been achieved. This will lead to the state’s 
process being considered invalid as it does not meet any statistical data criteria and 
will therefore negatively impact the position of the state. 

   DPH is using one eligibility tool in order to establish consistency 
   within the state, not to serve as a benchmark for the rest of the 
country. The scoring process to be used for the Michigan is based 
on a child’s individual performance and is not intended to meet 
statistical data criteria.

2) Do six passes in a row, as opposed to a completed block, equal a basal? 

   According to the scoring protocol, the basal is established by a 
   child being scored all passes within a range (block). Six 
   consecutive passes that span across blocks would not be 
   considered the basal.

3) With the new scoring system, is DPH expecting an increase in the number of children 
eligible through clinical judgement? 

   With the new scoring protocol, there will most likely be some 
   children who would have been eligible by established delay under 
   the old system and are no longer eligible by established delay 
   under the new system. Clinical judgement remains an eligibility 
category for children who demonstrate qualitative concerns that 
impact their participation in daily routines in natural settings. 
Eligibility through established delay and eligibility through 
clinical judgement should be considered separate categories and a 
child does not automatically qualify under one or the other.

4) Please justify giving equal weight to the sub-categories of feeding, toileting, and 
dressing/hygiene when averaging the scores. Consider the cultural and current 
understanding of the developmental domains versus the publication date. 

   DPH made a policy decision to average the three sub-categories of 
feeding, dressing, and toileting to arrive at an overall 
adaptive/self-help domain score, as required by the Office of 
Special Education Programs under IDEA, Part C. All scores in all 
developmental domains need to be discussed with families in the 
context of that individual family’s culture.

5) How was the decision to combine self-care skills by averaging them arrived at? 

   While this may be ok with toileting and dressing/hygiene, feeding can be a significant
issue and wiped out by those areas. For example, a 24 month old who passed toilet and dressing at 24 months, but was at 12 months feeding, which is significant, would not be eligible for services because it would average to 20 months.

*DPH made a policy decision to average the three sub-categories of feeding, dressing, and toileting to arrive at an overall adaptive/self-help domain score, as required by the Office of Special Education Programs under IDEA, part C. In the above example, the child would not be eligible under the category of established delay. However, a 24-month-old child with a 12-month delay in feeding would possibly be eligible through established risk, if there were a relevant diagnosis or clinical judgement if there were qualitative concerns.*

6) How does EI staff remain supportive of presenting issues while needing to also focus on accurate scoring?

*It is best practice for all evaluation/assessment reporting to begin with the identification of strengths and move toward a discussion of areas of concern. If the child is eligible through established risk or at risk categories, the discussion can end at that point and specific scores can be brought to the next session. If a specific score is required at that moment, to document eligibility through established delay, then clinicians need to let families know they need to take several minutes to score the EIDP accurately. General discussions as noted above can start with one clinician while other members of the team take a moment to calculate.*

7) Does DPH expect staff to bring calculators into a family’s home to score the Michigan?

*Yes.*

8) When doing the formula in the area of speech/language we are separating the E/I (Expressive / Imitation) and R (Receptive) items, so on Step #4 when we are dividing the # of items in the next age range by the # of months represented in that same age range, do we only count the number of items that are E/I or R?

*Yes, only expressive/imitative or receptive items should be counted.*

9) There is a shortcut to the scoring formula that supposedly always ends up with the same answer. Can we use that shortcut instead of the formula?

*Information regarding a shortcut has recently been brought to the attention of DPH and this scoring method is currently being researched. At this point, in order to ensure consistently across the state, all programs should be using the full scoring protocol, as presented at the 15 October 2003 Directors’ Training. DPH will share any information obtained about the appropriateness of the shortcut for future use.*
10) Page 11 of the colored scoring examples shows a block of items from the Preschool language Scale. Should these items be scored as part of the Michigan? 

No. Please refer to the white Michigan booklet that was distributed at the training on October 15, 2003. This is the document that should be used to make copies to use with children and families. It does not contain the Preschool Language Scale block. The Michigan items, and only the Michigan items, should be used to calculate the Michigan score.

11) Does DPH have any suggestions on how to talk to families about the use of the calculator? 

Programs are encouraged to be honest with families and let them know that a new scoring protocol has been implemented that requires the use of a calculator. Staff should feel free to let families know that it will takes several moments to score the evaluation/assessment and staff might want to thank families for their patience as there may be a short wait before specific feedback is given. Please refer to #6 of this document for further suggestions on sharing scores with family members.
1) Can EI clinicians omit presenting specific tasks on the Michigan when they feel they are not appropriate?

Because the Michigan is being used to determine eligibility for Early Intervention services in Massachusetts, all items need to be presented, until a ceiling is reached in each subsection, in order to obtain an accurate score. Clinicians are encouraged to utilize their informed clinical opinion when interpreting scores, and discussing individual tasks, with families.

2) Can the use of the scoring formula be modified in certain areas?

The new scoring protocol, known as “the formula” may not be modified in any area of scoring. Use of the new scoring protocol ensures consistency across the state in terms of determining eligibility for Early Intervention services. The new scoring protocol should be implemented as presented at the annual EI Program Directors’ training on 15 October 2003.

3) How is an omit scored?

Page eight of Volume one states “when an item can be presented and passed by substituting another sensory modality, the substitution should be used and noted in the scoring section and an O should not be used. Because an O represents the failure of a child to acquire a certain skill due to the nature of his handicap, an O is counted as a failure when establishing basal and ceiling levels.”

4) Is the DPH planning to design a score sheet for EIPs to use?

The DPH is not planning to design or require the use of a score sheet in implementing the new scoring protocol. Programs may choose to develop their own work sheet as a tool for their staff. If programs do so, and would like to share their work, DPH would be happy to help distribute the resource. Attached please find one example that a program has developed. Remember that this is a resource only, and not required by DPH.

5) Are EIPs expected to keep their score sheets for each section for each child?

EIPs are not expected to keep their score sheets for each section for each child. Only the final score in each section needs to be kept on file. However, clinicians should be able to “show” how any specific score was obtained if questioned by a parent or DPH.
If EIPs feel the best way to do so is to keep their score sheets, that is fine.

6) How does the new scoring system translate to determining a point to graph on the profile graph page?

The new scoring system does not translate to the profile graph at all. EIPs need to use the new scoring protocol, but are encouraged not to use the graph. It can be considered a resource that can be utilized somewhat with families who prefer a visual representation of a score, but it will never correspond completely to the scoring technique.

7) There is one example where step #7 needs to be applied twice. Is this correct or is something wrong with the formula?

Sometimes step seven needs to be applied more than once. That is fine-just follow the directions until a score is achieved. The green example in feeding shows where it actually needs to be applied three times!

8) What happens when there are no receptive items in a block?

Follow the scoring protocol directions as indicated. It will direct EIPs to only look at receptive items, wherever they fall.

9) Can items be scored as a pass by parent report?

The white copy of the EIDP scoring booklet that was distributed at the policy training in October 2003 has items coded that may be scored as a pass by parent report. Items marked PR (parent report), R (report), or interview may be scored as a pass by parent report. All other items not directly observed by EI clinicians must be scored as a fail. It would be best practice to include in the report any items that parents indicate children typically can do but were not observed to do on the specific day of the eligibility determination.

10) In scoring the “self-care” section for a child over 12 months of age, what should I use as the basal score?

Remember that in the “self-care” section, one score is obtained for each area, and the three scores are then averaged to obtain the child’s composite score in the Self-Care domain.

PLEASE NOTE that the toileting and dressing/hygiene areas do not begin to be scored until 12 months of age. Therefore, in order to obtain a basal for these areas in a child over 12 months of age, with no passes, “11 months” should be used. This will ensure a clinically accurate picture of the child’s overall score.