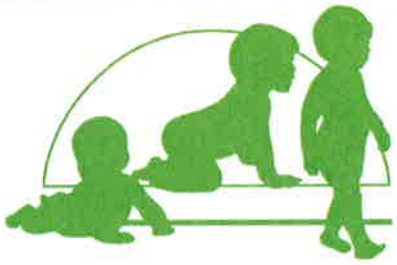
Washington State Department of
Early Learning

Early Support
for Infants
and Toddlers



Washington State Part C
State Systemic Improvement Plan (SSIP)

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Introduction:

Washington State Part C

State Systemic Improvement Plan (SSIP)

State Lead Agency and Local Lead Agency

The Department of Early Learning (DEL) is the State Lead Agency for the Individuals with Disabilities Education Action (IDEA) Part C program for Washington State. Within DEL, the Part C programmatic home is the Early Support for Infants and Toddlers (ESIT) program.

During Federal Fiscal Year (FFY) 2013, ESIT held contracts with 28 Local Lead Agencies (LLAs) statewide for the purpose of ensuring all families have equitable access to a locally coordinated system of early intervention services. As a result, 12,550 eligible infants, toddlers and their families received early intervention services during the past year. The types of organizations that administered each local early intervention system included:

3 County health departments;

4 County human service agencies;

1 Combined health and human service agency;

15 Nonprofit agencies; and

5 Educational service districts.

To ensure that services are coordinated and conform to IDEA Part C requirements, each LLA develops and maintains subcontracts or local interagency agreements with individual early intervention providers or providing organizations within their geographic service area.

State Systemic Improvement Plan (SSIP) Leadership Team

With knowledge about state and local structures and because of the technical assistance and guidance ESIT received, it was decided that formation of a state leadership team would benefit SSIP planning, development and implementation. ESIT staff determined that the SSIP Leadership Team would be comprised of ESIT staff and a representative group of stakeholders already engaged and invested in their local early intervention system.

State Office Staff

Members of the SSIP Leadership Team from the state office consisted of the majority of staff including the Part C Coordinator, Data Manager, Assistant Data Manager, Parent Participation Coordinator, Program Consultants, and State Interagency Coordinating Council (SICC) Program Specialist.

Stakeholders

In addition to state office staff, the SSIP Leadership Team needed a representative group of stakeholders. ESIT notified stakeholders statewide of the opportunity to join the SSIP Leadership Team. The notice strongly encouraged stakeholders with early intervention experience and expertise to consider joining the SSIP Leadership Team.

Subsequently, stakeholder applicants identifying experience in implementing IDEA Part C requirements were given priority. Additional preference was given to stakeholders that identified knowledge and interest in Washington Part C data and data analysis tools, the Annual Performance Report (APR), and the Integrated Individual Family Service Plan (IFSP)/Child Outcomes Summary (COS) process.

Fourteen stakeholders responded positively to the notice of invitation by identifying their early intervention interest, knowledge and experience. Stakeholders included individuals representing LLAs, early intervention service providing programs, a regional early childhood technical assistance provider, a representative from the state child welfare agency, and an infant mental health consultant (see Attachment A-SSIP Leadership Team list for more details). Of the fourteen stakeholder respondents, three indicated they were parents of children who had participated in early intervention services.

Statewide participation of SSIP Leadership Team members was possible because meetings occurred by webinar. Even though the entire SSIP Leadership Team was fairly large with approximately twenty members, having a large team ensured there was always sufficient representation, because not all team members could participate in all of the webinar meetings.

SSIP Leadership Team meetings began in April 2014 and have continued to occur up to the present time. The SSIP Leadership Team has been integral to addressing Phase I requirements by providing insight, expertise and feedback that often reflected differing

perspectives. SSIP Leadership Team meetings have occurred at least monthly with more frequent meetings occurring as the work has required. From April 2014 to February 2015, fourteen SSIP Leadership Team meetings have occurred. During the meetings, participants actively engaged in data and practice discussions that led to reasoned conclusions and action steps when needed (see Attachment B-Leadership Team meeting schedule).

Broad Stakeholder Involvement

LLA and Other Stakeholder Involvement

ESIT used its quarterly LLA meetings as a venue to obtain broad stakeholder input. LLA meetings served as an efficient way to gather feedback and input regarding SSIP related activities, data and timelines. In addition to LLA administrators, family resources coordinators (FRCs [ESIT service coordinators]), early intervention providers, and other interested community members participated. These SSIP Stakeholder meetings occurred in eastern and western Washington locations. They were initiated in November 2013 and have continued to occur quarterly (see Attachment C- LLA meeting schedule).

ESIT introduced the SSIP and Phase I requirements in November 2013. Since November 2013, two meetings have occurred each quarter providing a consistent opportunity for ESIT to provide SSIP information and solicit SSIP related feedback. These meetings included both large and small group processes. Both processes encouraged the in-depth discussions that were needed to generate stakeholder feedback and input on various components of the SSIP.

The State Interagency Coordinating Council (SICC) Involvement

ESIT staff presented information on the SSIP and gathered input from members of the State Interagency Coordinating Council (SICC) and members of the Family Leadership Involvement Committee (FLIC). During each SICC and FLIC quarterly meeting, members were updated on SSIP related data, activities, and timelines. The SICC provided advisory guidance that has helped in addressing potential SSIP related system issues. A special SICC meeting was held for members to review and provide feedback on the draft SSIP. Members who were unable to attend the meeting had an opportunity to provide written feedback (see Attachment D- SICC membership roster).

State Identified Measureable Result (SIMR)

As a result of data and infrastructure analyses and in-depth discussion that has occurred over the past year with the SSIP Leadership Team and stakeholder groups, the DEL/ESIT SIMR is:

"Increase the percentage of infants and toddlers with disabilities in Washington State who will substantially increase their rate of growth in positive social-emotional skills (including social relationships) by the time they exit the early intervention program."

These children will move closer to functioning to that of same-aged peers as reflected in Summary Statement 1.

Guidance and Technical Assistance

Throughout Phase I, Office of Special Education Programs (OSEP) funded technical assistance (TA) consultants assisted ESIT staff with planning and implementing Phase I activities. Beginning with the Western Regional Resource Center (WRRC) Fall 2013 meeting, ESIT began discussions with TA consultants regarding SSIP related planning and possible next steps. Because of the timelines set for completion of Phase I activities, ESIT staff determined it was imperative that planning begin as soon as possible. With foundational information about the new Results Driven Accountability (RDA) structure, and with some knowledge about the new SSIP requirement, ESIT sought out technical assistance. As a result, a two-day onsite technical assistance workshop was convened in the Olympia state office with ESIT, WRRC, the Early Childhood Technical Assistance (ECTA) Center, and the Center for IDEA Early Childhood Data Systems (DaSy) staff. During the two-day workshop, a draft Phase I timeline was developed; the SSIP Leadership Team concept was discussed and adopted; and a plan was made to look more deeply at child outcome data as a possible focus area for improvement.

TA consultants assisted the SSIP Leadership Team through all aspects of Phase I activities. They served in multiple roles that were essential to ESIT's progress. They participated in and/or facilitated all of the SSIP Leadership Team meetings. TA consultants hosted each webinar so that data and documents could be shared with the full Leadership Team. The technical assistance they provided gave ESIT staff the confidence to move forward with SSIP related work while the requirements continued to evolve and unfold.

Component 1:

Data Analysis

1(a) How Key Data were Identified and Analyzed

Washington State Early Support for Infants and Toddlers (ESIT) staff met with Office of Special Education Programs (OSEP) funded technical assistance (TA) consultants in January 2014 to begin Phase I planning that included broad data analysis and planning for stakeholder involvement.

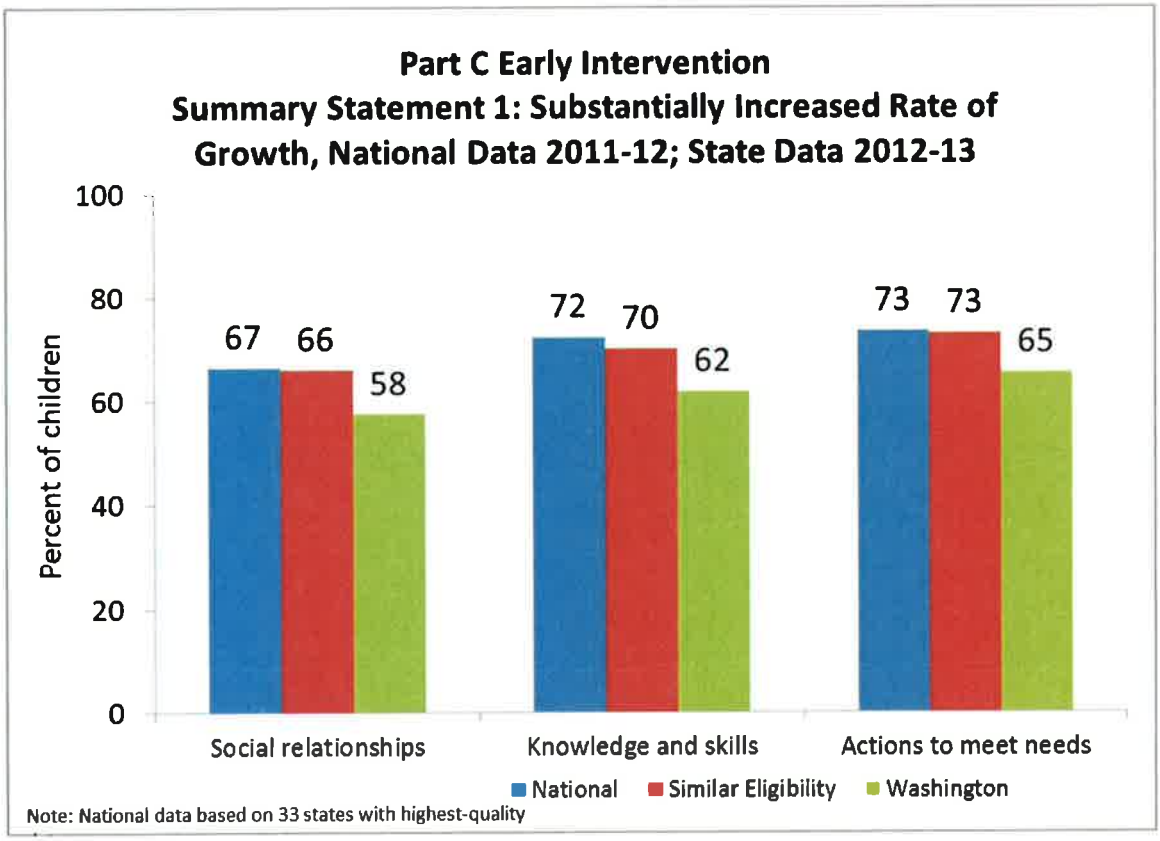
The ESIT program, within the Department of Early Learning (DEL), was able to assess the availability and relevance of SSIP related data obtained through other DEL early childhood programs. For example, the SSIP Leadership Team reviewed and discussed Washington State's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) data. This data proved to be very informative in identifying communities considered to be at "high risk" and were used to prioritize home visiting resources. This information, in combination with ESIT child level disaggregated data, assisted in the preliminary thinking about where to focus further data analysis. Ultimately, because it was found that some of the most "at risk" communities across the state had some of the strongest social-emotional supports and resources, the Leadership Team suggested focusing improvement efforts to those communities might not be the best approach. Rather, considering ESIT child level data and distributing supports and resources more equitably would generate the best result. Other data reviewed and considered were from the Kids Count web site. Because Kids Count data were difficult to disaggregate by county, attempts to use Kids Count data in a meaningful way were discontinued.

After considering these other data sources, it was determined that the abundance of child level data available through the Data Management System (DMS) would serve as the primary data source for SSIP related work. Additionally, using the Child Outcome Summary (COS) data and reports available through the DMS, would make engaging in meaningful data analysis possible along with the identification of a focus for improvement. DMS data would help to identify the SSIP focus area, assist in identifying why the problem is happening, and possibly give some direction to the action steps to be taken.

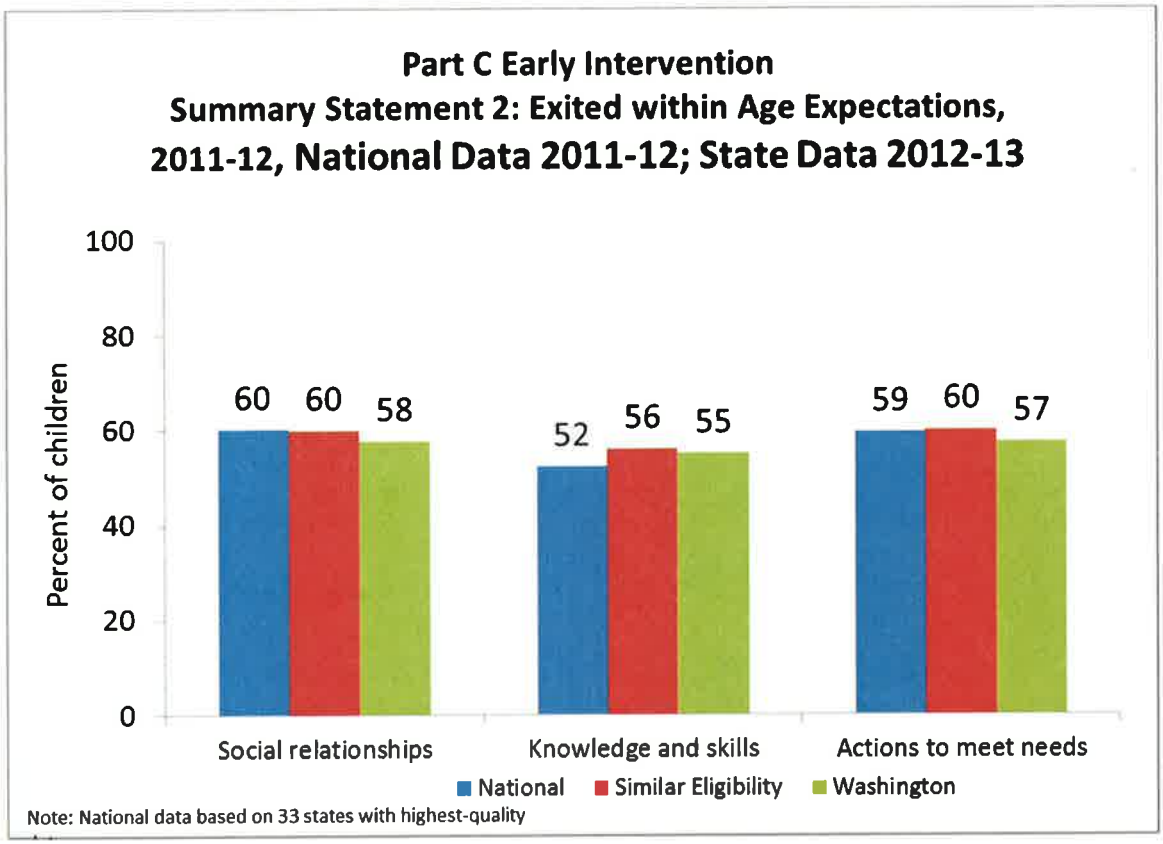
SSIP Leadership Team Meeting - April 3, 2014. During this meeting, the Leadership Team reviewed the 2012-2013 Annual Performance Report (APR) and 618 data with a focus on Indicator 3 (child outcomes) – Indicator 3(a) social-emotional skills and relationships, 3(b) knowledge and skills, and 3(c) action to meet needs. Also discussed were Washington's progress data reflected in child outcomes Summary Statement 1

(SS1) – the percent of children that substantially increased their rate of growth; and, Summary Statement 2 (SS2) – the percent of children that exit at age expectations. In addition, family outcome data were discussed. The data could not be linked with child outcome data, therefore the Leadership Team decided not to include it in the analysis.

Washington's child outcomes data were further analyzed. Washington's COS data were compared to national COS data and to data from other states with similar eligibility criteria. When considering SS1 progress data, Washington was lower in all three outcomes compared to national data and data from states with similar eligibility criteria. This data is represented in the following graph:



As shown in the graph below, Washington was similar in SS2 in all three outcomes compared to national data and data from states with similar eligibility criteria.



The Leadership Team concluded from this broad data analysis of child outcome data to focus on SS1, as opposed to SS2. The decision to look more closely at SS1 was made because when comparing Washington data to national data and data from states with similar eligibility, Washington's SS1 results were lower. In contrast, Washington's SS2 results were similar to national data and data from states with similar eligibility.

SSIP Leadership Team Meeting – April 9, 2014. During this meeting, SS1 data were reviewed and disaggregated by service area for the three child outcomes. Of the three child outcomes reviewed and discussed, Outcome 3(a), social-emotional, was the lowest. The Leadership Team explored and suggested possible reasons for the low SS1 social-emotional data. As the team explored possible reasons, several questions were posed. Are social-emotional SS1 data low because children are rated too high at entry? If so, is a high rating at entry particularly pronounced in younger children? To explore these questions, the SSIP Leadership Team reviewed data disaggregated by multiple variables,

as described in Component 1(b). For example, one of the data variables the team explored was age at entry, comparing children that entered early intervention under age one, between ages one and two, and between ages two and three. Another data variable explored was race/ethnicity.

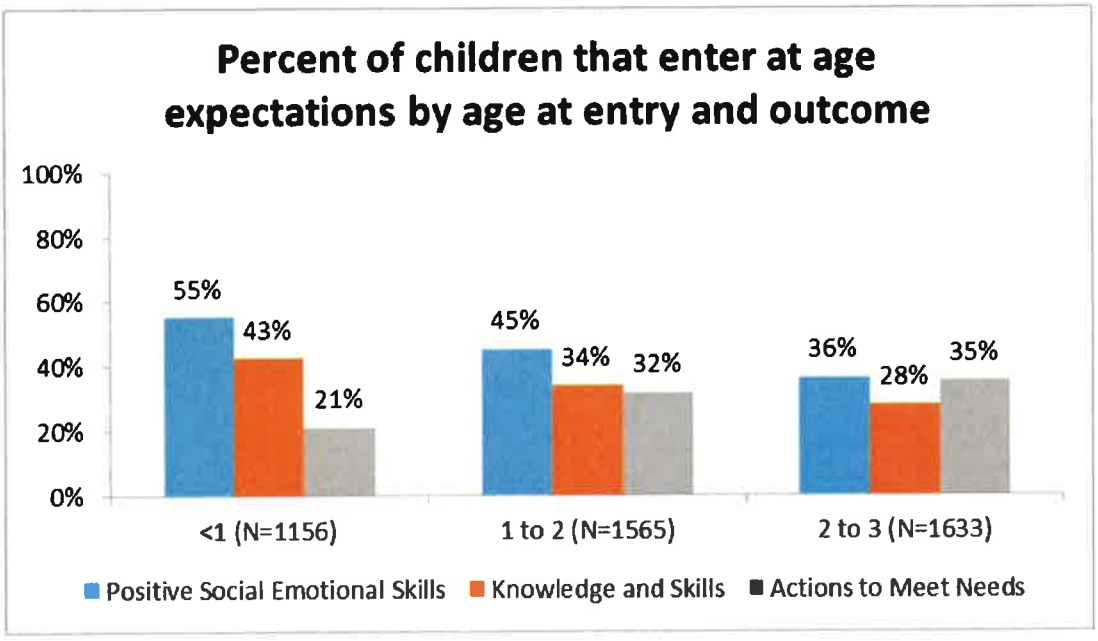
SSIP Leadership Team Meeting - April 22, 2014. Based on the disaggregated data reviewed and explored, four possible focus area options were considered and discussed that included:

1) Identifying low performing programs and providing additional supports

   The team considered focusing on low performing programs because for each of the three outcomes, there were a group of programs that were performing at a level below other programs and the state average.

2) Improving capacity of families and providers to support infants' social-emotional development

   The team considered focusing on Outcome 3(a) based on the comparison to national data described earlier along with the following: disaggregated data identified 55% of children less than age one who enter early intervention were identified as having positive social-emotional skills that were *at or above* age expectations (see graph below). At exit, 10% of these children were rated as *below* age expectations in positive social-emotional relationships/skills.



3) Improving providers' ability to understand and intervene with children's actions to meet needs

   The team considered focusing on Outcome 3(c) based on data disaggregated by age at entry. Only 21% of children less than age one entering early intervention were meeting age expectations in their ability to meet their needs. This was a surprisingly small percent of children and may indicate a misunderstanding of this outcome in very young children.

4) Improving the percent of Black or African American children that make greater than expected gains across all three child outcomes.

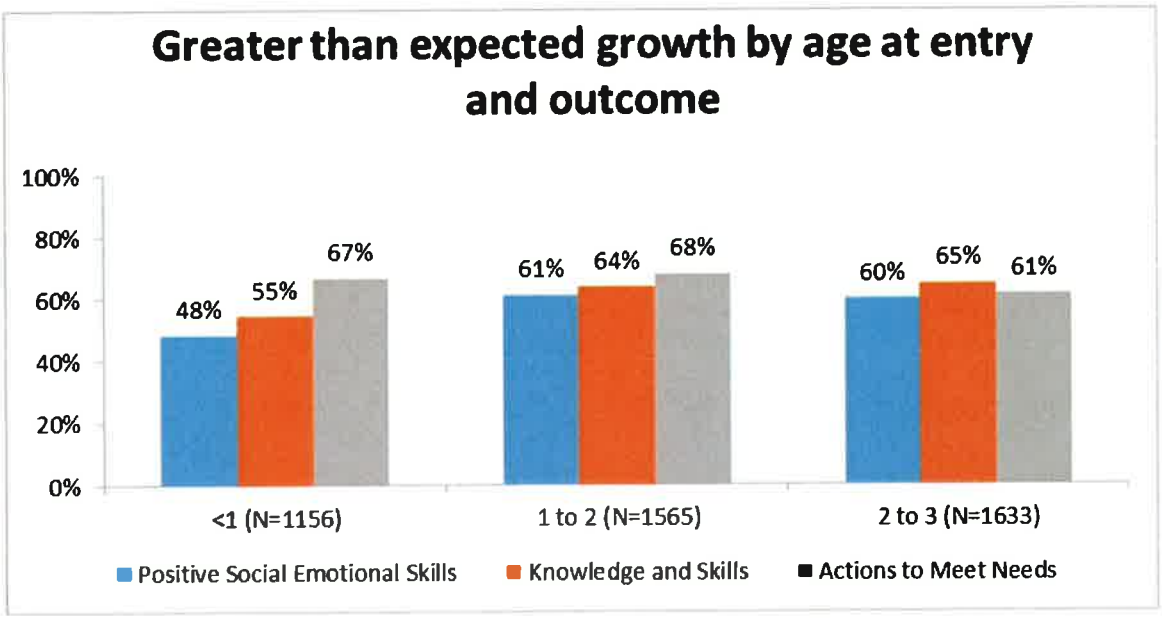
   Based on the data, when compared to other races/ethnicities, children who were identified as Black or African American had lower SS1 outcome ratings.

After further discussion and considering additional information related to the three child outcomes, the SSIP Leadership Team decided to focus more in-depth analysis on social-emotional skills and actions to meet needs, ultimately establishing consensus to focus on social-emotional skills. Nevertheless, the SSIP Leadership Team agreed that the larger stakeholder group should have the opportunity to discuss and consider both outcomes and related data before making a decision.

SSIP Leadership Team Meeting – May 2, 2014. The team discussed and identified possible reasons for low performance in social-emotional skills. Possible reasons identified included:

- Not enough time in service
- Social-emotional goals not included in the IFSP and not addressed in intervention
- Parents not receiving adequate information about supporting social-emotional development, and/or
- Serving a large proportion of children with parents in the military or children in foster care

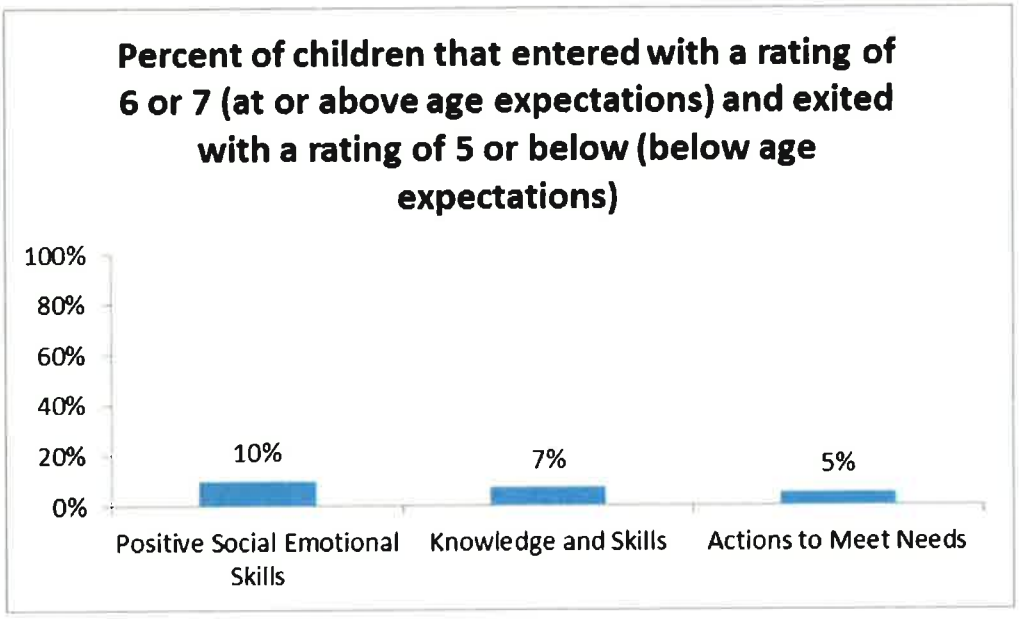
The Leadership Team analyzed data patterns across the three child outcome areas disaggregated by age at entry, to better understand SS1. Infants entering early intervention at less than one year of age showed the greatest discrepancy in performance across the three outcomes. Infants under the age of one were also much more likely to make greater than expected growth in actions to meet needs than in positive social-emotional skills (see graph below).



To better understand why this patterning was occurring, the team looked again at the percent of children that entered the program functioning at age expectations by outcome area. The data confirmed the highest percent of children rated as functioning

at age expectations in positive social-emotional skills are children that entered under age one.

Next, the team reviewed the percent of children that entered at or above age expectations and exited functioning below age expectations (see graph below). The data confirmed this was most likely to happen in Outcome 3(a), social-emotional skills and relationships, and least likely to happen in Outcome 3(c), actions to meet needs.



The Leadership Team hypothesized that the children who were not making greater than expected growth were those that were in services less than a year. However, the data showed that within age groups, greater than expected growth does not vary in a consistent pattern with length of time in service.

In summary, the team reviewed the percent of children that entered at or above age expectations and exited functioning below age expectations. The data confirmed this was most likely to happen in Outcome 3(a), social-emotional skills and relationships, and least likely to happen in Outcome 3(c), actions to meet needs. When disaggregating Outcome 3(a) data, it was determined that 55% of children less than age one who entered early intervention had social-emotional skills that were at or above age expectations. However, at exit, 10% of these children were below age expectations.

Stakeholder Group Meetings - May 21 (Bremerton) and May 28 (Spokane), 2014. The data analysis completed by the SSIP Leadership Team was presented at both Stakeholder Group meetings. Stakeholders were given a presentation that highlighted key findings and were given the opportunity to ask questions and request clarification.

Approximately 65 stakeholders participated and gave input. Stakeholder participants included LLA administrators, FRCs, early intervention service providers, and interested community members. ESIT staff facilitated a small group activity for stakeholders to discuss the focus area options of positive social-emotional skills and actions to meet needs. Based upon the data that were shared and the discussions that occurred, the majority of participants from both stakeholder groups meetings recommended focusing on positive social-emotional skills.

Summary: Focus for Improvement

Through broad data analysis and substantial stakeholder input, consensus was reached to focus on SS1 for Outcome 3(a): infants and toddlers who substantially increase their rate of growth in positive social-emotional skills, including social relationships. The broad data analysis included comparison of Washington SS1 and SS2 data to both national data and data from states with similar eligibility. It included analyzing the data disaggregated by a number of variables, including age at entry, length of time in service, and race and ethnicity.

Root Cause Analysis

After the broad focus area of social-emotional skills was identified as ESIT's focus for improvement, a root cause analysis process was initiated. A root cause analysis strategy was to engage in an interview process with a number of local programs. Through a series of planning calls with TA consultants (6/20, 7/18, and 9/2), SSIP Leadership Team meetings (7/21, 8/4, 8/13, and 9/3), ESIT staff workgroup meetings, and SSIP Leadership Team email correspondence, root cause hypotheses and interview questions were developed for the purpose of probing the hypotheses and confirming if the hypotheses were accurate.

The following root cause hypotheses were identified:

1. If a more sensitive/adequate and culturally appropriate assessment tool is utilized, then initial entry Child Outcomes Summary (COS) ratings for social-emotional outcomes will be more accurate and more functional social-emotional individual child outcomes will be identified.
2. If there are more consistent services related to social-emotional development in all geographic areas of the state, then exit COS ratings will improve.
3. If early intervention (EI) providers understand their own roles and responsibilities around improving social-emotional development, and understand the roles and responsibilities of other professionals (e.g., infant mental health clinicians), then providers will be able to deliver appropriate services and develop collaborative partnerships.
4. If the team had more contact with the family prior to completing the entry COS rating, the entry rating for social-emotional outcomes would be more accurate.
5. If a set of more culturally appropriate/sensitive/qualitative/functional family interview questions are used as families enter program, then social-emotional outcome entry ratings will be more accurate.
6. If EI providers receive more training on appropriate social-emotional development, then their entry and exit COS ratings will be more accurate.
7. If EI providers receive more training on appropriate social-emotional development, (that includes understanding levels of need, writing functional outcomes, and evidence-based interventions in natural environments,) then individual child outcomes will be achieved and the COS ratings for social-emotional outcomes at exit will be higher.
8. If EI providers received more training on appropriate social-emotional development and interventions, then providers will feel more confident and competent in their ability to deliver services to improve social-emotional development.
9. If all children and families receive appropriate, high quality support around social-emotional development, then exit COS ratings will improve.
10. If EI providers have the knowledge and skills to effectively support children with high social-emotional needs, then individual child outcomes will be achieved and the exit COS ratings will improve.
11. If infants, toddlers and families of color receive culturally competent services related to social-emotional development, then individual child outcomes will be achieved and higher social-emotional outcome ratings at exit will result.

12. If EI providers receive more training on the Washington COS process and ratings, then outcome ratings at entry and exit will be consistent and accurate.

The Local Contributing Factors Tool, developed by the ECTA Center, was used as a starting point to develop interview questions. The questions were divided into four categories: (1) assessment/tools, (2) services, (3) teaming, and (4) training (see Attachment E- Interview Questions).

To identify the local programs to be interviewed, ESIT staff reviewed SS1 data disaggregated by local program. ESIT staff identified programs with SS1 data that were considered "extreme" -- either low or high. This outlying data warranted further analysis to better understand it and make inferences. In addition, staff wanted to include programs with data closer to mid-range, Washington's largest programs, and programs from the east and west sides of the state.

The programs agreeing to participate in the interview process were located in the following geographic/county areas: Adams, Garfield/Whitman, Island, King, Pierce, Snohomish, Thurston/Mason/Grays Harbor, and Yakima.

Program Interviews

During the first two weeks of October 2014, ESIT staff completed local team interviews. King County (the largest county) participated by SurveyMonkey so that each service-providing agency would have the opportunity to provide input. The remaining programs were interviewed via phone conference, video conference, or in person. Each interview included a local team represented by, at minimum, an FRC, a service provider, and a supervisor.

The ESIT team analyzed the root cause data gathered from the interviews to look for trends. No clear trends emerged between the interview responses and the size of the local area or their COS ratings. A potential variable that did emerge was access to an Infant Mental Health (IMH) Specialist. The areas that either provide or partner with an IMH Specialist 1) used a more sensitive assessment tool, 2) consistently used Informed Clinical Opinion when needed to establish eligibility in the social-emotional domain, 3) consistently wrote functional social-emotional outcomes, 4) identified a variety of evidence-based practices used, and 5) provided a variety of high-level services for children with social-emotional concerns.

Another theme that emerged throughout the interviews was the need for more training in the following important areas: the COS rating process, typical social-emotional development, writing functional outcomes specific to social-emotional development, and evidence-based interventions that address social-emotional concerns.

SSIP Leadership Team Meeting – October 20, 2014. During this meeting, ESIT staff reported the interview results. A Leadership Team member suggested developing a survey to send to providers throughout the state, to determine if the trends found in the interviews were reflected statewide. ESIT staff developed a survey and sent it out statewide for providers to complete. The survey was sent to a list of 87 ESIT stakeholders, and LLAs were asked to forward it to their service providers. The survey was intended to confirm the themes that emerged from the interview results (see Attachment F- Root Cause Survey).

Stakeholder Group Meetings - November 4 (Ellensburg) and 12 (Everett), 2014. Approximately 30 stakeholders attended these meeting. They included LLA administrators, FRCs, early intervention service providers, and interested community members. ESIT staff facilitated a small group activity during which participants, as a group, discussed the survey described in the previous paragraph. Each participant then completed an individual hard copy survey – if they had not completed the online survey.

SSIP Leadership Team Meeting – November 24, 2014. Survey results were reviewed. Eighty-three providers from across the state completed the survey either online or during the meeting. Respondents were asked to rank the importance of elements that contribute to improvement in children's social-emotional development. Active and engaged family involvement throughout the child's participation in a program was ranked the highest, followed by IFSP team (FRC, Educator, Speech-Language Pathologist, Occupational Therapist, Physical Therapist) knowledge of social-emotional development, and early intervention services. Items ranked lower were use of evidence-based practices, culturally competent providers and services, and consultation from IMH Specialists.

The Leadership Team discussed these results. A member from the eastern part of the state, which is more rural, indicated that although access to IMH Specialists is important, it is difficult or non-existent in that part of the state, which likely explains the low rating. The Leadership Team also discussed that a definition was not included for evidence-based practices. Even though it did not emerge from the survey results, the Leadership

Team continued to hypothesize that with more training that emphasized evidence-based practices, the importance of using them would emerge.

Of the survey respondents, 62.20% indicated they have access to an IMH Specialist consultant and 57.50% indicated they have access to an IMH Specialist to provide direct services to children and families.

Summary: Root Causes Identified

Through a root cause analysis process that included gathering information from local program interviews and a statewide provider survey, as well as discussions with the Leadership Team, the following root causes were identified:

- Inconsistent use of sensitive assessment tools to identify social-emotional concerns
- Inconsistent understanding of the COS rating process
- Increased need for parent involvement during assessment and the COS rating process
- Limited writing of functional Individualized Family Service Plan (IFSP) outcomes for social-emotional concerns
- Inconsistent team knowledge of typical social-emotional development
- Insufficient knowledge and use of evidence-based practices to address social-emotional concerns
- Need for culturally competent staff and culturally relevant services
- Inconsistent availability of intensive social-emotional services
- Inconsistent availability of IMH Specialists and services

1(b) How Data were Disaggregated

As described in Component 1(a), child outcomes data were disaggregated across multiple variables including service area, entry and exit ratings, age at entry, race and ethnicity, gender, and disability category.

The following key data were discussed and resulted in the analysis provided below:

- Data - Washington data for SS1 and SS2 for the three child outcomes. Washington data were compared to the national data and data for states with similar eligibility criteria.

  Analysis - Washington data are lower in SS1 for all three outcomes. Washington data are similar in SS2 in all three outcomes. This data led the Leadership Team to focus on SS1.

- Data - SS1 data disaggregated by service area for the three child outcomes.

  Analysis - Low and high outlying data indicated that further analysis was needed to better understand the data. Local programs with both low and high outlying data were selected for the root cause analysis interviews.

- Data - Percent of children rated at or above age expectations at entry, by age of entry (entry at less than one year of age, between one and two years, and between two and three years) and child outcome.

  Analysis -

  Outcome 3(a) – Social-emotional skills: 55% of children less than age one; 45% between ages one and two; and 36% of children between ages two and three.

  Outcome 3(b) - Knowledge and skills: 43% of children less than age one; 34% between ages one and two; and 28% of children between ages two and three.

  Outcome 3(c) - Actions to meet needs: 21% of children less than age one; 32% between ages one and two; and 35% of children between ages two and three.

- Data - Percent of children that entered at or above age expectations and exited below age expectations.

  Analysis -

  Outcome 3(a) – Social-emotional skills: 10%

  Outcome 3(b) – Knowledge and skills: 7%

Outcome 3(c) – Actions to meet needs: 5%

- Data - SS1 (greater than expected growth) disaggregated by age at entry and child outcome

  Analysis -

  Outcome 3(a) – Social-emotional skills: 48% of children less than age one; 61% between ages one and two; and 60% of children between ages two and three demonstrated greater than expected growth.

  Outcome 3(b) – Knowledge and skills: 55% of children less than age one; 64% between ages one and two; and 65% of children between ages two and three demonstrated greater than expected growth.

  Outcome 3(c) – Actions to meet needs: 67% of children less than age one; 68% between ages one and two; and 61% of children between ages two and three demonstrated greater than expected growth.

- Data - SS1 (greater than expected growth) disaggregated by race and ethnicity and child outcome

  Analysis:

  Outcome 3(a) - Social-emotional skills: Children who were identified as Black or African American had the lowest percentage (45%)

  Outcome 3(b) – Knowledge and skills: Children who were identified as Native Hawaiian or other Pacific Islander had the lowest percentage (43%).

  Outcome 3(c) – Actions to meet needs: Children who were identified as Native Hawaiian or other Pacific Islander had the lowest percentage (42%)

- Data - SS1 disaggregated by gender and child outcomes

  Analysis - Minimal differences were identified.

- Data - SS1 disaggregated by primary language and child outcomes

Analysis - Minimal differences were identified.

- Data - SS1 disaggregated by disability category and child outcomes

  The Leadership Team raised concerns about data quality with this variable, as described in Component 1(c). Only disability categories with more than 30 children were included in the analysis.

  Analysis -

  Outcome 3(a) – Social-emotional skills: Children diagnosed with hearing loss and Down syndrome had the lowest percentage represented.

  Outcome 3(b) – Knowledge and skills: Children diagnosed with Autism and Down syndrome had the lowest percentage represented.

  Outcome 3(c) – Actions to meet needs: Children diagnosed with Autism and Down syndrome had the lowest percentage represented.

- Data - SS1 disaggregated by length of time in service (0.5-1 year, 1-1.5, 1.5-2, 2-2.5, and 2.5-3 years) and child outcome.

  Analysis -

  Outcome 3(a) – Social-emotional: Data increased slightly for children in services 1-1.5 years, and then demonstrated a decrease in each remaining time period.

  Outcome 3(b) – Knowledge and skills: Data remained the same for children in services 0.5-1 year and 1-1.5 years, and then demonstrated a decrease in each remaining time period.

  Outcome 3(c) – Actions to meet needs: Data remained stable in each time period and then decreased for children in services 2.5-3 years.

In summary, the most influential finding of the disaggregated data analysis was the concerning pattern identified for children under the age of one who entered above age expectations and exited below age expectations in Outcome 3(a). For additional information about the findings of the disaggregation analysis see Component 1(a).

1(c) Data Quality

The Leadership Team discussed concerns about possible data quality issues. The primary data quality issue that emerged concerned the possible lack of consistency in the COS rating process statewide. In an effort to increase COS rating consistency, ESIT staff released six COS training modules in February 2015. These training modules were initially developed with American Recovery and Reinvestment Act (ARRA) funding and were recently updated and revised to improve the content and quality of the modules. The revision process was led by ECTA and DaSy Center technical experts. A roll-out webinar was held to introduce LLA staff and early intervention providers to the contents of the modules. ESIT staff will provide training including an all-day session at the statewide Infant and Early Childhood Conference, and follow-up with LLAs who requested TA on their self-assessment plans. In addition, ESIT will be improving its professional development system to ensure practitioners are implementing the practices related to the COS rating process with fidelity. For more information, see Component 4 (Improvement Strategies) and Component 5 (Theory of Action).

The Leadership Team also identified data quality concerns about the disability category. There was low confidence in this category because it was not a requirement in the DMS to update a child's diagnosis over time. Therefore, if a child had a diagnosis at referral to early intervention it would be indicated in the DMS, however, there was inconsistent data entry when a child acquired a new diagnosis after enrollment in services. To address this concern, ESIT is considering developing a new DMS business rule that will require diagnosis information to be reviewed and updated during the annual IFSP.

1(d) Compliance Data Considered

ESIT used multiple data sources to assist in maintaining a high level of compliance (95% or above) for all APR compliance indicators. The data sources include DMS compliance data, LLA Self-Assessment information, and fiscal data. By reviewing this data, ESIT ensures there are rules, processes and methods in place that support compliance and improve performance. More details about each of these are described in the paragraphs that follow. The Leadership Team considered this data as it began SSIP Component 1 – Data Analysis.

APR compliance data obtained from the DMS was considered. The DMS creates an electronic IFSP record that documents essential child and family information from initial

contacts through transition. All child and family information must be entered into the DMS if it is needed to develop an IFSP. Both results and compliance data are collected from the DMS. In addition, a methodology for identifying and correcting non-compliance has been developed – ensuring any individual instance of noncompliance is corrected in a timely manner. This methodology is currently being implemented appropriately.

LLA Self-Assessment data, obtained annually, were considered. The Self-Assessment tool and process is designed to gather data from each LLA and their service providing programs on state selected data not available through the DMS. The Self-Assessment process occurs through a review of children's records. These data are used to substantiate compliance with IDEA and related requirements associated with each APR indicator, and to encourage the use of evidence-based early intervention practices associated with improved results for children and families.

Fiscal data, obtained monthly, were considered. The contract budget approval and monthly review process ensures IDEA Part C fiscal requirements are met. Allowable costs/expenditures are identified and monitored monthly. Budget amendment and revision processes clearly identify and track contractor budget changes over time. The prohibition against commingling of funds and supplanting, and payor of last resort are fiscal contract requirements that are monitored monthly through the fiscal review process.

The fiscal review process is initiated each month when the LLA submits a billing invoice on a form provided by DEL. The LLA is also required to submit a contract summary report of expenditures that is aligned with their approved budget. In addition, a monthly expenditure detail report that contains more specific expenditure information is required. The ESIT Fiscal Program Manager reviews all LLA expenditure reports and reconciles them with their billing invoices. If there are any discrepancies, the Fiscal Program Manager provides needed follow up.

Summary: Compliance Data Considered

The information discussed in this component suggests that the supervision structures described are sufficient to maintain a high level of compliance. The lack of administrative complaints, requests for mediation, and requests for due process hearings, further supports the notion that these structures are sufficient, and that noncompliance should not be a barrier to the effective implementation of SSIP improvement activities.

1(e) Additional Data

The DMS is not only a data management system but is also a case management system. Program administrators and FRCs have access to a variety of case management tools and reports related to children receiving early intervention services. As discussed in other components, IFSP data are entered directly into the DMS, including COS outcome information. Because of the abundance of child level data available for analysis through the DMS, as more questions arise over time, more data queries can be made. At this point, no additional data need to be collected or analyzed.

1(f) Stakeholder Involvement in Data Analysis

Stakeholders were involved in the data analysis in a variety of ways. TA consultants and ESIT staff worked together to plan activities, assemble resources, summarize and analyze information gathered, and facilitate Leadership Team meetings. ESIT staff kept DEL administrators informed. The Leadership Team actively engaged in data analysis during meetings. Eight local teams participated in interviews to respond to hypothesis questions. The broad stakeholder groups at LLA meetings in May 2014 (approximately 65 stakeholders) and November 2014 (approximately 30 stakeholders) participated by providing input on the State Identified Measurable Result and completing surveys about trends in social-emotional services, respectively. Eighty-three providers across the state also completed surveys. SICC and FLIC members provided input during quarterly meetings.

Component 2:

Analysis of State Infrastructure to Support Improvement and Build Capacity

2(a) How Infrastructure Capacity was Analyzed

The systematic process used to analyze our infrastructure was a two-step process. Step one included a broad analysis of infrastructure strengths, weaknesses, opportunities and threats of each Office of Special Education Programs (OSEP) recommended system component, with information grouped into themes for each component. Components discussed were: governance, fiscal, quality standards, professional development, data, technical assistance and accountability/monitoring. Step two was an in-depth labeling process that identified issues as leveraging or hindering improvement in the State-Identified Measurable Result (SIMR) focus area of social-emotional development.

Four webinar meetings were held during April and May 2014 in which TA consultants and the Leadership Team planned two stakeholder workshops. On May 21 and May 28, 2014 stakeholder meetings were held in Bremerton and Spokane. Approximately 65 stakeholders participated in a facilitated Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis activity. During this activity, small groups had time to discuss each system component, ask questions and give input to Early Support for Infants and Toddlers (ESIT) staff. In addition, participants were asked for information on state and local initiatives that might relate to ESIT's SSIP work.

To consolidate the SWOT analysis data, the ESIT team compiled the results and grouped information to identify themes for each system component. In a call on July 21, 2014, the Leadership Team identified the SWOT elements that could directly or indirectly leverage or hinder improvement strategies related to social-emotional development. Some of the most promising leverages and concerning hindrances emerged from this call (see Attachment G- Consolidated SWOT Analysis).

At stakeholder meetings August 20, 2014 in Renton and August 26, 2014 in Richland, stakeholders were asked to review the consolidated SWOT analysis. In small groups, participants further identified the SWOT elements that could directly or indirectly leverage or hinder improvement strategies related to social-emotional development. A total of 50 stakeholders from the two meetings were included in this activity. The document referenced above includes feedback gathered from these stakeholder meetings as well.

The ESIT team compiled this information and shared the results during the Leadership Team meeting on September 3, 2014. The consolidated SWOT analysis was reviewed to

see if it raised any additional hypotheses to those developed in the data analysis, Component 1(a), regarding possible root causes for challenges in social-emotional development.

This analysis was used by the Leadership Team during a December 2, 2014 meeting to inform possible improvement strategies to increase progress in social-emotional development.

2(b) Description of State Systems

This component provides a description of Washington's systems that make up its infrastructure that includes, governance, fiscal, quality standards, professional development, data, technical assistance and accountability/monitoring.

Governance

Washington State's Part C program, ESIT, is housed within the Department of Early Learning (DEL). DEL provides a wide range of early childhood programs that support social-emotional development in young children, birth to age five. Some of these programs include home visiting (Strengthening Families Washington), state preschool (Early Childhood Education and Assistance Program), Head Start State Collaboration, Early Achievers Quality Rating Improvement System, and child care licensing. This governance structure promotes ongoing partnerships between the statewide programs providing services to young children and their families. As a result, ESIT's guiding principles are closely aligned with DEL's agency mission and cross-agency Early Learning Plan, which outlines Washington's ten-year strategic plan to achieve progress in 36 outcomes, including social-emotional development. DEL's Early Learning Plan can be found on the website at http://www.del.wa.gov/partnerships/elac/elp.aspx. Early Learning Plan strategies 16, 25 and 26 are directly related to improvements in social-emotional development while strategies 4, 5, 6, 8, 9, 18, 27 and 28 indirectly support social-emotional development.

ESIT operates under federally approved Policies and Procedures and is currently developing administrative regulations (Washington Administrative Code) to formalize the governance structure and requirements for early intervention services.

Local Lead Agencies (LLAs) are responsible for facilitating and coordinating their local system of early intervention services. The types of organizations that contract with ESIT included:

- 3 County health departments;
- 4 County human service agencies;
- 1 Combined health and human service agency;
- 15 Nonprofit agencies; and
- 5 Educational service districts.

LLAs are responsible for meeting all requirements related to the contract general terms and conditions, early intervention services statement of work, deliverables schedule and approved budget. Through this structure, LLAs are given the authority to assist in the supervision and monitoring of the local system, provide training and technical assistance, and support and give direction to local improvement activities.

Additionally, each LLA develops and maintains subcontracts or local interagency agreements with individual early intervention providers or providing organizations within their geographic service area. They develop and maintain county plans that identify the local system of services and funding sources that are available to support direct service provision which includes implementing the ESIT System of Payments and Fees (SOPAF) policy. Contract requirements change over time to conform to new or changing federal and/or state requirements.

Fiscal

Funding for Washington's system of early intervention services is decentralized, primarily community-based, and comprised of hundreds of local service providers and numerous coordinating agencies. Early intervention services are funded from a variety of sources, and delivered through different administrative structures and local service delivery approaches. Washington's SOPAF policy clearly identifies and differentiates the services that must be provided at public expense from those services subject to family cost participation.

DEL/ESIT, the state's Part C lead agency, uses federal funds to ensure families have access to their local early intervention system. Eligible infants, toddlers and families receive the vital services that must be provided at public expense. These services include

1) implementing child find, 2) evaluation and assessment to determine eligibility, 3) service coordination, 4) administrative functions related to the development and review of the IFSP, and 5) implementing Procedural Safeguards.

ESIT contracts out the majority of the federal IDEA, Part C funds it receives to 28 LLAs statewide. LLAs must ensure all families have access to the services that must be provided at public expense and receive services as identified on the IFSP.

While access and coordination services are funded primarily with federal IDEA, Part C funds administered by ESIT, direct early intervention services are funded through state, local and private sources administered by other state agencies or programs. These funding sources include public insurance/Medicaid (Washington's Apple Health) administered through Washington's Health Care Authority (HCA), private insurance, county funds administered through Developmental Disabilities Administration (DDA) divisions, and state special education funds administered through local school districts. In some communities, private fundraising may generate additional financial support for local early intervention programs and services.

Quality Standards

ESIT uses guidance such as the IFSP Process and Resource Guide, the Procedural Safeguards Technical Assistance Guide, and various practice guides to set quality standards for all early intervention providers. In addition, ESIT follows the DEC Recommended Practices to assist in setting standards for service provision. Washington's Early Learning and Development Guidelines (http://www.del.wa.gov/publications/development/docs/guidelines.pdf) also serve to help parents, caregivers, child care and early intervention professions work together to help children develop and learn.

Professional Development

LLAs assure ESIT, through contracts, that all Part C providers including FRCs are qualified personnel. ESIT's guidance on minimum education and state licensure/certification/registration is posted on the website, which can be found at http://www.del.wa.gov/publications/esit/docs/qualified_personnel.pdf. The Office of the Superintendent for Public Instruction (OSPI) and Department of Health (DOH) license

or certify most providers in Washington. ESIT provides a statewide registration system, through contract, for FRCs which includes yearly training requirements.

ESIT offers three Basic Part C on-line training modules, quarterly Professional Learning Community (PLC) meetings, training on teaming issues, and quarterly topical trainings and webinars that are available to Part C agencies and providers statewide. One PLC meeting each year focuses on gathering information for the Summary of Functional Performance and the COS rating process. A series of modules on the COS process, developed in collaboration with the Early Childhood Technical Assistance (ECTA) Center and the Center for IDEA Early Childhood Data Systems (DaSy), were released in February 2015.

Two curricula, developed by and for parents, explaining Part C and Transition are on the website. These and printed materials explain and encourage family involvement in the COS process. ESIT Program Consultants assist LLAs and providers in pulling together state and national resources for local training needs and will assist in tailoring resources to help communities improve social-emotional development. ESIT is also a major sponsor and planner for the annual statewide Infant and Early Childhood Conference. A variety of Part C and early childhood topics are presented by state and national experts and a full day training on the new COS training modules will be presented.

In addition, ESIT has created thirteen guidance documents for service providers and FRCs, which are available on the ESIT website at http://www.del.wa.gov/development/esit/training.aspx. These practice guides are on the following topics: screening, evaluation and assessment, informed clinical opinion, natural environments, IFSP, summary of functional performance, functional outcomes, IFSP reviews, ongoing eligibility, qualified personnel guidelines, autism guidelines, using curriculum-based assessments and identifying the parent. These topics all influence the identification and service provision for infants and toddlers with delays in the area of social-emotional development.

Data

Through the DMS, child level data can be gathered from the records of all infants and toddlers determined eligible for early intervention services. All required data entered into the DMS is used to develop the IFSP including child/family demographic information.

Initial evaluation information, medical information, eligibility, COS data including a Summary of Functional Performance, the family statement, and individual child/family outcomes and services information are all required before an IFSP can be generated from the DMS.

All APR indicator and 618 data is retrieved from the DMS with the only exception being Family Outcome data (Indicator 4). Family surveys are submitted directly by families or LLAs, entered manually by ESIT staff and calculated through SurveyMonkey.

COS data must be entered into the DMS for all infants and toddlers prior to exiting if they have had six months of consecutive services throughout the year.

Technical Assistance

ESIT employs Program Consultants that serve as technical assistance liaisons to LLAs. In this capacity, Program Consultants provide timely consultation and support services. This occurs through email, phone calls and on-site visits depending on the needs of the LLA and their service providers. Quarterly LLA meetings occur in eastern and western Washington. Updates on implementing evidence-based practices, discussion and resource sharing occur at these meetings. Quarterly LLA meetings will be one of the main venues for providing training on social-emotional improvement strategies.

LLAs assure the State Lead Agency, DEL/ESIT, through contracts, that Part C agencies and service providers are appropriately supervised. ESIT provides a variety of written guidance, webinar recordings, and state and national resources on the website that can be used as the basis for topical technical assistance. These mechanisms will be used to guide implementation of improvements in social-emotional development.

Accountability and Monitoring

ESIT continues to direct its General Supervision and Monitoring System efforts to do the following:

- align and integrate activities with the State Performance Plan(SPP)/Annual Performance Report (APR);
- focus on compliance and quality practices, especially those most closely aligned with improved results for children and families; and

- direct state technical assistance resources to LLAs as needs are identified.

Data and the Identification and Correction of Noncompliance

All SPP/APR indicator and 618 data, with the exception of Indicator 4 - Family Outcomes, is gathered from the DMS. Child level data are gathered from all IFSPs entered into the system and used for SPP/APR reporting.

Annual Performance Report (APR) Indicators 2, 5, and 6 results data are obtained from all IFSPs on December 1 of each Federal Fiscal Year (FFY). Indicator 3 data are gathered throughout the FFY. Indicator 4 data are not collected through the DMS, but are gathered from hard copy surveys completed by families and submitted to ESIT throughout the year.

APR Indicators 1, 7, 8, 8A, 8B, and 8C compliance data are obtained from all IFSPs over a three (3) month period. In addition, review and annual IFSP data are collected for APR and 618 data reporting.

State staff review and analyze compliance data to assess the "reasons" for any noncompliance. When necessary, ESIT staff request and obtain clarification regarding reasons for the noncompliance to determine the root cause. If late services were due to exceptional family circumstances, findings of noncompliance are not made. If late services are due to reasons other than exceptional family circumstance, child specific noncompliance is identified and findings made. If it is determined the noncompliance is already corrected, a finding is still made, but a corrective action plan is not required. Even though correction occurs (the service provided though late), state staff still assess the level of noncompliance, identify the contributing factors, if any, and determine if the noncompliance is isolated or systemic.

Within three months from when compliance monitoring data are taken from the DMS, LLAs receive written notification. They are either provided written notice of findings of noncompliance and the need to make timely correction, or written notice of findings of noncompliance and that correction has already been verified. When required, each LLA administrator is directed to begin implementing required improvement activities to ensure correction is made, as soon as possible, but no later than one year from notification. When assigned, Corrective Action Plans (CAPs) identify the resources that need to be accessed and the timelines that need to be followed in order to achieve

compliance and/or improve performance. CAPs are required of all LLAs that do not fully correct identified noncompliance by the time annual determinations are issued.

Annual Determination Process

ESIT makes an annual determination of LLA efforts in implementing the requirements and purposes of IDEA, Part C. Each LLA's Annual Performance Report (APR) and 618 data are aggregated for annual reporting purposes. These aggregated data are used by OSEP to make ESIT's annual determination. ESIT disaggregates and evaluates these data to make LLA annual determinations based on the criteria established in the federal regulations. The enforcement actions and sanctions applied to ESIT are also applied to LLAs.

Dispute Resolution Options

The timely administrative resolution of complaints occurs through the implementation of mediation, complaint, and due process hearing procedures. Monitoring the use of these disputes resolutions options assists ESIT in identifying noncompliance and other system issues. By following each procedure's required steps and timeliness, the resolution of any dispute will occur in a timely manner. Families are made aware of their dispute resolution options throughout their participation in the early intervention program. Parent identified issues are typically resolved through informal procedures rather than utilizing the formal dispute resolution options that are available to them.

ESIT has a system in place to track and monitor mediation, complaint and due process dispute resolution activity.

Annual Local Team Self-Assessment Process

Each LLA Self-Assessment team (comprised of early intervention providers, FRCs, and administrators) are required to complete the Self-Assessment annually through a review of children's records. The Self-Assessment tool and process is designed to gather data from each LLA and their LLA providing programs on state selected data that are not available through the DMS. These data are used to substantiate compliance with Part C and related requirements associated with each SPP/APR indicator, and to encourage the use of the evidence-based early intervention practices that are associated with improved results for children and families.

On-site Targeted Technical Assistance

Targeted technical assistance (TA) is provided to individual LLAs or on a statewide basis as needs are identified. Monitoring, complaints, mediation, and due process data are used to identify and provide TA. On-site targeted TA is provided more frequently when ESIT or an LLA has identified an issue or set of issues that require focused attention. The TA visit includes the exploration of factors that may be contributing to the presenting performance or system concern/issue. Information, resources, and supports are provided based on the contributing factors or identified concerns and issues.

2(c) Systems Strengths and Areas for Improvement

The consolidated SWOT analysis included ideas that stakeholders felt would directly or indirectly leverage or hinder improvement in relationship to the SIMR, social-emotional development. The direct leverages and hindrances are discussed here as the main strengths and areas for improvement that were identified.

Governance

Strengths

Collaboration in delivering early intervention services, including social-emotional supports, is supported in most communities by strong local interagency agreements. ESIT's guiding principles are closely aligned with DEL's agency mission and Early Learning Plan, which outlines administrative support for initiatives such as improvements in social-emotional development.

Areas for Improvement

There were many concerns in this area. Washington's early intervention system is a decentralized system and therefore the state's early intervention governance structure is decentralized as well. ESIT has the responsibility for administering and supervising the statewide system but does not control the state funding for early intervention services. The federal funding ESIT receives was cited as inadequate, especially if it is to support additional training. There were also related concerns about variation and understanding of the COS process due to different governing structures in early intervention.

Fiscal

Strengths

The primary source of funding for direct early intervention services is state special education funding. This funding is apportioned every year and increases with the eligible population. This can be used for needed services to help improve social-emotional development. The eligibility criteria for ESIT and DDA has been aligned so that more children in need of social-emotional supports should be identified. Some counties have allocated some of their DDA funding to early intervention services, including social-emotional supports. Support for children with autism has increased recently with new benefits for Medicaid eligible children. An increasing number of early intervention programs can bill for social-emotional services through public and private insurance. There is state level policy work occurring to support additional state funding and state insurance plan reform to assist in supporting needed early intervention services including social-emotional supports.

Areas for Improvement

Many concerns for improvement were cited. Sources of public funding are inconsistent. For example, DDA funding is not available in every county. The amount of state special education funding varies when school districts contract for early intervention services. In addition, this primary state funding source for early intervention services is not administered by ESIT. The ability to bill insurance varies depending on the provider. Insurance rates and services covered vary depending on the area of the state and the type of insurance. It was noted that federal funding has not kept pace with program growth. In addition, providers are implementing the new System of Payment and Fees policy which has caused some concern about implementing parent fees.

Quality Standards

Strengths

The quality of service provision in natural environments has improved over time. Increasing knowledge, awareness and acceptance of evidence-based practices has supported increased service provision in natural environments. Support for early intervention approaches that include parent coaching and mentoring continues to

increase. Providers utilize multi-disciplinary teams to evaluate, assess, and deliver early intervention services.

Areas for Improvement

Due to lack of governance over developing quality standards in early intervention, concerns discussed were inconsistency in service delivery. Also, lack of infant mental health providers, lack of culturally competent staff and the use of evidence-based practices are hindrances to improving social-emotional outcomes.

Professional Development

Strengths

Early intervention providers have a basic understanding of typical development essential to completing COS ratings.

Areas for Improvement

More availability and depth of training was identified as a need in the following areas: social-emotional development, infant mental health, reflective supervision, cultural competency, and the COS process.

Data

Strengths

The DMS is a comprehensive database containing all children's records and providing real time information on progress toward improved social-emotional development at a variety of levels. Each child's record contains information about the level of family participation in the COS rating process.

Areas for Improvement

Stakeholders identified the need to improve information sharing with families about the integrated COS process that includes incorporating family input, and more training and technical assistance about the COS process.

Technical Assistance

Strengths

Neither strengths nor opportunities emerged from the consolidated SWOT analysis regarding technical assistance as it relates to social-emotional development.

Areas for Improvement

There were concerns about accuracy and consistency of COS ratings due to inconsistent technical assistance.

Accountability/Monitoring

Strengths

The DMS gives staff the ability to monitor progress toward improved social-emotional development for different sub-groups on program, county and state levels at any interval desired. Reports on COS rating progress are also immediately available on all these levels. There is immediate technical assistance available from program, county and state levels to staff in improving progress toward social-emotional development. Written practice guides provide a focal point for gathering and using data to inform the COS rating and write more functional outcomes. The contract required self-assessment tool is completed by program level teams each year and provides a vehicle for examining practices and planning improvement.

Areas for Improvement

Hindrances to improvement in social-emotional development included limitations of the tools used to assess social-emotional development, and possible data quality issues concerning the lack of consistency in the COS rating process statewide.

2(d) State-level Improvement Plans and Initiatives

During the infrastructure analysis, stakeholders identified existing state and local initiatives that could support SSIP efforts. They included:

- Home visiting
    - Parents as Teachers
    - Nurse Family Partnerships
    - Parent-Child Home Program
- Early Head Start
- Infant Mental Health Endorsement through Washington Association for Infant Mental Health, launched February 2015
- Promoting First Relationships
- Circle of Security
- Children Encouraged by Relationships in Secure Homes (CHERISH) program in King and Pierce Counties
- Adverse Childhood Experiences (ACES) work in local communities
- Parent 2 Parent
- Autism Centers of Excellence
- Early Learning Coalitions

Washington has been awarded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) expansion and competitive grants to support and expand evidence-based home visiting services. In addition, Washington has a unique public-private partnership between DEL and THRIVE Washington, to manage the Home Visiting Services Account (HVSA). Through this collaboration evidence-based home visiting models are being implemented. Since ESIT and home visiting reside in the same division of DEL, there will be increased professional development opportunities by sharing resources between programs.

DEL is developing a home visiting plan that will include the broader early learning community, including early intervention providers. Through this work, there may be opportunities for the sharing of training resources and collaboration.

In February 2015, the Washington Association for Infant Mental Health (WA-AIMH), launched the nationally recognized system of endorsement developed by the Michigan Association for Infant Mental Health. This will provide new opportunities for early intervention providers at all levels to become endorsed as professionals in the infant mental health field. The range of endorsement levels will be from infant mental health informed to infant mental specialists to infant mental health experts.

2(e) Representatives Involved

Stakeholders involved in developing SSIP thus far include:

- DEL administration
- ESIT staff, including administration, program, data, parent participation and support staff
- Leadership Team, including representatives of county human services, service providers, school districts, LLA and program administrators, FRCs, and parents
- LLA administrators, FRCs, school district staff and administrators, service providers, and agency administrators
- SICC participants including representatives of state government, state agencies such as Department of Health (DOH), Department of Social and Health Services (DSHS), Office of Superintendent for Public Instruction (OSPI), higher education and family members

The Leadership Team identified additional stakeholders to invite to participate in Phase II. They were invited based on their expertise in social-emotional development. Leadership Team members recommended individuals who are either Infant Mental Health specialists or consultants. Individuals who will participate in Phase II include representatives from:

- UW Readi Lab (Research in Early Autism Detection and Intervention)
- Parent groups
- Island County, CICC
- Kitsap County, Holly Ridge Center
- Snohomish County, ChildStrive
- Infant Mental Health practitioners
- University of Washington faculty
- Birth to Three Developmental Center
- Kindering, CHERISH project
- DOH Early Childhood Comprehensive Systems
- UW Medical Home Partnerships
- DEL Home Visiting Manager
- DOH ACES Coordinator
- Autism Outreach Project staff

2(f) Stakeholder Involvement in Infrastructure Analysis

Stakeholders were involved in the infrastructure analysis in a variety of ways. ESIT staff kept DEL administrators informed. The Leadership Team actively engaged in infrastructure analysis during meetings. During LLA meetings in May 2014, approximately 65 stakeholders participated in an initial SWOT infrastructure analysis and identified state and local initiatives that could support SSIP efforts. At LLA meetings in August 2014, approximately 57 stakeholders participated in an in-depth infrastructure analysis. These stakeholders identified the strengths, weaknesses, opportunities, and threats that could directly or indirectly leverage or hinder improvement strategies related to social-emotional development. SICC and FLIC members provided input during quarterly meetings and identified additional state and local initiatives.

Component 3:

State Identified Measurable Result (SIMR)

3(a) SIMR Statement:

As a result of data and infrastructure analyses and in-depth discussion that has occurred over the past year with the SSIP Leadership Team and stakeholder groups, the DEL/ESIT SIMR is:

Increase the percentage of infants and toddlers with disabilities in Washington State who will substantially increase their rate of growth in positive social-emotional skills (including social relationships) by the time they exit the early intervention program. These children will move closer to functioning to that of same-aged peers as reflected in Summary Statement 1.

The SIMR is directly aligned to Indicator 3, child outcomes data. The targets set for Indicator 3 will be used for Indicator 11 and to evaluate progress on the SIMR.

3(b) Data and Infrastructure Analysis Substantiating the SIMR:

Multiple data sources were used to identify and construct the SIMR. These include: numerous COS data reports from the ESIT DMS, two-hour interviews with eight local lead agencies regarding local implementation of the COS process, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) data from Department of Health illustrating statewide areas of risk, and multiple meetings with the SSIP Leadership Team and broad stakeholder groups.

Through broad data analysis and substantial stakeholder input, consensus was reached to focus on SS1 for Outcome 3(a): infants and toddlers who substantially increase their rate of growth in positive social-emotional skills, including social relationships. The broad data analysis included comparison of Washington SS1 and SS2 data to both national data and data from states with similar eligibility. It also included analyzing the data disaggregated by a number of variables, including age at entry, length of time in service, and race and ethnicity. See Component 1 for a detailed description of data analysis.

State infrastructure analysis was also used to identify the SIMR. Infrastructure analysis activities included: SWOT analysis with LLAs and identification of potential leverages and hindrances related to social-emotional development with the Leadership Team and stakeholders.

Stakeholders generated a list of current state and local initiatives related to social-emotional development. The Leadership Team reviewed the initiatives to analyze which activities have a similar focus and could be opportunities for collaboration.

The process used to identify and develop the SIMR solicited input from a variety of stakeholder groups, including: ESIT staff, the SSIP Leadership Team, LLAs, early intervention service providers, State Interagency Coordinating Council (SICC) and other state agency representatives.

3(c) SIMR as Child-Family Level Outcome

By utilizing Summary Statement 1 (SS1) of SPP/APR Indicator 3(a), positive social-emotional skills (including social relationships), the progress achieved in the SIMR will be a direct result of the developmental gains made by individual children. The focus of implementation in Washington will include the entire state rather than a subset of local programs.

3(d) Stakeholder involvement in Selecting SIMR

Stakeholders were involved in selecting the SIMR in a variety of ways. ESIT staff kept DEL administrators informed. The Leadership Team actively engaged in broad and in-depth data analyses and discussion about the SIMR during meetings and reached consensus to focus on Outcome 3(a). The broad stakeholder groups in May 2014 (approximately 65 stakeholders) reviewed options for the SIMR. The majority of participants from both stakeholder group meetings recommended focusing on Outcome 3(a), social-emotional skills. SICC and FLIC members provided input during quarterly meetings.

3(e) Description of Measure/Baseline Data and Targets

The method used to collect data for this indicator is the COS process. All infants and toddlers who have had an entry COS, and who have received at least six months of consecutive service will also have an exit COS completed. Entry COS data must be collected prior to completion of the initial IFSP. The exit COS data must be collected prior to the child's exit from early intervention. Rigorous DMS business rules enforce both of these requirements. The IFSP and the COS rating processes are integrated. The DMS is programmed to gather and aggregate child outcome data and summary statement data. Four thousand five hundred sixty eight COS ratings were completed for FFY 2013.

The number of COS ratings will continue to increase as the population of eligible infants and toddler increase. The baseline data and targets identified below are the same data and targets set for Indicator 3(a). As the SIMR will be statewide, baseline data and targets will be consistent with APR Indicator 3(a) SS1 data (see below)

Baseline Data

FFY	2013
Data	65.11%

FFY 2014 – FFY 2018 Targets

FFY	2014	2015	2016	2017	2018
Target	65.11%	65.11%	65.75%	66.25%	67.25%

Stakeholder meetings were convened to discuss APR baseline data and target setting for Indicator 3(a). Stakeholder meetings occurred on November 4, 2014 in Ellensburg and November 12, 2014 in Everett. A broad range of stakeholders participated in these meetings, including early intervention service providers, agency administrators, LLA and school district staff. The groups reviewed Indicator 3(a) SS1 and SS2, both historical and current data. Based on the review, stakeholders were invited to recommend a new baseline and assist with target setting for the next six years.

An overview of Indicator 3(a) and the parameters of target setting were presented. Participants met in small groups and reviewed data that reflected state trends over time. After much discussion and analysis, small group participants generated individual recommendations for a new baseline and annual targets for Indicator 3(a) SS1 and SS2. ESIT staff facilitated the discussion and answered questions as they emerged.

ESIT staff compiled the mean, median, and mode of stakeholder recommendations regarding Indicator 3(a) SS1 and SS2. Based on this data and with further discussion, a new baseline and targets were proposed. All stakeholder input was consolidated and presented to the SICC at the special APR review meeting that was convened on January 21, 2015 in Burien. The SICC reviewed, discussed, and gave feedback about the new baseline and targets set for this indicator. ESIT used all of the stakeholder input it received to establish the baseline and targets for this indicator. Because of the substantial volume of COS data that was available for analysis, stakeholders and ESIT staff were able to use data to assist in establishing a new baseline and setting targets for the next six years.

Component 4:

Selection of Coherent Improvement Strategies

4(a) How Improvement Strategies were Selected

A broad and in-depth data analysis occurred from April through November 2014. The following root causes for Washington's low Summary Statement 1 (SS1) data in child outcome 3(a), social-emotional skills and social relationships, were identified:

- Inconsistent use of sensitive assessment tools to identify social-emotional concerns
- Inconsistent understanding of the COS rating process
- Increased need for parent involvement during assessment and the COS rating process
- Limited writing of functional Individualized Family Service Plan (IFSP) outcomes for social-emotional concerns
- Inconsistent team knowledge of typical social-emotional development
- Insufficient knowledge and use of evidence-based practices to address social-emotional concerns
- Need for culturally competent staff and culturally relevant services
- Inconsistent availability of intensive social-emotional services
- Inconsistent availability of Infant Mental Health Specialists and services

During a Leadership Team call on December 2, 2014, a number of initial improvement strategies were developed. To begin the discussion, the group used the SPP/APR Improvement Strategies from FFY12 and identified strategies that were either directly or indirectly related to social-emotional development. The team continued to brainstorm additional strategies based on the trends from the root cause analysis and used the infrastructure analysis to align each strategy to its corresponding infrastructure component. ESIT staff subsequently added to the list of improvement strategies by incorporating DEC recommended practices.

Through phone calls with TA consultants on December 8 and 9, 2014, the 28 specific improvement strategies were organized under the following categories:

- Assessment
- Resource Leveraging
- Professional Development System
    - Training/Guidance Materials
    - Qualified Personnel

- Technical Assistance
- Accountability System Revisions
- Training/Professional Development Implementation
- Provider/Practitioner Knowledge and Skills
- Evaluation and Program Improvement

The next step was to prioritize the improvement strategies. A survey (see Attachment H-Improvement Strategies Survey) was sent to Leadership Team members to gather input on 1) the likelihood that each improvement strategy would be achieved, and 2) the likelihood that each strategy would have a positive impact on children's social-emotional development. Nine of the twelve Leadership Team members completed the survey. Half of the survey respondents indicated that two of the improvement strategies were highly likely to be implemented and highly likely to have an impact on children's social-emotional development. These strategies included: 1) the identification of assessment tools specific for social-emotional development, and 2) training on social-emotional assessment tools with follow-up support. Half of the survey respondents indicated that two of the improvement strategies were highly likely to have an impact on children's social-emotional development. These strategies included 1) collaboration with Early Head Start and home visiting programs to increase access to social-emotional resources, and 2) the ability to access Infant Mental Health experts for consultation or services.

Through a series of three phone calls with TA consultants in January 2015, ESIT staff learned that the initial improvement strategies identified were too specific. They were more reflective of the activities or steps needed to implement improvement strategies. Therefore, ESIT staff revised the strategies to reflect a broader perspective. The following broad improvement strategies were developed from the more specific strategies that were initially generated:

1. **Professional Development**
   Enhance the statewide system of professional development to support the creation of high-quality, functional IFSP outcomes and strategies related to social-emotional skills and social relationships, and implementation of evidence-based practices that address social-emotional concerns.

2. **Fidelity of Implementation**
   Develop a system of follow-up support for practitioners to ensure content of training and practices are implemented with fidelity.

3. **Qualified Personnel**
   Strengthen the expertise of current personnel and partner with statewide initiatives to increase the availability of early intervention personnel who have infant mental health expertise and provide culturally appropriate services.

4. **Partnerships and Resources**
   Collaborate and share resources with Early Head Start (EHS), home visiting, and other state and local initiatives to increase access to services and resources for families, and training for early intervention practitioners on social-emotional skills and social relationships.

5. **Assessment**
   Enhance statewide implementation of high-quality functional assessment and COS rating processes.

6. **Accountability**
   Expand the general supervision and accountability system to support increasing data quality, assessing progress toward improving children's social-emotional skills and social relationships, and improving results for children and families.

These broad improvement strategies were reviewed and approved by the Leadership Team during a call on February 12, 2015. The implementation of these strategies will lead to the following: 1) ESIT enhancing infrastructure to support LLAs, 2) LLAs supporting and supervising personnel to provide evidence-based services, 3) providers implementing culturally appropriate, evidence-based services for children and families, 4) families increasing their capacity to support their children's social-emotional development, resulting in 5) improved social-emotional outcomes for children.

4(b) How Improvement Strategies are Sound, Logical and Aligned

The Leadership Team and ESIT staff, with the guidance of TA consultants, spent time developing solid strategies that will lead to improvement of children's social-emotional development. The improvement strategies are sound and logical because they were created based on the root cause and infrastructure analyses.

The strategies are aligned because each strategy is interrelated; to be successful, no individual strategy can be carried out in isolation. The fidelity of implementation will be supported through an enhanced system of professional development. Joining with other state initiatives that support social-emotional development will help ESIT leverage resources for training and the preparation of qualified personnel. Through these qualified personnel, assessment processes will be improved, evidence-based practices will be implemented, and accountability measures focusing on improved results will be strengthened.

During the infrastructure analysis, stakeholders identified existing state and local initiatives that could support SSIP efforts (see Component 2).

During a State Interagency Coordinating Council (SICC) meeting on January 21, 2015, members identified additional initiatives. Initiatives specific to social-emotional development include the following:

- Families in Transition (FIT)
- Frontiers of Innovation
- Universal Developmental Screening efforts
- Essentials for Childhood
- Healthier Washington
- Results Washington
- DEL Infant Toddler Childcare Consultation
- University of Washington Childcare Quality and Early Learning Center for Research and Professional Development
- University of Washington Institute for Learning and Brain Sciences
- THRIVE Washington

Representatives from a number of these initiatives have been invited and have agreed to participate in Phase II SSIP activities.

4(c) Strategies that Address Root Causes and Build Capacity

1. **Professional Development** was chosen as an improvement strategy because the need for training in a variety of topics was identified in both the root cause and infrastructure analyses. The specific root causes this strategy addresses are:

- Limited writing of functional Individualized Family Service Plan (IFSP) outcomes for social-emotional concerns
- Inconsistent team knowledge of typical social-emotional development
- Insufficient knowledge and use of evidence-based practices
- Need for culturally competent staff and culturally relevant services

In addition, the infrastructure analysis identified the following training needs:

- Infant Mental Health and reflective supervision
- Cultural competency
- COS rating process
- Typical social-emotional development of children

2. **Fidelity of Implementation** was selected as a strategy to follow an implementation framework. Once the professional development/training activities occur, there will be a system in place to ensure that full implementation is reached. Providers will be trained on evidence-based, culturally competent practices, which need to be effectively provided to ensure improved child outcomes. The specific root causes this strategy addresses are:

- Insufficient knowledge and use of evidence-based practices
- Need for culturally competent staff and culturally relevant services

3. **Qualified Personnel** was identified as a strategy because there is inconsistency across the state with early intervention providers who are Infant Mental Health-Informed and with access to Infant Mental Health Specialists to provide consultation or services. This strategy addresses the following root causes:

- Inconsistent availability of intensive social-emotional services
- Inconsistent availability of Infant Mental Health Specialists and services
- Need for culturally competent staff and culturally relevant services

4. **Partnerships and Resources** was identified as a strategy because, as indicated in Component 4(b), there are a number of state and local initiatives that align with the SSIP efforts toward improving social-emotional development. By partnering with existing social-emotional initiatives, ESIT will leverage these resources to work toward improved social-emotional outcomes. This strategy addresses the following root causes:

- Inconsistent availability of intensive social-emotional services
- Inconsistent availability of Infant Mental Health Specialists and services
- Need for culturally competent staff and culturally relevant services

5. **Assessment** was chosen as an improvement strategy because there were a number of concerns regarding assessment practices identified through the root cause and infrastructure analyses. The following are the root causes that this strategy addresses:

- Inconsistent use of a sensitive assessment tool to identify social-emotional concerns
- Inconsistent understanding of the COS rating process
- Need for increased parent involvement during assessment and the COS rating process

In addition, the infrastructure analysis identified the following needs in this area:

- Concerns about accuracy and consistency of COS ratings
- Limitations of tools used for assessment of social-emotional development

6. **Accountability** was selected because a number of concerns were raised in the infrastructure analysis about data quality and consistency of COS ratings. The specific root causes this strategy addresses are:

- Inconsistent understanding of the COS rating process
- Need for increased parent involvement during assessment and the COS rating process

In summary, ESIT's improvement strategies address the root causes identified through data analysis and the system component needs identified through infrastructure analysis. In addition, the improvement strategies reflect, and are consistent with, the key elements of the implementation process described by the ECTA center.

4(d) Strategies Based on Data and Infrastructure Analyses

As reflected in Component 4(a), through the data and infrastructure analyses, root causes were identified which informed the selection of improvement strategies.

For example, one theme that emerged from both the root cause and infrastructure analyses was the need for more provider training. The following training topics were identified:

1. Typical social-emotional development
2. Infant mental health
3. Reflective supervision
4. Cultural competency
5. COS rating process
6. Writing functional outcomes specific to social-emotional development
7. Evidence-based practices that address social-emotional concerns

As a result, these topics are embedded in the broad improvement strategies.

The flow of activities to implement the broad improvement strategies are described in the Theory of Action (see Component 5). Improvement strategies will be implemented at multiple levels – state, local, provider and family. The implementation of these strategies will lead to the following: 1) ESIT enhancing infrastructure to support LLAs, (2) LLAs supporting and supervising personnel to provide evidence-based services, 3) providers implementing evidence-based services for children and families, 4) families increasing their capacity to support their children's social-emotional development, resulting in 5) improved social-emotional outcomes for children.

4(e) Stakeholder Involvement in Selecting Improvement Strategies

Stakeholders were involved in selecting improvement strategies in a variety of ways. The Leadership Team engaged in discussion about the strategies during a call in December 2014. TA consultants and ESIT staff further organized the strategies. Leadership Team members completed a survey to prioritize the strategies by providing input on 1) the likelihood that each improvement strategy would be achieved, and 2) the likelihood that each strategy would have a positive impact on children's social-emotional development. In February 2015, approximately 75 stakeholders discussed the strategies and provided input during meetings on the east and west sides of the state and during the State Interagency Coordinating Council meeting.

Component 5:

Theory of Action

5(a) Graphic Illustration

*See Attachment I- Theory of Action

Washington State Department of Early Learning

Theory of Action

Early Support for Infants and Toddlers

Strands of Action	If DEL/Early Support for Infants and Toddlers	Then Local Lead Agencies and/or Early Intervention Program Administrators	Then Early Intervention Providers	Then Families and Children	Then
Professional Development for Early Intervention Services	...enhances the statewide system of professional development for early intervention services and designs a system of sustained follow-up support to ensure practices are implemented with fidelity....	...will assure ongoing support and supervision of the personnel who are providing culturally appropriate, evidence-based services for children with social-emotional needs...	...will create high-quality, functional IFSP outcomes and strategies related to social-emotional skills and social relationships, and implement evidence-based practices, including coaching parents and caregivers, to address social-emotional needs of all children...	...will receive culturally appropriate and evidence-based social-emotional services, ...will have increased capacity to support and encourage their children's positive social-emotional development, and ...will achieve their individual IFSP outcomes.	**...there will be an increased percentage of infants and toddlers with disabilities who will substantially increase their rate of growth in positive social-emotional skills, including social relationships, by the time they exit the early intervention program.**
Qualified Personnel	...strengthens the expertise of current early intervention personnel to become infant mental health informed, and partners with statewide initiatives to increase the availability of infant mental health specialists for consultation...	...will support early intervention personnel to become infant mental health-informed practitioners and make efforts to recruit and retain diverse providers...	...will have more knowledge about infant mental health-informed practices, have access to infant mental health specialists for consultation, and represent the diversity of the children and families they serve...		
Assessment	...enhances statewide implementation of high-quality functional assessment and COS rating processes...	...will-provide ongoing support and supervision of the implementation of high-quality, functional assessment and COS rating processes...	...will (1) use appropriate assessment tools to identify infant or toddler social-emotional needs, (2) use multiple sources of assessment information, (3) include families in both the assessment and COS rating processes, and (4) use Informed Clinical Opinion to determine eligibility in the social-emotional domain...		
Accountability	...expands the general supervision and accountability system to support improving data quality, assessing progress, and improving results...	...will review and utilize COS reports to determine if (1) training is needed to improve data quality, (2) children are making sufficient progress in their early intervention program, and (3) make program-level improvements as appropriate...	...will provide accurate and consistent COS data, assess progress of children served, and make practice adjustments...		

The Theory of Action is divided into four strands of action:

1. Professional Development for Early Intervention Services
2. Qualified Personnel
3. Assessment
4. Accountability

The strands are a starting point for the Theory of Action that originated from the broad improvement strategies. The 'Professional Development' and 'Fidelity of Implementation' improvement strategies are both incorporated into the first strand, titled 'Professional Development for Early Intervention Services'. The 'Qualified Personnel' and 'Partnerships and Resources' strategies are both incorporated into the second strand, titled 'Qualified Personnel'.

The Theory of Action describes a flow of action steps from the State Lead Agency, Department of Early Learning (DEL)/Early Support for Infants and Toddlers (ESIT), to Local Lead Agencies (LLAs), to early intervention providers, to children and families, to the State Identified Measurable Result.

5(b) How Improvement Strategies will Lead to Improved Results

The first strand of the Theory of Action is Professional Development for Early Intervention Services. The rationale for this strand is described as follows: If the ESIT program enhances the statewide system of professional development and designs a system of sustained follow-up support to ensure that practices are implemented with fidelity, then the next step is that LLAs and/or early intervention program administrators will assure ongoing support and supervision of providers. If that occurs, then early intervention providers will receive the necessary training and follow-up support to provide evidence-based practices. Then families will increase their capacity to support their children's development so that children will demonstrate improvement in their social-emotional skills and social relationships.

The second strand is Qualified Personnel. In this strand, the action step for ESIT is to join with other statewide initiatives to increase the availability of infant mental health-informed providers. If this happens, then LLAs and/or early intervention program administrators will support their staff to participate in training. Then early intervention providers will have more knowledge about infant mental health. As a result, families will

receive culturally competent, evidence-based services, which will lead to children demonstrating improvement in their social-emotional skills and social relationships.

The third strand is Assessment. The action for ESIT is to enhance statewide implementation of functional assessment and the COS rating process. If this happens, then LLAs and/or early intervention program administrators will be better able to provide ongoing support and supervision of these processes to providers. Then early intervention providers will take appropriate steps to assess children's social-emotional development. If this occurs, then families will have increased capacity to support their children's social-emotional development and children will demonstrate improvement in their social-emotional skills and social relationships.

The fourth strand is Accountability. The rationale for this strand is as follows: If ESIT expands the general supervision and accountability system, then LLAs and/or early intervention program administrators will have the support needed to train their providers and will use their data to make improvements. Then early intervention providers will have accurate and consistent data to make practice adjustments, as needed, to improve services to children and families. As a result, children will demonstrate improvement in their social-emotional skills and social relationships.

In summary, there is a high likelihood that the theory of action will lead to a measureable improvement in the SIMR. The strands of action are based on in-depth data and infrastructure analyses, DEC recommended practices, and ECTA Center implementation framework.

5(c) Stakeholder Involvement in Developing the Theory of Action

Stakeholders were involved in creating the Theory of Action in a variety of ways. ESIT staff, with the support of TA consultants, developed an initial draft of the Theory of Action in January 2015. The Leadership Team engaged in discussion of the draft during a call on February 12, 2015. Stakeholder meetings were held on February 18 and 24, in Spokane and Tumwater, and a State Interagency Coordinating Council meeting was held on February 25. During these three meetings, approximately 75 participants worked in small groups and responded to the following questions:

1. Is the Theory of Action understandable?

2. Does it demonstrate the flow of work from the state to local programs to providers to children and families?
3. How would you use this document at the local level to describe SSIP?
4. Do you think this plan will effect change? Why or why not?

Stakeholders provided very useful input that ESIT staff summarized for a Leadership Team call on February 27. The Leadership Team reviewed all of the feedback and recommended the input that was then integrated into the Theory of Action.

Ashmun, Connie
Regional Coordinator Disabilities, Puget Sound Educational Service District, Renton

Barnes, Maryanne
Director, Birth to Three Development Center, Federal Way

Bersch, Janelle
Early Childhood Coordinator, North Central ESD 171, Wenatchee

Cromar, Magan
Early Intervention Program Manager, King County DDD, Seattle

Denman, René
Director, Toddler Learning Center, Oak Harbor

Greenwald, Lisa
Chief Program Officer, Kindering, Seattle

Hall, Carol
Early Childhood Director, ESD 112, Vancouver

Hill, Sheri
Early Childhood Policy Specialist

Kardes, Ivy
Special Education Coordinator, Griffin School District, Olympia

Mbajah, Nelly
Early Childhood Program Mgr., Children's Admin., Dept. of Social and Health Services

O'Brien, Colleen
Part C Program Manager, Spokane Regional Health District, Spokane

Turcotte, Mary
Early Intervention Specialist, Olympia School District, Olympia

Wilson, Brayde
Parent Infant Program Specialist, Hearing, Speech & Deafness Center, Seattle

Zapp, Connie
Director, Holly Ridge Center, Bremerton

April 3, 2014

April 9, 2014

April 22, 2014

May 2, 2014

July 21, 2014

August 4, 2014

August 13, 2014

September 3, 2014

September 19, 2014

October 20, 2014

November 24, 2014

December 2, 2014

February 12, 2015

February 27, 2015

Local Lead Agency (LLA) Meeting Schedule

Attachment C

November 13, 2013	Tacoma
November 19, 2013	Wenatchee
February 25, 2014	Chehalis
March 25, 2014	Ellensburg
May 21, 2014	Bremerton
May 28, 2014	Spokane
August 20, 2014	Seattle
August 26, 2014	Richland
November 4, 2014	Ellensburg
November 12, 2014	Everett
February 18, 2015	Tumwater
February 24, 2015	Spokane

Allen, Kylee
Service Provider: HeadStart

Arnold, Valerie
State Education Agency

Barnes, Maryanne
Service Provider

Bushaw, Stacey
Health Care Authority

Cromar, Magan
Service Provider

Denman, René
Service Provider

DuBois, Paul
State Insurance Agency

Frangomeni, Anna
Parent

Geneman, Major Bonnie
Military

George, Janet
Agency: Services for the Blind

Greenwald, Lisa
Service Provider

Gunshows, Margaret
Tribal

Kocher, Amy
Parent

Ladwig, Darci
Parent

Lavik, Jena
Parent

Liebe, Dr. Diane
Service Provider: Physician

Nardella, Maria
State Health Agency

Quiqley, Kevin
DSHS Agency

Quiqley, Suzanne
Service Provider

Sanchez, Sugely
Parent

Sawyer, Representative David
Legislature

Spybrook, Janet
Personnel Preparation

Williamson, Greg
State Lead Agency

Assessment/Tools

1. Do your families have an opportunity to see the COS and family interview questions prior to the interview?

2. What interview format(s) does your team use to get family and child assessment information specific to social-emotional development for the IFSP and COS rating?

3. What tools are used by your team to get family and child assessment information for the initial IFSP and COS rating? For periodic reviews? For annual IFSP meetings?

4. How does your team select assessment tools? For example, do you have criteria to determine if a new assessment tool is needed or which tool will be purchased? Are resources available to purchase new tools

5. Are the current assessments you use culturally relevant to the children your team serves and given in their native language?

6. Does your team have a tool sensitive enough to measure social-emotional development, if needed?

7. How does your team consider social-emotional needs even when the tool is not the most sensitive?

8. Who is doing the assessment and do they have training in social-emotional development? (Do they have training on using the tool? Do you have resources to support training?)

9. How are your team members connecting the assessment with the child outcomes rating process?

10. Describe how team members are gathering family information. To what extent do team members feel competent and confident in interpreting the functional information about children's social-emotional skills?

Services

11. Do your IFSP teams write individual outcomes for intervention for children with social-emotional concerns?

12. What is the basic level of social-emotional supports provided to all children and families? What is the high level of support? What supports do you have access to in the community?

13. Does your team provide or partner with licensed infant mental health specialists? If yes, at what point?

14. What kind of social-emotional intervention services are in your IFSPs (who provides and how much, etc.)?

15. What are the barriers to social-emotional services (i.e. training, travel)? How does funding impact your ability to hire licensed infant mental health specialists?

16. What are some examples of culturally competent practices in your program related to social-emotional needs?

17. What evidence-based interventions in natural environments are your team members using?

18. Do your strategies include coaching of families in regards to supporting or facilitating social-emotional development with their child?

19. Do your IFSPs include any family outcomes?

20. What supports are currently being offered to parents who have mental health needs?

21. Do families' needs exceed the scope of training of your team?

Teaming – Including Family and FRC

22. Who participates in which steps of the COS rating process? What steps do families participate in the process?

23. How is information shared between the FRC and the rest of the team throughout the evaluation process?

24. How many times and for how long do providers in your area meet with the family prior to deciding the COS rating?

25. How does your team support and/or coach each other about families you work with?

26. Which service providers address social-emotional skills on your team (OT, PT, SLP, Teacher) prior to making a referral to a licensed infant mental health specialist?

27. Is there a licensed infant mental health specialist available to consult with your team? Do they provide any training to your team members? And if so, on what topics?

28. What supports and/or supervision are in place to ensure that your team members are delivering culturally competent social-emotional services?

29. Does your team include providers with the same culture/ethnicity as the families you serve?

Training

30. Describe your comfort level in your knowledge about social-emotional developmental skills?

31. Do your team members have training around VERY young infants and toddlers? What is your understanding of what typical social-emotional development looks like for children under 1 year old?

32. What types of training on social-emotional development in young children are currently available to your team members?

33. What types of training have your team members received about writing functional outcomes regarding social-emotional development in young children? Regarding evidenced-based interventions?

34. What kinds of resources specific to social-emotional development are your team using to support your COS rating discussions?

35. What types of training have your team members received on cultural awareness?

36. What COS training is provided to new team members?

37. How do you address ongoing COS training needs?

38. How are the processes for entry and exit ratings the same? How are they different?

Summary

39. Why do you think Washington's social-emotional outcome ratings are lower than the national average?

40. Is there anything else you'd like to share?

ESIT: SSIP Survey 11-2014

1. There are many elements that contribute to high quality COS ratings. Please rank the following items in order of importance in relation to high quality COS ratings, with 1 as MOST important and 6 as LEAST important.

	1	2	3	4	5	6
Knowledge of the COS process	○	○	○	○	○	○
The evaluation and assessment process	○	○	○	○	○	○
Active and engaged family involvement throughout the evaluation, assessment, and COS rating process	○	○	○	○	○	○
Culturally competent providers and services	○	○	○	○	○	○
IFSP team (FRC, Educator, SLP, OT, PT) knowledge of social-emotional development	○	○	○	○	○	○
Consultation from Infant Mental Health Specialists	○	○	○	○	○	○

2. For the following questions, consider how important you think each element is, independent from the other elements.

	1 - Not at all	2 - Very little	3 - Some	4 - Very much	5 - To a great extent
***To what extent does knowledge of the COS process contribute to high quality COS ratings?**	○	○	○	○	○
*To what extent does the evaluation and assessment process contribute to high quality COS ratings?	○	○	○	○	○
***To what extent does active and engaged family involvement throughout the evaluation, assessment, and COS rating process contribute to high quality COS ratings?**	○	○	○	○	○
*To what extent do culturally competent providers and services contribute to high quality COS ratings?	○	○	○	○	○
***To what extent does IFSP team (FRC, Educator, SLP, OT, PT) knowledge of social-emotional development contribute to high quality COS ratings?**	○	○	○	○	○
*To what extent does consultation from Infant Mental Health Specialists contribute to high quality COS ratings?	○	○	○	○	○

3. There are many elements that contribute to children's development of social-emotional skills. In this section, consider how these elements contribute to improvement in children's social-emotional development during their participation in early intervention services.

Please rate the following items in the order of importance in relation to improvement in children's social-emotional development, with 1 as MOST important and 6 as LEAST important

	1	2	3	4	5	6
Active and engaged family involvement throughout a child's participation in a program	○	○	○	○	○	○
Culturally competent providers and services	○	○	○	○	○	○
Early Intervention Services	○	○	○	○	○	○
IFSP team (FRC, Educator, SLP, OT, PT) knowledge of social-emotional development	○	○	○	○	○	○
Consultation from Infant Mental Health Specialists	○	○	○	○	○	○
Use of evidence-based practices	○	○	○	○	○	○

4. For the following questions, consider how important you think each element is, independent from the other elements.

	1 - Not at all	2 - Very little	3 - Some	4 - Very much	5 - To a great extent
*** To what extent does active and engaged family involvement throughout a child's participation in a program contribute to improvement in a child's social-emotional development?**	○	○	○	○	○
*To what extent do culturally competent providers and services contribute to Improvement in a child's social-emotional development?	○	○	○	○	○
***To what extent do early intervention services contribute to improvement in a child's social-emotional development?**	○	○	○	○	○
*To what extent does IFSP team (FRC, Educator, SLP, OT, PT) knowledge of social-emotional development contribute to improvement in a child's social-emotional development?	○	○	○	○	○
***To what extent does consultation from Infant Mental Health Specialists contribute to improvememnt in a child's social-emotional development?**	○	○	○	○	○
*To what extent do evidence-based practices contribute to improvement in a child's social-emotional development?	○	○	○	○	○

5. Do you have access to an Infant Mental Health Specialist to consult with?

○ Yes

○ No

6. Do you have access to an Infant Mental Health Specialist to provide direct services to children and families?

○ Yes

○ No

7. What is the LLA for the area you serve?

	Local Lead Agency	2nd Local Lead Agency	3rd Local Lead Agency	4th Local Lead Agency
Choose one from Menu 1. If you serve more than one area, please choose your next area from Menu 2 (and so on).				

8. Do you have any additional comments you'd like to share?

9. Please mark the box that best describes your role in early intervention:

- ○ LLA
- ○ FRC
- ○ Service Provider
- ○ Other (please specify)

Thank you for your participation!!

Done

Governance

Direct Leverages:

- Strong interagency agreements with local partners
- Alignment within DEL
- Transfer state funds to DEL

Indirect Leverages:

- Partnership with the Center for Childhood Deafness and Hearing Loss
- Community collaboration
- Interagency Coordinating Councils (state and county)
- Communication between state office and local programs
- Clear, specific policies and procedures
- State and local flexibility in implementing change
- Use Nurse-Family Partnership model to encourage use of evidence-based practices
- Strengthen local training between Children with Special Health Care Needs and ESIT
- Collaborate with DDA to support a lifespan perspective
- Increase school district administrators' understanding of IDEA Part C
- Create parent leadership opportunities at state and local levels
- Strengthen training with primary care physician to address "what is early intervention?"
- Expand intentional focus on local partnerships
- Increase understanding with public health nurses and WIC to increase referrals
- Maximize collective impact for all youth, across agencies
- Create a civic group to give guidance to local programs
- Establish a cap on administrative rates retained by school districts

Direct Hindrances:

- Decentralized authority, inconsistent implementation of requirements
- Variety in local providers (school districts, providing agencies, private providers)
- Responsibility to implement Part C, but no state funds to do so
- State budget constraints
- Inadequate funding
- Lack of funds available for training
- Limited purpose of COS
- Subjectivity of COS
- Variation in COS ratings locally

- School districts provide or contract for minimum services which can be inadequate

Indirect Hindrances:

- Local control and focus on community-specific issues
- Lack of consistency between school districts, medical providers and specialists
- Continual training needed for providers and funders due to turn-over in staff
- Rigidity in timelines
- Using COS data in a punitive way and for systems level decisions
- Multiple levels of fiscal decision making within organizations
- Disproportionality in funding, services, outcomes, access, culture and language
- Different insurance reimbursement rates
- Impact of separate funding silos
- Lack of consistency in requirements across insurance companies
- System of Payments and Fees Policy potentially limits early intervention services
- Transition procedures vary significantly between school districts
- The 45 day timeline for evaluation is inadequate

Fiscal

Direct Leverages:

- State Special Education funding
- County DD eligibility aligned w/Part C eligibility
- Some counties fund direct services B-3 (DDA)
- Autism benefits (B-3)
- Some programs can bill for services (accessing all funds)
- Communicate benefits of EI and early learning
- Develop a plan to submit to legislature requesting funds to support SSIP work
- Medicaid is trying to come up with ways to bill for services (IMH S/E)
- Increase in Medicaid $$ to fund more Part C services (FRC)

Indirect Leverages:

- Small grants (flexibility) w/in programs
- Some federal funds available to support work
- Bring OSPI funding into DEL (at state)
- Change to have a Medicaid EI program
- Certifying FRCs to bill Medicaid (licensure, training, etc.)

Direct Hindrances:

- Inconsistent public funding distribution – from none to a variable amount

- Different reimbursement amounts and requirements (school districts) from different providers
- Inconsistent funding – siloed system
- Wide variability of what school districts pay for, i.e. how much and what kind of services
- Insurance (minimal or non-existent) doesn't cover service costs
- Inability to bill insurance
- Need to stretch dollars further
- Limited federal funds, no state funds to support statewide SSIP activities
- ESIT does not control major funding sources
- DDA funding levels (fixed, inequitable)
- Inequity between public and private insurance
- SOPAF – families choosing to reduce services

Indirect Hindrances:

- Funding from DDA is inconsistent and no allocation per child
- Funding siloes and different expectations for managing the funds
- Some programs lack access to school district funding
- Expectation of 12 month services/SDs receive funds on 9 or 10 month services (budget office needs to understand 12 month services)
- Cost of billing insurance (time, etc.)
- Have to fundraise (in some programs)
- Federal allocation is not addressing numbers served
- Too many audits, too many funders (not aligned)
- Federal dollars not keeping pace with increase in caseload

Quality Standards

Direct Leverage:

- Doing better at natural environments statewide

Indirect Leverages:

- Multi-disciplinary
- Collaborative inter-agency agreements
- Universal developmental screening
- More standardized way to gather COS data
- Exploring screening tools that are sensitive to social-emotional development, e.g. DECA
- Training about COS
- Parent training/coaching

Direct Hindrances:

- Kids falling through cracks
- Inconsistency of services
- Lacking consistency across state – access and implementation of services
- We don't have the resources to provide Evidence-Based Intervention
- Lack of training/therapists needing to provide infant mental health
- Lack of ECMH providers
- Not enough qualified personnel
- Cultural competency

Indirect Hindrances:

- COS subjective, guessing, not always a team, flawed
- Not standardized administration (COS)
- FRCs – no required standard (e.g. Bachelor's) early child development training
- Implementation/training
- EI standards don't match medical model
- Medical model/providers with different perspectives/school models
- Doctors not referring
- Assessment and screening tools may not be sensitive to specific populations and social-emotional development
- Decentralized system leads to different beliefs about quality
- Too narrowly defining re: quality in service provision/natural environments
- Funding issues
- Lack of resources in smaller counties (related to funding)
- Insurance reimbursement for medical model
- Inconsistent funding
- Funding for training
- Staff shortages
- Great things happening that aren't on IFSP "other"
- Not enough time (team time and 45 day)

Professional Development

Direct Leverage:

- Understanding typical development (for COS rating)

Indirect Leverages:

- Trans-disciplinary teams for COS
- Distance learning opportunities
- Infant and Early Childhood Conference

Direct Hindrances:

- Availability and depth of training (especially IMH – reflective supervision)

- Training on cultural competency
- Training on child development for COS
- Varying levels of knowledge about COS rating and typical development

Indirect Hindrances:

- Loss of trained staff due to money
- Time to do online modules
- Agency differences in training and culture
- No mandate for all providers for Part C training
- COS training not mandated
- Hard to recruit and retain qualified providers
- Loss to other higher paying systems
- Equipment to support training
- Time available for training
- Funding for training
- Geography – travel to training

Data

Direct Leverages:

- Families participation in rating process
- Comprehensive data system in place
- Possibility of common ID number

Indirect Leverages:

- Parent Portal
- Enhanced practice guide/COS

Direct Hindrances (none listed)

Indirect Hindrances:

- More TA, training around COS process
- Informing families about the importance of the COS process

Technical Assistance

Direct Leverages:

- Ongoing mentoring/TA after basic training
- No accuracy/consistency of data entry/reports
- Poor accuracy/consistency of COS

Indirect Leverages (none listed)

Direct Hindrances (none listed)

Indirect Hindrances:

- Staff turnover
- Funding issues to implement practices/TA

Accountability/Monitoring

Direct Leverages:

- DMS Quarterly monitoring
- Technical Assistance available
- Self-Assessment Tool
- DMS/Reports available
- More practice guides around work group/play group

Indirect Leverages:

- Discuss family survey at intake – this is what we hope to accomplish
- Outcomes by agency/FRC
- Measure achievement of child/family
- Clear expectation for summary of functional performance
- COS: Validity of outcome measures report

Direct Hindrances:

- Get stuck in one tool/limiting
- Quality of rating – COS
- Inconsistent data entry

Indirect Hindrances:

- Inconsistent input from family survey
- Useful Reports
- DMS too scripted (routines)

State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

Purpose of the Survey

Over the past several months of SSIP information gathering, a variety of possible social-emotional related improvement strategies have been identified. As an SSIP Leadership Team member, we would like you to think about the improvement strategies that you believe *will most likely be implemented by providers* and we would like you to identify the*improvement strategies that you believe will have the most direct impact on children's social-emotional development and skills.*

Therefore, based on your perspective and opinion, please respond to each improvement strategy with the following two criteria in mind:

1) How likely will the identified improvement strategy be implemented over the next several years?

2) How likely will the identified improvement strategy have a positive impact on a toddler's social-emotional develop and skills.

Based on your responses, the SSIP Leadership Team will discuss and prioritize the improvement strategies.

This survey will take approximately 10-15 minutes to complete and the results will be discussed on upcoming SSIP Leadership calls. Please complete the survey by December 19, 2014.

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

Instructions for survey

Each improvement strategy will require you to assign a rating based on the statements listed below:

1) How likely will the improvement strategy be implemented by LLAs/providers over the next several years?

2) How likely will the improvement strategy have a positive impact on a toddler's social-emotional develop and skills.

The rating scale will consist of 3 options:

1. **Very likely (probable)**
2. **Most likely (possible)**
3. **Not likely (very remote)**

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

1. Identify an assessment tool specific for social emotional development.

	Very likely(probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills.	○	○	○

Comments

2. Explore the development of an infant IFSP to better meet the needs of newborns and thier families

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills	○	○	○

Comments

3. Collaborate with Early Head Start and Home Visiting programs to increase access to social emotional resources and to increase knowledge of social emotional development .

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills.	○	○	○

Comments

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

4. Develop a system of follow up support for practitioners that includes mentoring, reflective supervision and observation, etc. to ensure training content and practices are implemented.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

5. Will utilize revised ESIT child outcomes online training modules and receive follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

6. Identify and explore exisitng cultural competency trainings and resources already in use with a plan to expand statewide with follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

7. Develop training on writing functional IFSP outcomes in the area of social emotional development and provide follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

8. Revise the *"Evaluation, Assessment and Eligibility Practice Guide"* to provide clarity regarding the need for active parent involvement in the evaluation, assessment, COS rating selection and eligibility determination process.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments)

9. Create a pool of individuals across the state who are certified in infant mental health.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

10. Recruit, retain and train bi-cultural staff and provide follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the identified improvement strategy **be implemented** over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

11. Revise *"Self-Assessment Tool"* to include questions about how parent involvmement in the COS process occurs.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

12. Modify LLA contracts and interagency agreements, as needed, to reflect the new technical assistance follow-up support structure .

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

13. Develop local LLA administrator's guide, provide training and follow up support for performing periodic COS data reviews.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

14. Provide training on integrating the *Child Outcome Summary* process with the IFSP process that also includes providing follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

15. Provide training on a social emotional assessment tool with follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

16. Train on the use of *"Informed Clinical Opinion"* in determining eligibility using the ICO Practice Guide and other resources.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

17. Require all new early intervention staff or others to complete ESIT's early intervention training modules.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

18. Provide DMS COS report training and follow up support.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

19. Provide training and follow up support on the revised *"Self-Assessment Tool"*.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

20. Providers will consistently use appropriate assessment tools to identify social emotional needs and skills.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

21. LLA Administrators will utilize DMS COS reports to assess progress and help develop program improvement strategies.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

22. Providers will access infant mental health experts when available.

	Very likely (probable)	Most likely (possible)	Not likely (very remote)
How likely will the improvement strategy **be implemented** by LLAs/providers over the next several years?	○	○	○
How likely will the improvement strategy **have a positive impact** on a toddler's social-emotional develop and skills?	○	○	○

Comments

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State Systemic Improvement Plan(SSIP) Improvement Strategies Impact Survey

Thank you!

Thank you for your participation and valuable input to the SSIP development process.

Prev Done